North East Care Management Limited

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Inspection report

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Date of inspection visit:
03 August 2016

Date of publication:
22 August 2016

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

North East Care Management is specialist brain injury service, based in Blyth, Northumberland. They provide personal care to one adult with a brain injury. The service also offers support to adults and families of children with brain injuries. This included overseeing private care arrangements, recruiting and training support workers, placing personal assistants and facilitating access to welfare, housing, medical and legal rights. In addition they offer behavioural and family therapy, other services, advice and guidance. This aspect of the service is not regulated by the Care Quality Commission.

The inspection was carried out on 3 August 2016 by one inspector and was announced. We gave 24 hours' notice of the inspection because we needed to seek the permission of the person who used the service to visit them at home. We needed to be sure staff would be available to access records. We previously inspected this service in January 2014 and found they met all of the outcomes they we inspected.

The service had two registered managers in post, one of which was also the registered provider. 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 liaised with the registered provider as the other registered manager was unavailable during this inspection.

The person who was supported at home with personal care told us they felt safe with the support from their care team. Their relative confirmed this. Policies and procedures were in place and up to date to protect people from harm and were available for staff to ensure they understood their responsibilities.

There had been no incidents or accidents within the service. The provider told us a procedure was in place and incidents and accidents would be investigated and reported in a timely manner to external agencies such as the local authority or CQC. The provider told us they would analyse incidents and accidents and review care needs, risk assessments and implement preventative measures as necessary.

The service managed risks associated with the health, safety and wellbeing of the person who lived at home, including staff being vigilant for changes in care needs. The person's care needs had been assessed for all aspects of daily living and we saw evidence which demonstrated records were reviewed and monitored regularly.

Medicines were managed safely and medicine administration records were thorough, accurate and signed by two members of the care team. Medicine was stored appropriately. The staff followed strict guidance regarding the ordering, receipt, storage and disposal of medicine. All other records relating to the management of the service were well maintained.

We saw there was enough staff employed by the service to meet the person's needs and support them safely

at home and in the community. Staff records showed the recruitment process was robust and staff had been safely recruited. Training was up to date and staff had a mix of skills and experience. The provider gave staff opportunities to develop themselves and achieve qualifications in health and social care.

The provider carried out staff supervision and appraisals which were regular and documented. The care team and a relative attended meetings held with the person in their home on a regular basis and minutes were recorded. The management also held regular staff meetings. This demonstrated that the person, their relative and the care team had plenty of opportunities to speak to the management and raise any concerns. Competency checks were undertaken by the management and a senior care team member to assess the staff's suitability for their role.

There was evidence to show the provider and care team had an understanding of the Mental Capacity Act (MCA) and their responsibilities. The service assessed the person's mental capacity and reviewed it as necessary. Care records showed that the person had been involved in making decisions, but more complex decisions that were made in their best interests' had been appropriately taken with other professionals and a relative involved.

The person told us that when needed, staff provided assistance with meals of their choice. The staff we observed and spoke with displayed kind, caring and compassionate attitudes and the person told us everyone was nice to them. We observed staff treated the person with dignity and respect and it was obvious they knew each other well. They enjoyed a friendly relationship which was full of humour.

The management and care team had built a person-centred care plan for the person receiving support at home. Specific needs such as personal care, nutrition and medical needs had been initially assessed and were regularly reviewed with the involvement of the person, their relative and external professionals. The records described in detail the person's life history, family members, interest and hobbies. These were kept within the person's home to ensure they had access to their own information.

The service promoted activities which were indicative of the person's hobbies and interests. The care team ensured the person was included in their community by arranging and escorting the person on holidays and short breaks. Individual activity plans encouraged the person to get involved in activities which they showed a keen interest in, such as swimming, bowling and snooker.

There had been no complaints received by the service. However there was a robust policy and procedure in place. The provider told us they would record complaints and investigate them thoroughly, providing a full response to the complainant. Any minor issues which had been raised were dealt with immediately. The person we visited told us they had nothing to complain about but felt confident to tell their care team or the management if something was wrong. The staff and other relatives who used the support services also told us they had no complaints about the service.

Regular quality monitoring took place. The management undertook daily, weekly and monthly audits to ensure the quality and safety of the service. The provider asked staff and relatives for feedback and gave them the opportunity to do so. Surveys had been recently issued to gain the opinions of staff and relatives about how the service was managed and how it could be improved. We observed a good response to surveys, which allowed the provider to gather an overall opinion of the service. No comments were made about further improvements on the surveys.

The provider had extensive knowledge in this specialism and had worked with people who have suffered traumatic brain injury for many years. The provider was well established in her role, having known the

person they supported in their own home for nine years. The care team was consistent and those we spoke with told us they felt supported, valued and they enjoyed working for the company.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff undertook safeguarding training and understood their responsibilities towards protecting people from abuse.

Risk assessments were in place to reduce the likelihood of a person coming to harm.

The recruitment of staff was robust.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were trained in a variety of topics specifically to meet the needs of the person who used the service.

Staff told us they were well supported in their role and had regular supervisions, team meetings and an annual appraisal.

The provider and staff had an understanding of the Mental Capacity Act and worked within the principles.

Is the service caring?

Good

The service was caring.

Staff displayed kind, caring and compassionate attitudes towards the person who used the service.

Staff treated the person with dignity and respect.

The provider had involved the person, their relative and staff in creating the care plan and during the review.

The person who used the service was provided with relevant up to date information and explanations about the service.

Is the service responsive?

Good

The service was responsive.

Care records were person centred. They contained lots of detailed, personalised information about the person.

Activities were focussed on the person and whatever they felt like doing each day. Staff also accompanied the person on short breaks and holidays.

No complaints had been received. People knew how to complain and felt confident to do so.

Is the service well-led?

Good

The service was well-led.

There were two registered managers in post and they were aware of their responsibilities.

A clear staffing structure meant all staff knew what they were accountable for.

Feedback was sought from the person who used the service, relatives and external professionals.

Audits were carried out to monitor the quality and safety of the service.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 3 August 2016 and was announced. The inspection was conducted by one adult social care inspector.

Prior to the inspection we reviewed all of the information we held about North East Care Management, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

In addition, we contacted local authority adult safeguarding teams and commissioner's to obtain their feedback about the service. All of this information informed our planning of the inspection. We asked the provider to complete a Provider Information Return (PIR) prior to the inspection which they submitted in a timely manner. The PIR is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with one person living in their own home. We spoke with their relative to gather their views about the service and two members of their care team. We also spoke with two parents who had used North East Care Management support services for their children. We spoke with the registered provider, who is also a registered manager regarding the management of the service. The other registered manager was not available during the inspection.

We reviewed records held by the provider. This included looking at one person's care records, one staff file and records relating to the quality monitoring of the service.

Good

Is the service safe?

Our findings

We asked the person who received a service at home if they felt safe with support from their care team. They said, "It's brilliant"." We asked their relative if they felt the person was safe and they told us they were. During our visit to the person's home we observed the atmosphere was friendly and relaxed, with the person enjoying a good relationship full of humour with the member of staff on duty.

Safeguarding policies and procedures were in place for staff to follow in order to protect people from abuse or improper treatment. The provider told us there had been no accidents or incidents of a safeguarding nature within the service. Staff had attended safeguarding training and were aware of their responsibility to report safeguarding matters and told us they had no safeguarding concerns. They told us they were confident to use all the policies and procedures in place and that they would have no hesitation to report any issues to the management.

The person's care needs had been thoroughly assessed and they had detailed risk assessments associated with them. We saw that risks to the person's health and wellbeing along with generic risks around the property had been assessed and were reviewed monthly, such as support with road safety and ensuring their home was secure at night. Risk assessments detailed possible hazards, probability, contributing factors and management strategies. We saw the person moved safely around their home and staff told us they were vigilant with regards to changes in the person's needs and regarding any repairs or hazards in the property.

We saw in care records that an emergency procedure and a personal emergency evacuation plan were in place in case of a fire for the person who used the service at home. The care team were aware of their responsibilities with regards to a safe evacuation. Records were kept in the home regarding safety checks such as tests of the smoke alarms. This meant staff monitored risks to health and safety and implemented control measures to mitigate such risks.

The person who used the service required one to one support at home and when accessing the community and the service had assessed the staffing levels to be able to manage this need. The provider told us about the support required whilst the person was at home and we saw this recorded in the care records. The person had a dedicated care team which was consistent and reliable. There was enough staff employed to ensure all of the person's needs were met.

There were robust recruitment procedures in place and the staff files contained evidence which showed staff were recruited safely. The provider had carried out pre-employment vetting checks including gaining references from previous employers, completing interview documentation and obtaining an enhanced Disclosure and Barring Service (DBS) check for each employee. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are employed. The staff records contained evidence of an induction process, training, shadowing of more experienced staff and on-going development. This demonstrated that the provider recruited suitable people with a mix of skills, knowledge and experience to meet the needs of the person who used the service.

We checked how the service managed the person's medicine needs. Two members of staff signed the Medicine Administration Record (MAR) after administration, which we saw was well maintained and up to date. The person told us they received their medicine in a safe and timely manner and their relative confirmed this. There was strict guidance in place for the staff to follow with regards to the ordering, receipt, storage and disposal of any medicine. MAR's were audited daily by staff before handover and overseen on a weekly and monthly basis by the management. The provider told us any discrepancies would be reported to her immediately. There were no issues around the management of medicine and the care team had worked proactively with the person and external healthcare professionals to ensure this.

Good

Is the service effective?

Our findings

The staff we spoke with told us they felt fully supported in their role and confirmed that training was regularly refreshed. We saw in staff records that all staff had undergone an induction and more recently all staff were completing the new 'Care Certificate' induction process. The Care Certificate is a benchmark for the induction of staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective, compassionate care. The provider told us, "Completing the Care Certificate gives the existing staff an opportunity to refresh their knowledge." The service used a range of training providers and healthcare professionals to meet their training needs.

Accredited training was delivered to staff in topics such as moving and handling, safe handling of medicines, first aid and health and safety. On-line training and distance learning was used to refresh staff of other key topics such as confidentiality, communication and consent. External specialist nurse assessors delivered training on invasive care procedures and carried out competency checks. General observations on staff competency were carried out by senior care staff during announced and unannounced supervision sessions.

Supervisions were carried out approximately every six weeks by the provider. The provider used a variety of communication methods to meet with staff including 'Skype' and 'Facetime' if face to face meetings could not be arranged. Skype and Facetime involved having a spoken conversation over the internet using a software programme and a webcam [camera]. Supervision sessions covered the staff members work with the person and the objectives to work towards, training needs, development and an action plan. We saw a history of supervisions sessions throughout employment and an annual appraisal. The appraisal process included a self-appraisal and measured the staff member's competency with regards to dependability, teamwork, attendance and performance. One staff member told us, "Yes, we have supervisions every six weeks with (provider)." Another confirmed, "Yes, I'm fully up to date with supervisions, training and meetings."

Care team meetings took place regularly and the person living at home attended these as did their relative. The relative also told us the provider was in regular contact over the telephone to discuss care needs and progress. There was good communication within the care team and processes were in place for handing over information between shifts. We reviewed handover notes which included details on activities undertaken, appointments, expenditure and security.

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 person, their relative, the provider and external health and social care professionals had made some decisions in the person's best interests. We saw evidence in staff records which showed staff had received training about the Mental Capacity Act and best interest's decision making.

The person who used the service at home told us the staff supported them to prepare and make meals only

when they requested their assistance, for example when using the oven. The person told us they liked a particular member of the care team to take them grocery shopping and this was always accommodated. The person said they enjoyed the meals they made and enjoyed regular meals out with members of staff. There were no specific dietary requirements for staff to be aware of; however staff were attentive towards changes in nutritional needs and any risks associated with the person completing this task for themselves. Staff records showed staff had completed food hygiene training.

Care records demonstrated the service involved external health and social care professionals when the person's needs changed. The records showed that staff had made referrals to a GP, a consultant, various therapists and they worked closely with the person's care manager within the local authority. Records were made of the communication and any progress or outcomes were monitored. The person's relative confirmed they were kept abreast of any communication between, or involvement of, external professionals.

Good

Is the service caring?

Our findings

The person we spoke with used terms such as "brilliant" and "spot on" to describe their care team. It was evident from our observation and the conversations we had, the person had an excellent relationship with the care team, some of whom they had known for many years. Throughout our visit with the person there were a lot of positive interactions between the person, their relative and the member of staff on duty with lots of humour and jokes. The provider had established boundaries and the care team were very good at maintaining a positive relationship within these.

The staff we spoke with and observed, displayed kind and caring attitudes as they described the person's care needs, their role and the activities they supported the person with.

Discussions with the provider and two members of the care team revealed that the person who used the service did not have any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that the person who used the service was discriminated against and no one told us anything to contradict this. Staff records showed that all staff had undertaken equality and diversity training.

The service was very accommodating of the person's needs. Staff responded well and adapted to meet the person's needs as they changed. The person's care file showed that the provider and care team had taken the time to research activities, holidays, short breaks and other areas that may be of interest to the person.

Care records showed that the person and their relative had been involved in the care planning process. The person had contributed to the information recorded about themselves such as likes, dislikes, interests and hobbies. The person had also been able to sign the documentation to consent to the agreed care and support and also to allow information to be shared with relevant third parties.

We reviewed a person specific 'Service User Guide' and an up to date 'Statement of Purpose' which the service had produced and shared with the person who used the service. These documents contained information about the company's values and the limitations of service. They explained what the 'service user' could expect from the company and how the service would be delivered. They provided information on quality assurance, complaints and useful contacts. Some of the company's policies were also included for the person's information such as staff conduct, health and safety, confidentiality and storage of data.

The person used the support of an advocate. A relative acted in this role and sometimes the provider or member of staff did as advocacy is a service the company has to offer; however the provider told us that they were aware of how to involve an independent mental capacity advocate from the local authority if they thought it was necessary. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Care records which contained the person's sensitive information were kept locked away at the provider's office and a copy was available at the person's home. The staff we spoke with were aware of the importance

of maintaining confidentiality and privacy. We observed a member of staff treated the person with dignity and respect throughout our visit. Staff records showed staff had completed training courses in dignity, privacy and respect.

Staff supported the person to maintain their independence and we observed the person doing things for themselves. Staff encouraged the person to undertake tasks themselves and supported them only when necessary. For example, the staff used to support the person overnight, however the staff had proactively supported the person to a level of independence which meant they no longer needed this service.

Good

Is the service responsive?

Our findings

We found care records were person-centred. The records contained introductory sections such as, 'About me', 'Things I'm good at' and 'Things I like' as well as detailed care needs assessments and care plans. These sections of the records contained information such as mobility, senses, balance and sleep. These were all thoroughly completed to a good standard with personalised details. For example, the records contained comprehensive information about past history, interests and hobbies. The provider asked the person to complete a 'client self-assessment' on a quarterly basis and they used this information when reviewing the person's care needs and care plans. It also gave the person the opportunity to monitor their own progress.

The provider was responsible for reviewing and updating care plans and assessments, however there was evidence that the person, their relative and the care team all had input into this. The care team were very familiar with the person and their care needs. Assessments had been carried out for each aspect of the person's daily life. Consideration had been given to the person's likes and dislikes, preferences and abilities when assessing certain activities.

The person decided which activities to took part in. The provider told us the activities plan centred on the person and what they wanted to do each day. The care team encouraged the person to follow their own interests and engage in activities which were personal to them. When we asked the person what activities they take part in, they told us, "I like to go swimming, bowling and to the cinema. I play snooker and sometimes football. I work at the Scope shop sometimes, and I go to the pub for karaoke." They added, "(Staff member) goes on holiday with me, I go to the Calvert Trust at Kielder and we've been to Spain a few times."

The provider oversaw a daily activities budget on behalf of the person. We reviewed financial logs detailing the daily expenditure. The care team retained receipts as evidence of expenditure and information was recorded about the type of activity and the costs involved. For larger expenditure, the provider liaised with the person's deputy from the Court of Protection. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at the time because they may lack capacity to do so.

The provider and staff told us about the importance of the person maintaining a relationship with their family. The person and their relative both confirmed that staff accompanied the person on family outings and holidays.

We observed the person was given choice in all aspects of their care and support. One member of staff told us, "We do whatever (person) wants to do at the time." The provider's mission statement refers to being committed to promoting choice, independence and dignity. Their aim is to reintegrate people back into their local communities and enable them to lead a fulfilling life. Our observations and the evidence we saw indicated that this aim was being achieved.

The service had received no complaints. The provider told us that when minor issues were raised, they were

dealt with straight away by the provider either in person, by telephone or email. The person we visited had no complaints about the service, the staff or the management. Their relative confirmed this and was very complimentary about the service. A complaints policy and procedure was in place and had been made available to the person who used the service. The provider told us they would respond to people who complained the same day, and investigate immediately. We reviewed the complaints policy. It informed people of how to complain, what would happen and who would be informed i.e. the local authority. The staff and other relatives who used the support services also told us they had no complaints about the service.

Good

Is the service well-led?

Our findings

The service was operated on a daily basis by the provider who was also a registered manager. The provider had employed a second registered manager however they were unavailable during this inspection. Our records showed the provider had been formally registered with the Care Quality Commission (CQC) since March 2011 and the second registered manager since November 2015. The provider was aware of her responsibilities and had submitted statutory notifications to us as and when required.

The service had a history of compliance with the regulations associated with the Health and Social Care Act 2008. Two previous inspections by CQC in January 2014 and December 2012 found the service was fully compliant with all of the outcomes we inspected. The provider was present during this inspection and assisted us by liaising with staff and the person who used the service.

The provider had an extensive history of working with adults and children with a brain injury. She had experience of working in social care before setting up this service over ten years ago. The provider was very knowledgeable about the person who used the service having supported them for nine years.

Policies and procedures were well established and had been recently updated in order to ensure staff were fully supported to meet the high standards which the provider had set. The provider had recently invested in a quality management system and was in the process of migrating all of the records into the new system which would increase the effectiveness of managing and monitoring data.

There was a clear staffing structure in place, which included the provider, an additional registered manager, a senior support worker and the care team. The whole team was aware of their responsibilities and what they were accountable for. The staff worked regular shifts which were consistent for both them and the person who used the service. The staff we spoke with told us they had no problems covering shifts for each other or with holidays or payroll.

The culture of the service was open and transparent and the staff we spoke with were keen to make life as easy and interesting as possible for the person who used the service. The staff took their lead from the provider who was skilled, knowledgeable and experienced in care management. The staff respected the provider and told us, "(Provider) has been amazing and supportive", "(Provider) is very good to us" and "I've never had a problem getting in touch with (provider)."

We asked two members of staff if they enjoyed their job. One member of staff said, "I really enjoy it" and the other said, "I have worked for (provider) for many years now so I must like it, (provider) is very good to the staff." Both members of staff told us they felt supported and valued at work.

Staff and 'customer' surveys were regularly completed and the results of both were collated by the provider in order to get an overall opinion of the feedback. We reviewed six staff responses which all indicated an 'excellent' response to satisfaction. This demonstrated the provider was actively seeking feedback from the care team in order to drive improvements through the service. We also saw 'excellent' responses were

received from clients and relatives in response to questions asked about reliability, professionalism, responsiveness and trust. One comment read. "I'm happy with everything."

Audits and checks of the service were in place to ensure the person was receiving safe, quality care which met their needs. We reviewed audits from January 2016 to July 2016 which related to accidents, incidents, late calls and missed calls. None of which had occurred, although the system was set up to monitor any trends which may occur in the event of issues arising. Audits of medicine administration records were completed on a daily, weekly and monthly basis; however no errors had been identified.