Community Integrated Care

# Cheshire & Greater Manchester Regional Office

## Inspection report

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## Ratings

| Overall rating for this service | Good |
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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

We carried out an announced inspection of The Cheshire and Greater Manchester Regional Office (CIC) on the 10 and 18 November 2016.

Cheshire & Greater Manchester Regional Office is registered as a domiciliary care agency (DCA) and is part of Community Integrated Care. Community Integrated Care is an organisation who provides support and personal care to young adults and children living in the community in supported living, extra care facilities and in people's own homes. The service currently provides support covering a large geographical area covering: Halton; Wigan; Knowsley; Cheshire/Wirral and St Helens. CIC is a registered charity operating on a not for profit basis, established since 1988 and also a company limited by guarantee.

The main office is located within a residential area of Widnes and there is ample parking within their own car park for visitors.

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

We last visited this service on 20 and 25 November 2013. At that time the registered provider met all the regulations we used to assess the quality of support.

People told us that they felt safe with the staff team and had no concerns about the support they received. Staff demonstrated a good understanding of protecting vulnerable adults from abuse and had received training in this and whistleblowing.

Recruitment procedures were robust with all required checks made before new staff supported people.

Risk assessments were in place and these related to all aspects of people's lives including risks posed by the environment and through the support provided. All risk assessments were up to date. Emergency plans were in place outlining how each person would be assisted in the even to the need to evacuate or a wider environmental emergency.

Medicines were managed safely. People told us that they received their medicines when they needed them and that they were never missed. All staff had received medication training and had their competency to do this checked.

Staffing levels were maintained. Systems were in place to ensure that the right number of staff were available to meet people's needs.

A structured induction process was in place. This involved training new staff and ensuring that they were competent to support people alone.

People told us that the staff team knew what their needs were. Staff received training appropriate to the needs of people. Staff received supervision and annual appraisals to ensure good practice.

While the nature of the service did not deal directly with deprivation of liberty safeguards, staff had received training in this and demonstrated an understanding on how this affected people in their daily lives.

The nutritional needs of people were met. This included an indication of people's likes and dislikes as well as the level of support they required in preparing meals. Where more specialist nutrition was necessary, staff had received training in this.

People felt cared about by the staff team and stated that they were free to make decisions about their daily lives. Staff were able to outline the main priorities of their work and these included respecting people's homes, promoting their privacy and supporting them as much as possible.

People who used the service were given information about the support they wold be given.

People had access to their care plans. All care plans were accompanied by an assessment of need which gave a very detailed account of each person's life, wishes and routines. All care plans were reviewed monthly with a wider annual review each year. All care plans had daily records which were detailed.

People knew how to make a complaint and a complaints procedure was in place ensuring a robust system of reporting concerns.

The registered provider demonstrated an accountable and transparent approach to managing the service. Staff felt supported and were given the opportunity to influence the running of the service.

People who used the service and their relatives were invited to comment on the support they received and comments were positive.

The registered provider had a robust auditing system in place to ensure that quality of support was maintained.

## 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.

People told us that they felt safe with the staff team.

Staff demonstrated a good understanding of how people should be protected from abuse and they had received training in this.

Medicines were safely managed

Risks faced by people in their daily lives were identified, acted upon and kept up to date.

### Is the service effective?

Good

The service was effective.

People told us that the staff were knowledgeable and knew how to meet their needs,

Staff received training, support and supervision appropriate to their role.

The registered provider was aware of the Mental Capacity Act and associated safeguards and took the capacity of people into account in their everyday support.

The nutritional needs of people were taken into account.

### Is the service caring?

Good

The service was caring.

People told us that they felt cared about and that staff adopted a friendly and supportive approach with them.

People told us that their privacy and dignity was taken into account

People had their wellbeing promoted by staff.

Information was provided to people about what they could expect from receiving support by the agency.

## Is the service responsive?

Good

The service was responsive.

People told us that staff met their everyday needs.

Care plans were personalised and took all the needs of people into account.
People were supported to undertake their chosen activities within the wider community.

The registered provider had a robust complaints procedure and people knew who to talk to if they had concerns.

## Is the service well-led?

Good

The service was well led.

People told us that the agency was well organised.

The registered provider had robust audits in place to monitor the quality of the support provided.

The registered provider adopted a transparent and accountable approach to the delivery of the support it provided.

The provider was aware of its responsibilities as a registered body.

# Cheshire & Greater Manchester Regional 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 10 and 18 November 2016 and was announced. 48 hours' notice was given to the agency of our intention to visit so that we could be sure that people employed by the registered provider would be available to assist us.

The inspection was carried out by one adult social care inspector.

As part of our inspection, we asked registered providers to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned to us when we asked.

We contacted local authority commissioning groups and the local safeguarding team about information they held in respect of the registered provider. They did not have any concerns.

We reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at six care plans and other records such as six staff recruitment files, training records, policies and procedures, quality assurance audits and complaints files.

We spoke to eighteen people who used the service. Discussions were held by telephoning people. We spoke to seven members of staff as well as the registered manager and members of the quality assurance team.

Good

# Is the service safe?

## Our findings

People told us "I am in safe hands here yes." "[staff] make sure we are safe and looked after" and "They [staff] make sure my home is safe and secure." They told us "The staff are always here, I have them all the time they are never late" and "I always have the same staff"

Staff told us that they were aware of what to do if they received any concerns or allegations of abuse. They told us that they had received training in safeguarding and this was confirmed through training records. Procedures were in place for staff to report abuse as well as information for people who used the service to raise any concerns they had as well. These procedures included those provided by Local Authorities as well as one devised by the registered provider. Staff were aware of the idea of raising concerns about poor practice through whistleblowing and a procedure was in place for this. Any safeguarding concerns were recorded through a computerised system. The registered manager had access to this to ensure that appropriate action was taken. The registered manager was able to provide evidence that low level concerns were reported to Local Authority safeguarding teams when required. Low level concerns are those issues that can be addressed quickly before people come to more significant harm.

Recruitment procedures were robust. A recruitment policy and procedure was in place. Files contained references to verify the suitability of people to perform their roles. A Disclosure and Barring check had been made on each person. Known as a DBS, this process is designed to check if people had been convicted of offences which would affect their suitability to support vulnerable adults. DBS checks had been obtained before applicants (or candidates) started work at the service. Other documents were available including job descriptions, health checks and application forms. Interview notes were also available demonstrating the values of applicants to support people. A scoring system had been used to identify which candidates had the necessary skills to support people.

Assessments were in place highlighting the risks faced by people from their environment and during the support they received. Risk assessments were all up to date and had involved the individual person it related to where possible. Risks were in place for those environmental issues that could pose a risk as well as activities which took place within each person's home such as cooking and support with cleaning, medication as well as personal security. Other risks identified included activities outside, personal relationships, risks to other people, risk of neglect, self-harm and financial risks. Each risk assessment reflected the individual concerned and where people were at more significant risk; this was included within assessments. The level of risk identified the actions that staff should take to minimise risk. Where new activities or pursuits had been identified by people, these were encouraged yet details where present indicating that risks were seen as having positive benefits and not just restrictive ones.
Emergency plans were in place for each person. These were detailed and took every aspects of their needs into account of they needed to be evacuated. Further contingency plans were in place if emergency evacuation was needed due to some local event which could affect people. A business continuity plan was also in place to deal with those incidents that affected the running of the business from the registered office. Risk assessments were in place for those staff working alone.

Staff told us that they had received medication training and this was confirmed through the training plan and training records. In addition to this staff had their competency to administer medication checked annually. Details of the medicines prescribed to people were available in person support plans and the preferred method for them receiving this was recorded. Some people told us that they did not receive medication. People, who required assistance with medicines from staff, told us that the staff team managed their medication safely. They told us that medication was always there for them when they needed it and that it was never missed. Medication records were appropriately signed and were checked on a daily basis by the registered manager and supervisors to ensure that medication had been administered. People told us that their medicines were safely locked and secured.

A system was in place for the reporting of accidents and incidents. These included full details of each accident and incident and actions taken to minimise re-occurrence or to identify trends and patterns. A computerised system was in place with the registered manager being able to access details of all accidents or incidents that had occurred. Each event was rated in relation to the degree of risk faced by the individual or others. Dependent on the degree of risk, events were escalated to senior managers within the organisation to ensure that action was taken and that the organisation's response was transparent and actions accountable.

Rotas were available. These outlined how people who used the service were to be supported. Rotas included reference to those people were one to one support was required. Where this level of support was required, rotas evidenced that this was maintained at all times. Where people required occasional support at key times of the day, rotas demonstrated that these times were covered. Other people required 24 hour support in their own homes. For these individuals, weekly rotas were available indicating that cover was fully provided through the day and night with shortfalls in staffing being covered to ensure continued support. A computerised system was in place for ensuring that staff had arrived at people's homes. This was designed to ensure that people were being safely supported .

Training records confirmed that staff had received training in infection control. Risk assessments included reference to those instances where people required support with intimate personal care tasks. Assessments included reference to the need for staff to take personal hygiene into account as well as using personal protective equipment (PPE) such as gloves and disposable aprons where needed. Health and safety audits included direct observations of staff using PPE appropriately.

Good

# Is the service effective?

## Our findings

People told us "They [staff] know their job and they are very experienced", "They are very aware of my needs and provide good one to one support" , "They always ask me first" and "New staff are put with someone I already know until they get to know me".

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the management team. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. We checked whether the service was working within the principles of the MCA

The nature of the support provided by the registered provider was such that deprivation of liberty applications were not ordinarily needed to be made. The registered manager confirmed that deprivation of liberty applications had been made in those instances where they needed clarification as to whether they were appropriate. Training records confirmed that staff had received training in the principles of the Mental Capacity Act and staff confirmed that they understood the principles of this legislation. Included in care plans was reference to each person's capacity to make decisions relating to their own lives. Staff told us that they understood that big decisions involving people's lives needed to be discussed with the person themselves and other parties to ensure that the person's best interests were served.

No one who used the service was subject to a court of protection order or lasting power of attorney. The court of protection has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

The registered provider obtained consent form people wherever possible. There was evidence that people had signed their care plans or risk assessments to confirm their consent. For others, consent was gained verbally and communication assessments aided staff in indicating when people agreed to support or not.

The registered provider had introduced a supervision format known as "You Can". This included aims that were linked to the main objectives of the registered provider. Each supervision session included an account of the knowledge, skills and behaviour of each staff member and sought accountability for actions, the maintaining of relationships with those they supported as well as developing their skills. Supervision sessions took place regularly and included an annual appraisal for each member of staff. Staff told us that supervision took place regularly.

Training records were available. These included health and safety topics such as infection control, first aid, food hygiene and fire awareness. All these were up to date. A computerised system identified when staff were due to have refresher training in these topics. In addition to this, training was available in relation to medication awareness, safeguarding and mental capacity act awareness. Staff confirmed that they received

regular and relevant training. Some people who used the service had health needs that affected their daily lives. Training and awareness sessions had been given to the staff team to ensure that these needs could be met.

New staff received a structured induction. This was evidenced through recruitment records for newer staff. The induction process used by the registered provider was linked to the care skills certificate. The Care Certificate is provided by the Skills for Care organisation and is the start of the career journey for staff and is only one element of the training and education that will make them ready to practice. Induction included a training programme. This included mandatory health and safety topics as well as medication administration and safeguarding. New staff were expected to shadow existing members of staff until such time as they were deemed competent in their new role. The induction process included mandatory training in health and safety topics as well as medication administration and safeguarding vulnerable adults.

Care plans included reference to the communication skills of each person supported. This involved how people communicated and how communication or key words could give staff an indication of what people were saying non- verbally. These assessments were included within the initial "getting to know me" document. Records included what people used sign language or other methods and the best way that staff could effectively communicate with each person.

Assessment documentation outlined the nutritional needs of each person. This was then translated into a plan of care which detailed how people's nutrition could be effectively meet by staff. Care plans included an indication of the likes and dislikes of people in relation to food. Some people required support in preparing meals and this was included within care plans as well as risk assessments. All staff had received training in food hygiene. Some people had health needs which were included in nutritional assessments. Some people received nutrition through a PEG feed which is an alternative way of receiving nutrients because of some other enduring health issue. In these cases, staff had received training in how to do this, care plans outlined the steps needed to do this effectively and how to best support people through this process. Records were maintained on the amount of nutrition people had received through this method.

Good

# Is the service caring?

## Our findings

People told us "Staff are lovely, they can't do enough, they have been with me for a while", "They [staff] are very good you know", "Yes I am very looked after by all of them, of course", "They [staff] always knock on my door first they never just come in", "I have personal care yes, they always make sure I am covered up you know what I mean, I like that", "It's a new experience to me having carers, but it's great"," "My family is always kept up to date as well and they always tell me" and "Staff tell me everything so I know what is going on".

Staff outlined the approach they took in supporting people. They said that they considered their work made a difference to people's lives and that was their main aim. They said that they fully respected they were working in people's homes and that was important. Part of their role was to support people with activities and in planning holidays and that this was an extension of how they cared for people through their involvement. They told us that caring for someone was their main role.

Quality assurance questionnaires made reference to whether people considered their privacy and dignity was promoted. In all cases responses considered that this was done and comments were positive about the way people had been treated as individuals.

Records indicated that the registered provider sought to ensure that the wellbeing of people was promoted. This involved details about their health needs and the support provided in assisting people to attend GP appointments and other health agencies. Care plans included details of the main health needs of people and the action to be taken to enable these needs to be met. Records were available outlining the action staff had taken in response to a health problem and the outcomes for each person. Additional information was in place evidencing that people were supported in attending general health check-ups to ensure their continued wellbeing. Staff told us that when someone becomes ill, a team approach is used to ensure that the person is looked after and recovers.

Information was provided to people who used the service in a number of ways. These included a supported living guide, tenant handbook and policies and procedures. All this information was presented in a format that met the communication needs of people and included pictures and symbols. The supported living guide gave detailed information including what the aims of the registered provider were, how they would have their needs assessed, how they would be assisted in settling into new support arrangements and how personal care planning would involve them. Further information was available relating to finances, keeping people safe and their human rights. All information was up to date and had been reviewed.

Further information was provided to people who used the service through a regular newsletter. These provided information about the support they received and people were free to contribute to the newsletter with any news that they had and wished to share.

The emphasis on person centred care plans was to outline the individual needs of people. No care plans were the same with each outlining the very specific needs and support that people had and would receive.

This meant that people were treated as individuals with the aim to enable people to be as independent as they could.

A confidentiality policy was in place. This was up to date and assured people who used the service that their personal details would not be shared with people unless they agreed. Staff had signed a confidentiality policy to confirm that their practice would not disclose personal details externally.

Good

# Is the service responsive?

## Our findings

People were aware of their care plans and felt that they could contribute to them. They said that all care plans and risk assessments were regularly reviewed. People told us that they could do whatever they wanted in the lives: "If I want to go anywhere I can, I just say what I want to do"
People knew how to make a complaint. They told us 'If I was not satisfied I would say, I know who to speak to' and "If I've got a problem, I know I can talk to someone". They told us that they were able to be supported by the staff team with activities. They said "When we go on supported activities I feel safe as it is planned well to ensure people get the best time out of it."

Assessment information was available and completed prior to people receiving support from the service. This consisted of a "getting to know me" document. This included detailed information relating to all aspects of people's daily lives including their physical and social needs. Other information included people's communication needs, an account of their general capacity to make decisions for themselves, preferences and significant individuals who were involved in their support. There was evidence that each person had had the opportunity to contribute to these and people told us that they were involved in reviews of these.

Assessment information was then translated into a plan of care. The registered manager told us that care plans were being re-devised. This was to ensure documents were easier to follow for people who used the service and the staff team who supported them. Older care plans seen contained the information needed to support people yet contained too much information hence the redevising of care plans. Newer care plans provided information that people who used the service and staff could easier refer to. All care plans were person centred and included a thorough account of all the needs people had and how these should be met. Care plans included reference to what was important to each person, what others liked and admired about them and how best to support them in all aspects of their daily lives. These were presented in a format which included pictures and symbols allowing people to better understand how their needs were to be met.

All care plans were reviewed on a monthly basis. This included staff sitting down with individuals to assess what activities they had done, how their health needs had been met as well as other issues that had occurred through the month. Where possible people had signed their reviews to confirm their agreement with it. A more thorough review of care plans took place annually and this included meetings with the individuals and all others who were connected with the support they received.

Care plans were supported by daily records to enable people's progress and their support to be assessed. These notes were detailed and provided a full account of any significant issues that people had experienced.

Records indicated that people either pursued activities in the local community or had obtained paid or voluntary employment. Details of people's preferred activities were included within care plans and included the numbers of staff needed to support them or any risks involved in pursuing activities. Care plans also included the wishes and aspirations of people in relation to employment or specific life goals.

A complaints procedure was available. This was presented in a format using pictures and symbols designed

to assist those who had specific communication needs. The procedure outlined how complaints would be investigated and dealt with. Complaints records were logged with details of timescales of when they needed to be responded to. Our records showed that no complaints had been received by us in relation to the registered provider.

Good

# Is the service well-led?

## Our findings

People had positive views of the service and the support they received. While they did not specifically mention the running of the service, they had experienced positive support from the registered provider.

Staff told us that they felt support by the management team and considered them to be approachable. They told us that managers "Helped the best they could" and that they felt safe working for the organisation. Staff told us that managers were involved in the individual support and reviews of people who used the service. Staff told us that it was a good company to work for.

The registered provider had established a system for auditing. A quality assurance team was employed by the registered provider and their role involved all aspects of quality assurance throughout the region. This role included visits to people's homes to look at areas such as medication, finances, support plans, and protecting vulnerable adults from abuse. Findings were then transferred to an action plan. The frequency of visits was determined by the degree of risk found on each visit and responses to issues being addressed. In some cases where issues were identified, quality assurance officers conducted reactive training for staff showing them how to achieve best practice in each area. Visits were aligned to those standards that CQC use in determining the quality of the service provided.

All incidents, accidents, training and safeguarding issues were computerised allowing the registered manager to access these and ensure action had been taken. All senior managers within the organisation had access to these figures. Any issues arising would be fed back to senior managers within the organisation on a monthly basis. This was to ensure that the quality of support provided met the needs of the people who used the service.

Questionnaires had been sent to the people who used the service. This had been done in 2014 and related to a series of questions such as whether people were happy with the support provided, whether staff were reliable, whether staff took their time to support people and whether people felt as though they had choice and control over their lives. Views expressed by people and their families were positive and concluded that people were happy with all aspects of the support they received.

In addition to this, staff had been invited to express their views on the quality of the support they provided. The results of this had been positive with some room for improvement identified. Where suggestions to improve had been raised, the registered provider had sought to be transparent in outlining those areas for improvement and stating what action was to be taken in order to address them. Staff had been invited to take part in a staff focus group. Staff had been invited to elect representatives to attend these meetings so that their views could be taken into account by the executive team. All staff had access to a social media group which was only available to employees of the registered provider. This enabled information to pass throughout the organisation and for staff to have direct contact with the senior management team of the registered provider.

The registered manager demonstrated a good understanding of the responsibilities of their role and of

registration with CQC. The registered provider always informed us of any incidents that adversely affected the wellbeing of people who used the service. The certificate of registration was on display in the main office and details on that were correct.