J S Parker Limited

J S Parker - Northern House

Inspection report

Northern House
73 Carter Knowle Road
Sheffield
South Yorkshire
S7 2DW

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21 May 2019
29 May 2019

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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

About the service: J S Parker Northern House provides a case management service to adults with an acquired brain injury and are living in their own homes. This includes developing care and support packages and liaising with healthcare and other professionals on the person's behalf.

The service is registered with the Care Quality Commission for the regulated activity of 'personal care'. At the time of this inspection, a total of 108 people used the service. However, only 33 people were in receipt of support that included personal care.

People's experience of using this service: We found a strong leadership framework in place. This meant there were clear lines of accountability within the organisation and systems which supported the running of the service were well-embedded. The service benefited from a long-standing and highly experienced registered manager. They were well supported by a dedicated and enthusiastic multidisciplinary team.

People's care files showed that their care needs had been thoroughly assessed, and they received a good quality of care from staff who understood the type of support they needed. Care plans were highly personalised and gave clear information on how to support people beyond just their physical needs to ensure their entire person-hood was upheld. People's goals and aspirations were clearly identified in their care records and we saw many examples where the service had helped them to fulfil these.

Staff were effective in their roles and sought the best outcomes for the people they supported. The service benefited from a range of in-house professional expertise which meant a responsive level of training and continuous development was provided in line with the person's needs and developments in best practice.

People were given every opportunity to be valued and equal partners in decisions around their care and support. For example, people or their representatives were empowered to select the own staff team and ask questions during staff interviews. The service encouraged people to maintain a healthy diet and worked collaboratively with external services to promote people's wellbeing. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Rating at last inspection: At the last inspection the service was rated 'Good.' (published 22 November 2016).

Why we inspected: This was a planned routine inspection based on the previous rating.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 remained safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service remained effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service remained caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service remained responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service remained well-led.

Details are in our Well-Led findings below.

J S Parker - Northern House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by an inspector from the Care Quality Commission (CQC).

Service and service type:
The service provides domiciliary care to people in their own homes.
The service had a manager registered with CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 24 hours' notice of the inspection visit. This was because the service is community based and we needed to ensure staff would be available to support the inspection.

What we did:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about. We sought feedback from other external agencies such as local safeguarding and quality teams and no serious concerns were shared with us.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection:
We spoke with three people and one person's relative who received a service from J S Parker Northern House. We spoke with the registered manager, regional quality and training manager, two case managers

and two support workers.

We reviewed two care plans and associated `documentation and five staff files in relation to recruitment and supervision records. Multiple records relating to the management of the service and a variety of policies and procedures developed and implemented by the provider were reviewed during and after the inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
• People were protected from abuse and neglect.
• People and their relatives told us they felt safe with the staff.
• Staff were clear of the actions they would take if they suspected abuse, or if an allegation was made. The provider had developed and trained their staff to understand and properly apply safeguarding policies and procedures.

Assessing risk, safety monitoring and management;
•Risks associated with people's care and support were identified and plans were in place to help manage the risks.
• People's care records included risk assessments which were used to assist in the reduction of potential risks. These were regularly updated and monitored as part of the service's audit system. Any shortfalls were identified and addressed.
• Staff at all levels were aware of how to manage risk within the service.

Staffing and recruitment:
• Through a collaborative recruitment process people and their relatives were able to select a staff team which was right for their needs. Case managers supported the selection process to ensure safe recruitment practices were followed and legal standards were met.
• People and their relatives told us their family members consistently received care from the same staff. This helped to build positive relationships and provide consistency of support. One relative said, "Oh yes, [relative] feels safe. [Relative] has had the same ones [staff] for the last 9 to 11 years" and "We have never experienced a late or missed call. If they [staff] are ever stuck in traffic and will be a few minutes late they always let me know."

Using medicines safely:
• Where support with medicines was part of an assessed need, appropriate systems and procedures were in place to ensure this was managed safely. This included arrangements for the storage, administration and disposal of medicines.
• All staff had completed training before they were able to administer medicines and received an annual review of their knowledge, skills and competence.
• People had a support plan that included information about any medicines they were prescribed and clear guidance about the support people required from staff.
• Case managers carried out regular checks of people's medication records to ensure they were receiving their medication safely.

Learning lessons when things go wrong
• People benefitted from a service that used lessons learned to improve, and to minimise the risk of accidents and incidents occurring.
• Systems were in place to support the analysis of any accidents and incidents, to support planning and to reduce the risk of reoccurrences. All incidents were reviewed by the registered manager and people's allocated case managers to ensure the service was responsive to risk or emerging risk. Where an incident or future risk had been assessed as serious, senior managers carried out further quality checks to promote people's safety.
• Staff were clear they should report any accidents and incidents and maintain clear written records. Records showed appropriate actions were taken to reduce reoccurrences, such as changes to people's care plans.

Preventing and controlling infection
• People said staff used personal protective equipment (PPE) such as disposable gloves and aprons to help in the prevention and control of the spread of infection.
• Staff received training in infection prevention and control and case managers observed staff practice, to ensure people were receiving their care safely.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience:
• People were supported by staff who had the skills and knowledge to care for them effectively.
• People were confident about the staff's training and competence.
• New staff completed a blended learning program of classroom-based training and a period of shadowing with an experienced staff member before they began to work unsupervised. The training package aligned with the Care Certificate, a nationally recognised set of standards for health and social care workers.
• Staff inductions were person focussed and tailored to people's individual support needs. For people with specialist support needs, the service organised extra training for staff, so they consistently provided safe and effective care. For instance, one person said, "All the staff are well trained. I had a seizure in the bath once, I was dead weight. The carer helped me until I came to and supported me to the floor. I felt mega safe. If they weren't there I would have a hit the board like. They all know what to do when I have a seizure. They talk to me and make sure there is nothing I can bang my head on."
• The provider's supervision and appraisal system gave opportunities to staff to review their individual work and development needs. Staff told us they had regular supervision and praised the standard of support they received from their case manager. One staff member said, "I enjoy my job. My case manager is always on the end of the phone if I need them."
• At each JS Parker site they had a nominated 'champion' to lead on key areas related to people's support. For example, there were champions for Mental Capacity Act, dignity, medicines, data protection. The medicines champion was a registered nurse and had a specialist interest in medicines. It was their responsibility to keep abreast of changes in medicine practice or policy and share learning with other staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; staff working with other agencies to provide consistent, effective, timely care; and supporting people to live healthier lives, access healthcare services and support:
• People's care and support was planned in partnership with them and staff understood people's diverse values, beliefs and preferences.
•The service applied a holistic approach to supporting people, which were not directly related to people's emotional and physical health but contributed to their overall wellbeing. For example, one case manager supported a person to purchase a property which was suitable for their preferences and physical needs. As the person's new home was adapted to their needs it enabled them to be more independent in their own home.
• Advice provided by healthcare professionals was incorporated into people's care plans, so staff were providing care which met people's health needs.
• Staff had a good knowledge of the healthcare needs of the people they supported.
• Due to the nature of the service provided by JS Parker, a range of professionals were involved in a person's

journey from the point of first referral. This included solicitors, health and social care professionals and the criminal or civil courts. This meant comprehensive and detailed assessments of need had been completed from a very early stage.
• The service and professionals working within it, had been fully accredited with the British Association of Brain Injury Case Managers, with several professionals, including the registered manager, accredited as advanced practitioners. This meant the service operated within a framework that offered high levels of quality assurance around standards, competencies and a code of ethics.

Supporting people to eat and drink enough to maintain a balanced diet:
• People were supported to receive a balanced diet where needed. One staff member said, "[Person's name] has progressed so much since we started working with them. We have built up a lot of trust. They are eating much healthier, before they used to only eat snacks."
• People's care file showed that their needs had been assessed in relation to nutrition and hydration and took into consideration their preferences and dietary requirements. Plans for eating and drinking were developed jointly with people and where appropriate, other professionals such as a dietician or speech and language therapist.

Ensuring consent to care and treatment in line with law and guidance:
• 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".
• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. The application procedures for this in community settings are called the Deprivation of Liberty Safeguards in Domestic Settings (DiDS) and can only be authorised through the Court of Protection.
• The provider had a clear process for obtaining consent before care and treatment was provided.
• Staff had received relevant training and demonstrated a good working knowledge of capacity, what constituted a deprivation of a person's liberty and best interest process.
• Some people who used the service had deputies appointed by the Court of Protection to oversee their care and finances. Case managers worked collaboratively with people's deputies to ensure decisions about their care and finances were made in best interest.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People's cultural needs were assessed when their care packages were devised. Their cultural backgrounds and religious needs had been recorded and we saw, where required, care packages had been designed around this.
• Through talking to staff, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic were respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality.
• People told us they felt staff treated them well and upheld their rights. Comments included, "Yes, it's a good service, I don't know what I would do without them" and "They [staff] are doing a grand job."
• The provider had received many written compliments conveying high levels of satisfaction in the service they received. One relative commented, "We can't thank [case manager's name] enough, at a really difficult and stressful time for us, [case manager] came over and sorted everything with the hospital."

Supporting people to express their views and be involved in making decisions about their care
• People who used the service told us they took part in regular reviews with their case manager, where they could voice their opinions about the care provided and were involved in decisions about any changes.
• People's choices in relation to their daily routines were listened to and respected by staff.

Respecting and promoting people's privacy, dignity and independence
• People and their relatives told us they received exceptional care from kind, considerate and caring staff.
• We heard lots of positive examples where people's independence was actively encouraged and promoted by the service. One example, we saw the service supported a person's goal to move from a residential care setting into their own accommodation with a package of care in place. Although the needs of the individual were at first complex and required 24-hour support, staff worked closely with this person to set goals and targets daily to enable them to be more independent.
• One person we spoke said, "All the carers encourage me to practice walking. I'm in a wheel chair at the moment but I can walk a few steps for a few minutes at a time before getting tired. A carer always stands beside me or behind me, so I don't take a tumble. I feel much safer with them there."
• One staff member said, "We always ask the client first to keep them involved. We try to promote their independence by encouraging and praising their achievements."
• Staff felt especially valued and respected, their views were listened to and considered. This led to a content and motivated staff team.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• Care plans were written in a person-centred way that gave staff clear guidance about how to support individual people. Care plans were developed with people and not for people. One person told us, "My care plan gets updated all the time, as my ability gets better they make changes. My case manager reviews my care plans a lot. I don't have owt to do with my care plan, which is my choice."
• Each person who received a service was allocated a case manager. Case managers were responsible for assisting people in setting up and managing their own package of care. One case manager told us everyone's care package were "client centred and bespoke". Case managers would also typically provide support and professional expertise around issues such as co-ordination of care and therapy services; design, implementation and monitoring of care/support plans; assistance with welfare benefits and attendance at legal proceedings.
• Through the case management approach, people were supported to access a range of services including occupational therapy, physiotherapy and psychology. This multidisciplinary approach helped to ensure care and support was joined-up and responsive to people's individual needs.
• The service actively encouraged people to take positive-risks and capitalised on the skills and expertise of the case management team to ensure positive risk taking was planned and delivered in the safest possible way. For example, one person wanted to go on a skiing trip with their family, which was an activity they enjoyed prior to their injury. Initially the person's GP was concerned this trip could not be done safely. The case manager's professional expertise enabled them to have robust conversations with the GP about the person's support needs and to work together to develop a suitable plan, which also satisfied the GP's safety requirements to approve the trip. The person's case manager said, "We do try really hard to allow people to do the things they want to do."
• The Accessible Information Standard (AIS) was introduced by the Government to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service to be highly effective in ensuring people's communication needs were met. This included communication via email, easy-to-read documents, large print, and staff trained in British Sign Language.

Improving care quality in response to complaints or concerns:
• The provider's policies and procedures relating to the receiving and management of complaints were clear and well managed, so that complaints improved the quality of care people received.
• People were actively encouraged to discuss their concerns and due to the high levels of open engagement this impacted positively on the number of received complaints. All people and relatives we spoke with said they felt confident raising a concern should they need to. Comments include, "I've never had to make a complaint. I feel confident raising a concern if I need to" and "If we have any problems I know I can just ring them."

End of life care and support:

• At the time of our inspection, the service was not supporting anyone who required end of life care. The registered manager told us they had systems in place to document a person's preferences and priorities for care when they reached the end stages of their life and health professionals would be consulted as part of this process.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture:

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
•The service was well-led and staff at all levels were clear on their roles and responsibilities to monitor performance and risk of care delivered. The service benefited from a long-standing and experienced registered manager and they were well supported by a dedicated and enthusiastic multidisciplinary team. Staff commented, "[Registered manager] is very supportive", "I'm proud to work at JS Parker. Through our work we maintain a caring ethos", "No matter what the situation is and how you [registered manager] may feel, you are just so professional and have the amazing ability to see both the bigger picture but then also how it affects all of us, our clients and the people who work with us. You're an example of a great leader" and "I've worked here for 11 years. I have always thought the service has done right by the client."
• There was a well-established and fully embedded governance framework in place. Systems and processes for audit, quality assurance and questioning of practice were highly effective. Although the service is required to identify people who were in receipt of a regulated activity for regulatory purposes, the registered manager told us all people (regulated and non-regulated) who received a service, were subject to the same quality assurance processes. This ensured JS Parker provided a consistently good service across the entire organisation.
•The registered manager and wider leadership team had a good understanding of their roles in ensuring good governance and compliance with legislation. This was evidenced through an effective clinical governance framework operated at both local and national level. For example, organisational learning had been implemented around staff who were deemed to be 'lone workers' and emergency arrangements for out-of-hours.

Continuous learning and improving care; working in partnership with others; planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:
• The service followed best practice and pursued opportunities to improve care and people's experience to attain better outcomes. This was well evidenced through membership and accreditation with a range of professional organisations including the British Association of Brain Injury Case Managers (BABICM). The service had developed a clinical induction program for case managers spanning across three years to help them achieve 'advanced practitioner' status.
• The provider were active campaigners for the rights of people with acquired brain injuries and strived to improve care not only for their clients, but for all people with acquired brain injuries. For example, the provider participated in a consultation on improving decision making practices for vulnerable people, which was led by the National Institute for Health and Care Excellence (NICE). NICE is a national organisation

which provides advice to improve health and social care.
• The service was outward looking and always sought new opportunities to work with others. Staff attended local registered manager forums, skills for care events and education seminars provided by relevant organisations.
• Staff within the service were active members of various forums and associations to maintain their competency and status as registered professionals.
• There was an open, honest, caring and positive culture across the service. This was clearly led from the top down. The management team operated an 'open door' policy and people told us the registered manager and senior leadership team were supportive and approachable.
• The registered manager notified the CQC in accordance with regulation. The service had robust systems in place to ensure all correspondence or requests from the CQC were recorded and complied with in a timely manner.
• All accidents and incidents graded as moderate risk or above result in a lessons learned from being completed, which was then shared across all provider locations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The registered manager told us it was their philosophy the service should be person-led and not process led. This was clearly evidenced in the service's high-levels of stakeholder engagement, which actively encouraged people, staff and outside professionals to question practices in order to raise standards. Where response rates were low, the management team thought of new and creative ways to improve engagement. For example, surveys were trialled on different colour paper to make it stand out in a pile of documents. A variety of mediums were considered so giving feedback was convenient and straightforward.
• The service had a personalised approach to gathering feedback from people who used the service. As part of the provider's annual quality assurance process people were offered a yearly review, either with the registered manager or a senior case manager not directly linked to their care. This enabled people to speak freely about the service they received with a senior staff member in the organisation. We saw clear evidence these discussions were meaningful, and feedback was responded to quickly. As part of this quality assurance process the provider also sought feedback from support staff and professionals involved with each person's package of care.
• Staff completed an annual survey, so they could submit feedback about working at the organisation. The information and data collected was brought together into an annual quality report which was made available to people and stakeholders. In addition to the staff survey, they were able to access 'Yammer', which is a private social media platform and enabled staff to communicate internally. Staff spoken with said they felt listened to and the quality of communication was good at all levels in the organisation.
• People who were new to the service were given an information pack which included the company's Statement of Purpose, complaints procedure and details of their dedicated case manager.
• The service's clinical training lead completed 'Equality and Diversity Train the Trainer' course. They embedded their learning into practice by updating the provider's policies and procedures and in-house program of training on equality and diversity.