Northern Case Management Limited

Head Office

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an announced inspection which took place on 19 October 2016. The service was previously inspected in December 2013 when it was found to be meeting all the regulations we reviewed at that time.

Head Office, Northern Case Management (NCM) is situated in a business complex close to Bury town centre. The service is registered to provide domiciliary rehabilitation and support to adults and children with acquired brain and spinal cord injury. At the time of our inspection there were five people using the service.

There was a registered manager in place at the time of the inspection. 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. The registered manager was supported by a team of professionally qualified case managers. Case managers were responsible for assessing facilitating, planning and advocating for the individual needs of people who used the service. A team of support workers was in place to provide the care each individual required, under the direction and supervision of a case manager.

We found the provider's recruitment procedure needed to be improved in order to fully protect people who used the service from the risk of unsuitable staff. This was because additional checks had not been completed for those applicants who had previously worked with vulnerable adults or children. The registered manager told us the recruitment processes would be changed with immediate effect.

Staff were recruited to work specifically within a team supporting a particular individual. People who used the service or their relatives were involved in the recruitment process. Staff received a comprehensive induction programme when they started work at the service; this included mandatory training as well as an introduction to the values and policies of the organisation. Staff told us they were well trained and received the supervision and support they required to be able to carry out their roles effectively.

People we spoke with during the inspection provided positive feedback about the caring nature of staff. Staff told us they were committed to improving people's quality of life and promoting the independence of the people they supported. People were involved in reviewing the care they received and identifying the goals they wished to achieve.

Staff had a good understanding of how to keep people safe and protect their rights should they be unable to consent to the care and support they required. The registered manager and case managers were aware of the action to take should care practices amount to a deprivation of liberty under the MCA.

Care records we reviewed contained risk assessments and detailed information for staff to follow in order to manage the identified risks. The safety of people's home environment was also regularly monitored by staff.

People were supported to access health services. Staff monitored people's nutritional needs and encouraged individuals to maintain a healthy diet.

A number of quality assurance processes were in place including the monitoring of complaints, accidents and incidents. Regular feedback was also sought from people who used the service and their families. All the staff we spoke with demonstrated a commitment to continuous service improvement. Staff also told us they felt their views were listened to and acted upon by senior managers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements needed to be made to the recruitment procedures in the service to ensure people were fully protected from the risk of unsuitable staff.

Staff had received training in safeguarding adults and were aware of the correct action to take should they witness or suspect abuse.

Risk assessments were in place to help ensure people received safe and appropriate care. Appropriate systems were in place for the safe handling of medicines.

Is the service effective?

Good

The service was effective.

Staff had a good understanding of the MCA. There was a commitment to encouraging people to make their own decisions and choices. Staff were aware of the action to take to protect people's rights should they lack the capacity to make decisions about their care and treatment.

Staff received the necessary induction and training to allow them to carry out their role effectively and safely. Systems were in place to ensure staff received regular support and supervision.

People who used the service received the support they required to be able to access the health services they needed.

Is the service caring?

Good

The service was caring.

During the inspection staff were observed to be respectful and caring in their approach. People made positive comments about the caring attitude of staff.

Staff demonstrated a commitment to providing person-centred

care which supported people to achieve their goals.

Staff were aware of their obligations to ensure the confidentiality of people's personal information was maintained.

Is the service responsive?

Good

The service was responsive.

People we spoke with during the inspection told us the care provided was appropriate to their needs or those of their family member. People were involved in developing and reviewing support plans.

Systems were in place to respond to any concerns or complaints people wished to make.

Staff supported people to develop and maintain their social contacts and interests; this helped to promote people's well-being.

Is the service well-led?

Good

The service was well-led.

The service had a manager who was registered with the Care Quality
Commission. All the staff we spoke with demonstrated a commitment to a process of continuous improvement in the service.

Systems were in place to assess and monitor the quality of the service provided. Arrangements were in place to seek and act upon feedback from staff, people who used the service and their families.

Head 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 October 2016 and was announced. In line with our current methodology we gave the provider 48 hours' notice that we were undertaking this comprehensive inspection; this was to ensure that the registered manager and staff were available to answer our questions during the inspection. This announced inspection was carried out by one adult social care inspector.

Before the inspection we asked the provider 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 what improvements they plan to make. Prior to the inspection we reviewed the PIR and looked at information we held about the service and provider, including notifications the provider had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted a number of professionals who were responsible for organising and commissioning the service on behalf of individuals and their families; feedback received is included within the full report.

During the inspection we visited the registered office and spoke with the registered manager, the two directors of the service, the training coordinator and five case managers. With their permission we visited one person who used the service in their own home and spoke with two support workers. Following the inspection we spoke by telephone with a relative.

During the inspection we reviewed the care records for four people who used the service and the completed medication records for one person. In addition looked at a range of records relating to how the service was managed; these included staff recruitment and training records, quality assurance processes and policies and procedures.

Requires Improvement

Our findings

People we spoke with told us they had no concerns about the safety of the support provided by staff from Head Office, NCM. Comments people made to us included, "I am confident that [name of relative] is safe" and "I feel safe. They [staff] protect my interests and won't let anything bad happen to me."

We looked at the personnel files for five staff employed to work in the service to check if there was a safe system of recruitment in place. We noted that all of these files contained an application form, at least two references and a criminal records check, called a Disclosure and Barring service check (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. However we noted that the provider's recruitment procedure did not include undertaking the additional checks required when applicants had worked previously with vulnerable adults or children. These checks help to ensure that people are not appointed who are unsuitable to work with vulnerable groups. The provider told us they would ensure the recruitment procedure was updated immediately and a review completed to ascertain for which staff these additional checks were required.

We were told that staff were recruited to work with a specific individual, rather than across the service, and that each person had a small team of staff who supported them. This meant that, wherever possible, the person who used the service or their family were involved in the recruitment process; this was confirmed by the relative we spoke with. Specific job descriptions were drawn up to reflect the support needs of the person who used the service, including their likes and dislikes as well as the preferred age and gender of the staff who would be caring for them. We were told that a number of bank staff were employed to cover sickness absence or annual leave if necessary and that these staff had received training in the specific needs of the people they could be expected to support.

Policies and procedures for safeguarding adults and children from harm were in place. These provided guidance for staff on identifying and responding to the signs and allegations of abuse. The staff we spoke with were able to tell us what action they would take if abuse was suspected or witnessed. They told us they would also be confident to use the whistleblowing (reporting poor practice) policy in place in the service. This told staff how they would be protected and supported if they reported abuse or other issues of concern.

Records we reviewed showed that staff had completed training in safeguarding adults. The case managers we spoke with told us that safeguarding was also regularly discussed during team meetings, supervision and

appraisal sessions. They told us support workers were also encouraged to regularly contact case managers should they have any concerns about a person for whom they were providing care and support.

We saw that a safe system of medicine management was in place. We were shown the policy and procedure in relation to the safe management of medicines that all staff had access to. We were told that all staff had completed training in the safe handling of medicines; our inspection of training records confirmed this information was correct. We also saw that competency assessments were regularly undertaken to ensure staff understood how to administer medicines correctly. The person we visited at home told us, "I used to get pain but I don't now. They [staff] always give me my painkillers; I appreciate this."

All the care records we reviewed contained detailed risk assessments relating to the needs of each individual; these included nutrition, moving and handling, the use of equipment and environmental risks in people's own homes. Risk management plans were in place to guide staff on the best way to support people safely. We saw that risk assessments had been regularly reviewed and updated when people's needs had changed. This should help to ensure staff provided safe and appropriate care to people who used the service.

We looked at the systems in place to reduce the risk of cross infection. We saw that staff had received training in infection control. Personal protective equipment (PPE) was provided for and used by staff when carrying out personal care tasks in people's homes; this should help prevent the spread of infection.

We noted that there was always a member of staff on call outside of office hours in order to provide advice to staff and people who used the service in the event of an emergency. The service also had a business continuity plan in place to inform of the action they should take in the event of a disruptive incident occurring such as the failure of the gas/electricity supply at a person's home or at the registered office. We saw that a personal emergency evacuation plan (PEEP) had been completed for all people who used the service; this provided information to staff about the support each person would require in the event of an emergency at their home.

Good

Our findings

People we spoke with told us staff from Head Office, NCM had the required skills to be able to deliver effective care to people. Comments people made to us included, "Staff are on top of all the training they need" and "I have no doubt that my clients lives are enriched and enhanced through their involvement with staff from NCM."

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005. The 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. However, people cared for in their own homes are not usually subject to DoLS.

The registered manager was knowledgeable about the provisions of the MCA, including understanding what level of care and support might amount to a deprivation of liberty in a person's own home, given that many of the people they supported required 24 hour care. They told us they were aware of the process to follow to ensure a person's rights were protected by way of an application to the Court of Protection by the responsible local authority and that regular discussions took place with social workers involved in people's care regarding this process.

We saw that all staff had received training in the MCA. Staff told us they would always ensure that they were providing care in the least restrictive manner possible. All the case managers we spoke with told us people's capacity to make decisions was regularly reviewed during their supervision sessions with support workers. They told us specialist assessments were also requested where necessary to help inform assessments of people's capacity to consent to their care and support. The person we visited at home told us they were always able to make choices about the support they received. They commented, "I can choose things for myself and everything is perfect."

People's care records contained assessments of each individual's capacity to make specific decisions in relation to their care and treatment. These included whether people were able to consent to taking their medicines as prescribed and the action staff should take if a person lacked capacity to make particular

decisions including organising meetings to decide what was in the person's best interests; this should help protect the rights of people who used the service.

We checked the arrangements in place to ensure staff had the necessary induction, training and supervision to help them deliver effective care. We looked at the induction pack for the service and saw this included training, shadowing experienced staff and the completion of administrative tasks. We spoke with the training coordinator employed by the service who confirmed that the induction programme included training in first aid, safeguarding and the MCA, moving and handling, fire safety and infection control. Staff were also provided with an individualised induction programme tailored to help them understand the particular needs of the person they had been employed to support; where appropriate this included training provided by health colleagues in epilepsy, diabetes and PEG feeding; PEG feeding allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus.

The staff members we spoke with confirmed they had received a comprehensive induction when they started work at the service. They told us they considered this had prepared them well for their role in supporting the individuals with whom they were employed to work. Staff also told us they received regular supervision and appraisal and were able to access additional training they felt necessary for their role. We saw that a central record was held of the supervision, appraisal and training completed by staff; this was regularly reviewed by the office manager to ensure staff were up to date in all areas.

Staff we spoke with told us they tried to ensure people they supported had a nutritious and balanced diet, either by making healthy choices on the person's behalf if they were unable to do so for themselves or by helping people to choose healthy options when shopping for food. We saw that nutritional risk assessments were completed when necessary and referrals made to specialist services such as dieticians or speech and language therapists. We noted advice received from professionals was included in the care records for staff to follow.

Staff told us they would usually accompany people who used the service to appointments with health professionals, although they would always ensure the person had a choice about whether staff were present during the consultation. One person told us, "I tell staff if I need to go to the doctor. They will come with me to help me communicate." We noted that care records included a 'patient passport'. This document included important information about each person's support needs and medical conditions and was given to health care professionals if the person needed to go to hospital; this should help to ensure healthcare staff had the information they needed to care for and support the person in the way they preferred.

Good

Our findings

We received complimentary feedback about the caring attitude of staff. Comments people made included, "I love my staff; they treat me perfectly well" and "[My relative] smiles and laughs a lot with staff so I know he is happy with them."

Staff we spoke with demonstrated a commitment to providing high quality care and to promoting people's independence as much as possible. A staff member told us, "Promoting independence is part of the ethos of what we do. We set goals with people and listen to them about what they want to achieve."

During the inspection we observed interactions between staff and people who used the service both in the registered office and in a person's own home. We saw that staff were respectful and caring in their approach and had a good rapport with people. All the staff we spoke with demonstrated respect for the fact that they were supporting people in their own homes. This meant people who used the service were central to any decisions made.

It was evident from our discussions with staff that they knew people who used the service very well. They were able to tell us about people's likes and dislikes and what support they required. Staff were also able to tell us about people's interests and hobbies and things that were important to them.

Records we reviewed showed there was a stable staff team in the service. This meant people who used the service had the opportunity to develop consistent relationships with the staff who supported them. We also saw that people's care records included information about their family, interests and preferred daily routines. This helped to ensure staff were able to develop meaningful and caring relationships with people who used the service.

Policies and procedures we reviewed included protecting people's confidential information and showed the service placed importance on ensuring people's rights, privacy and dignity were respected. We saw care records were stored securely in the registered office, although people also retained a copy of their records in their own property. Records we reviewed showed staff had received information about confidentiality and data protection to guide them on keeping people's personal information safe.

Good

Our findings

The care records we reviewed showed that case managers completed a comprehensive assessment of people's needs before they started to use the service; this helped to ensure that the appropriate staff team was in place to provide the support each individual required.

We saw that all the care records we reviewed contained care plans which described how people wished to be supported; this included information from family members about the person's wishes and preferences when the person was unable to communicate this for themselves. A family member we spoke with told us they considered that staff always provided the care their relative needed.

Records we looked at showed each person who used the service, or their family members as appropriate, had regular meetings with the team who provided their support. This meant the support plan was regularly updated to meet the person's needs. The relative we spoke with confirmed they had been involved in regular reviews with the staff team who supported their family member and were able to make any changes to the support plan they felt were required. The person we visited at home told us staff always responded appropriately to their needs. They told us, "I know I can change things if I want but everything is perfect."

All the care records we looked at had been regularly reviewed and updated when people's needs changed. Support workers told us they received regular updates from other colleagues in the team or the case manager responsible for organising the support plan regarding any changes in a person's condition or the support they wished to receive. A copy of each person's care records was held in the registered office. We noted the copy we reviewed in a person's home was up to date and matched the office copy; this meant everyone had access to up to date information about the support the person required.

Staff told us they would always encourage people to undertake activities they had previously enjoyed or to find new interests and experiences for people to try; this helped to prevent social isolation and promote people's well-being. One staff member commented, "We try to restore people's lives as close as possible to that they had pre-injury, if that is what they want. We find out what people's interests and goals are and link in to local resources to help them achieve these."

We saw there was a system in place for logging and responding to any complaints received by the service. There was a complaints policy in place which gave people information about the response they should expect if they raised any concerns about the support they received; this information was also included in the service agreement given to people when they started to use the service.

People we spoke with during the inspection told us they were aware of how to contact the office or the case manager responsible for their care or that of their family member. A system of file notes was in place for recording any contact with individuals who used the service or their family members. The relative we spoke with told us they had regular contact with the provider of the service. They told us, "[Name of provider] set the team up for [name of family member] in the first place. If I have any worries or concerns I will ring her and she will sort things out." We were told the fact that case managers maintained regular contact with people who used the service and their families meant any concerns could be dealt with immediately. The person we visited at home told us, "I haven't got a complaint about anyone." The provider informed us that if any concerns were raised, no matter how small, they would visit people to try and resolve matters as soon as possible. A case manager also told us, "We get direct feedback from people on every visit. If a person made a complaint the director would go straight out to see them to try and sort things out."

Good

Our findings

The service had a registered manager in place as required under the conditions of their registration with CQC. The registered manager was responsible for managing two separate sites on behalf of the provider. The two directors of the service were also closely involved in overseeing the quality of the service people received. The people who were supported by the service had a case manager identified to oversee their care and support package; this was the staff member people and their families saw as their main link to the organisation.

All the staff we spoke with told us they enjoyed working in the service. Comments staff members made to us included, "It's a really supportive environment", "There is an open door policy from the managers" and "I feel the service is well-led. We have regular communication, meetings and feedback." The registered manager commented, "It's a great place to work. [Name of provider] set up the service and is passionate about providing an excellent service to all our clients."

We saw that one of the directors of the service was the chairperson of BABICM. This is a national organisation which seeks to promote the development and training of case managers working in the field of acquired brain injury. Within this role the director had contributed to the development of a set of competencies for case managers which several staff in NCM had achieved and were therefore recognised as advanced case managers.

We saw that the service was proactive in providing training and support to other professionals and organisations working in the field of acquired brain injury. The provider told us this was because they were committed to trying to ensure that all people who had experienced a brain injury were able to access high quality, professionally trained staff.

We asked the registered manager about key achievements in the service since the last inspection. They told us they had made changes to the service following feedback from the inspection at NCM's other site in Leeds. This included improving the way people's capacity to make particular decisions was recorded. Changes had also been made to the systems for the administration of people's medicines; this showed that the provider was committed to a process of continuous service improvement.

Records we reviewed showed a senior management meeting was held every six weeks. Following each of these meetings a company feedback meeting was arranged to which every staff member was invited. The company feedback meetings were used to inform staff of any developments within the service. Staff we

spoke with told us they were encouraged to contribute to discussions at these meetings and that their ideas were always listened to.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. We saw there was a centralised system in place to monitor that care plans and reviews were up to date. Case managers we spoke with told us they completed regular spot checks of the performance of support workers when they visited people who used the service. They told us they also sought feedback from people during these visits; this feedback was recorded on the centralised file note system and shared with senior staff as necessary.

Before our inspection we checked the records we held about the service. We found that the service had notified CQC of any accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken by the service to ensure people were kept safe. We saw that a log was maintained of any accidents and incidents which had occurred; this was reviewed regularly to see what lessons could be learned to help improve the service people received.

The provider distributed an annual satisfaction questionnaire to people who used the service and their families. The results were published in an annual report on the website for the service. This report showed the action the service had taken in response to the feedback received, the improvements which had been made and areas for further development.

An annual questionnaire was also distributed to support workers to gather their views about working in the service. We looked at the results from the most recent questionnaire completed in December 2015 and saw that all the responses from staff were very positive.