Sense

SENSE - Community Services (North)

Inspection report

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Date of inspection visit:
14 September 2016

Date of publication:
05 December 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?	Requires Improvement

Summary of findings

Overall summary

The service provides domiciliary care to two people with sensory impairments in their own homes. Both people also attended a day service run by the provider but we did not inspect this as it was outside the scope of our regulations. The domiciliary service was last inspected on 6 February 2014 and met all the regulations we inspected at that time.

This inspection took place on 14 September 2016 and was announced.

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.

There were safeguarding policies and procedures in place and staff had received training related to the safeguarding of vulnerable adults. Safe recruitment practices were following which helped to protect people from abuse. There were suitable numbers of staff working in the service. Regular staff visited people to maintain consistency and to avoid causing distress to people.

A policy was in place for the safe administration of medicines, and we spoke with staff who confirmed that medicines were appropriately stored, administered and recorded. A lone working policy was in place which recognised the potential risks to staff who were working in isolation away from other colleagues. On call managerial support was available to staff out of hours.

Risks in people's homes had been assessed, as had individual risk to people including those related to health needs or behavioural disturbance and distress. Person centred support plans were in place which detailed the support needs of people, and how staff should interpret the individual communication by people which could indicate their happiness or discontent in a situation. People were supported with eating and drinking, and training and competency assessments had been carried out to ensure staff could do so safely where people required specialist support such as enteral feeding [through a tube in the abdomen].

Staff received regular training, supervision and appraisals. Staff meetings were also held. Staff were line managed on a day to day basis by the day centred managers where they also worked, and did not have regular contact with the registered manager.

Staff were caring and respectful in their discussions about people who used the service. Care records were also sensitively written and courteous. The privacy and dignity of people was maintained and people were afforded maximum independence and privacy within clear boundaries for safety.

The registered manager was not taking day to day charge of the service when we carried out the inspection. They explained to us that they had taken on a regional operational role which prevented them from doing

so and that they planned to de register with the Care Quality Commission [CQC]. Responsibility for the day to day running of the service had been delegated to two day services managers who were not registered with CQC. They took responsibility for monitoring staff training, carrying our supervision, appraisals and competency assessments, holding staff meetings, monitoring care and support plans and responding to enquiries from family members. Although the registered manager could be contacted for advice and support when necessary, we judged that they were unable to provide sufficient managerial oversight of the service due to their other commitments and responsibilities. Quality assurance systems were insufficiently structured to ensure the quality and safety of the service, and the responsibility for carrying out certain checks and audits was unclear. We have made a recommendation about this.

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.

Safe recruitment procedures were followed which meant people were protected from abuse.

Risks to people were assessed and reviewed to ensure the safety of people who used the service. The safety of staff was also considered and there was a personal safety and lone working policy in place.

Medicines were managed safely and a procedure was in place to ensure the competency of staff administering medicines.

Is the service effective?

Good

The service was effective.

The service was operating within the principles of the Mental Capacity Act and staff had received training. Guidance was available for family carers which explained the act.

Staff received regular training, supervision and appraisal. New systems were being developed to ensure that staff training was clearly documented and easy to interpret.

People were supported with eating and drinking and specialist support was sought if required.

Is the service caring?

Good

The service was caring.

Staff spoke respectfully about people and language used in care records was sensitive and courteous.

The privacy and dignity of people was maintained. They were afforded maximum independence and privacy, whilst ensuring safety was not compromised.

No one was accessing any formal advocacy at the time of the inspection. A service user reference group attended services and

meetings within the organisation to represent the views of people who used the service.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place which were up to date and regularly reviewed. A relative told us they were involved in regular reviews of the care and support provided.

People were supported to take part in the activities identified in their support plan, or could choose how to spend their time.

A complaints procedure was in place and the provider shared compliments and complaints received nationally to enable wider learning at local level. Compliments were also shared and celebrated.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

A registered manager was in post but they did not take day to day charge of the service. They had recognised that they were unable to provide the level of management necessary so had applied to CQC to de register as the manager of the service.

There were some quality assurance systems in place, but the person responsible for carrying out these checks was unclear, and they were not always clearly documented.

Staff told us they felt well supported and a relative told us they had no concerns about the quality 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.

This inspection took place on 14 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service to two people and we needed to be sure someone would be available to assist us. The inspection was carried out by one inspector and took place at the office base for the service.

We looked at two staff recruitment, training and supervision records, and the care and support records of two people who used the service. We also reviewed information we held about the service including any statutory notifications that the provider had sent us. 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.

We spoke with the registered manager, two relatives, four staff members and a community nurse. We were sent information following the inspection to support us with our enquiries.

Before the inspection, the provider completed 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.

Good

Is the service safe?

Our findings

There were policies and procedures in place related to the safeguarding of vulnerable adults. Staff had received training in safeguarding and told us that they knew what to do in the event of concerns. One staff member told us, "We do safeguarding training but I have never seen anything to concern me. If I did I would report it to my manager straight away. I also know there is a whistleblowing policy which we can follow." There was a designated safeguarding lead in the organisation and was available for staff to seek advice and support related to safeguarding issues.

A policy for the safe administration of medicines was in place, and we spoke to staff who confirmed that they followed this in practice when visiting people at home. Staff had received training in the administration of medicines. We asked how the competency of staff was monitored with regards to administration of medicines. The manager explained that due to the small number of hours of support delivered to people in their own homes, and the fact that people who used the service found changes to their routine difficult, staff competency was observed while working in day services. There were clear instructions in place regarding how each person liked to take their medicine, and the level of support they required. Staff told us that they documented medicines administered on a medicine administration record [MAR] after they had given it, and they also recorded in the diary held in the service at the request of family members. We did not view these records in people's homes, but we checked sample MARs held in the office which were completed satisfactorily.

Safe staff recruitment procedures were followed to ensure staff were suitable to work with vulnerable people. We were provided with the records of two staff members after the inspection as all staff recruitment files were held in a central office in Birmingham. The records showed that application forms had been completed for each person, and where there had been difficulty obtaining a second reference this was pursued and an alternative sought. One reference was from the applicant's most recent employer, and any gaps in employment were explained. Applicants had been screened by the Disclosure and Barring Service (DBS) to ensure they were suitable to work with vulnerable people. This helped to protect people from abuse. There were suitable numbers of staff employed. Due to the flexibility of the staff and people who used the service, there had not been any occasions where the service could not be provided. Staff were willing to change their days and times of visits to suit the needs of people where necessary. There had been no missed calls.

A personal safety and lone working policy was in place. Lone working is defined as any situation or location in which a person works without a colleague nearby. This includes working into people's own homes. We spoke with a staff member who told us that they were aware of how to seek support if necessary. There were on call arrangements for staff to seek support from a manager out of hours.

Risks had been assessed in relation to the home environment in which people were working, and also individual risks to people. Assessments of people included the risks associated with behaviour, choking, seizures, and bathing. Staff had received relevant safety training including health and safety, guiding techniques, first aid and behavioural interventions which helped them to support people to remain safe.

Good

Is the service effective?

Our findings

We reviewed staff training records held in the office but the information was not readily available or easy to interpret. A new learning and development department had opened within the organisation and this had resulted in some changes in the way that training was delivered and documented. We were provided with further information following our inspection about the training staff had received which was clearer. Work was continuing to ensure training records were easy to understand. There were some gaps in training but plans were in place to address these. Staff records showed that they had received training in moving and handling, nutrition awareness, food hygiene, positive interactions, equality and diversity, and living life. We spoke with a staff member who told us, "We receive plenty training. We have just done MCA and challenging behaviour training. We did training about risks of choking on or aspirating food." This meant that staff were trained in areas relevant to the care they provided which was updated on a regular basis.

Staff received regular supervision and appraisals. All aspects of service delivery, including supervision and appraisals, were underpinned by what was referred to as "I statements." These reflected the values of the organisation and there were eight statements which included; 'I will listen to others, I will understand and respond, I will respect others, I will be honest and open, I will participate and contribute, I will take informed risk, I will find things to celebrate.' There was an additional statement which was 'No decision about me without me' which was used in care settings to promote inclusion and involvement of people who use services. The registered manager told us, "The I statements lead everything we do. We use them in supervision and they are drilled in, staff quote them. They are owned by everyone and are part of the induction training for everyone. We use them in our conduct with everyone, including other agencies; they are a very effective set of values."

Supervision took place every six weeks and we spoke with a member of staff who told us, "There is regular supervision, and if I had any concerns I would speak to my line manager in between. If we were worried about the behaviour of someone we would all meet up; it's good to discuss risks or strategies so that we are all doing the same." Staff told us they felt well supervised and supported. We saw records of supervision and appraisal which were entitled 'My performance plan'. This meant that the provider sought to meet the support and development needs of staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We spoke with staff who confirmed

their understanding of the MCA and under which circumstances decisions might need to be taken in the best interests of people who used the service. Best interests decisions can be made and recorded when the person lacks capacity to make a decision for themselves. One staff member told us they would highlight if they had concerns about restrictive practices; they told us, "We would complete restriction forms if we felt there were any restrictions being placed on people." We asked staff under which circumstances they might need to consider best interests decision making and they were able to give hypothetical examples.

We checked care records and found that the service was operating within the principles of the MCA. The registered manager told us, "Staff ensure people's best interests are met by developing support plans and creating weekly planners which are based on the needs, likes and preferences of people supported." Care records included individual guidelines to inform staff about how people could make choices and decisions and what support they would need. Information was provided for staff about each individual and under which circumstances they could consent and how, depending on their ability to communicate this. People who used the service had care plans in place which were necessarily structured and routine, therefore there was little deviation from these as this caused people to become unsettled or upset. This meant that the amount of decisions people were asked to make during visits from staff were limited to a degree. A guide for families and carers about the MCA was provided by the service.

The level of support people needed with eating and drinking was clearly documented. One person was nil by mouth and staff had been trained in the enteral feeding technique used. Enteral feeding involves the use of a tube into the gastrointestinal tract to provide people with their nutrition as opposed to orally. An information pack and further guidance was recorded in care records which advised staff of the action to take in the event of any problems, including who to contact. We observed that competency checklists had been completed related to enteral feeding but it was unclear how often these took place, and some forms were undated. We spoke with a day services manager who told us that staff had received initial training from an NHS practitioner, but they had later trained a member of staff to deliver training in house to ensure that training and timely advice could be provided to staff. Eating and drinking assessments in care files included information about portion sizes, likes and dislikes, presentation and special dietary requirements, swallowing difficulties [dysphagia] and choking.

We recommend that documentation related to the safety and competency of staff to support people with nutritional needs via enteral feeding, is more clearly recorded.

The health needs of people who used the service were considered during assessments but family members who lived at home with people took responsibility for arranging routine health checks and appointments. The community nurse of one person told us, "The intervenors [staff] work very well with [person] and have known them a long time. We are providing additional training about health needs to improve their knowledge of [a specific health complaint]."

A relative told us that staff communicated effectively with their relation and said, "[Staff member] is competent in British Sign Language which is such a wonderful addition because they can sit and talk; they provide an excellent service."

Good

Is the service caring?

Our findings

We did not visit people who used the service so were unable to observe staff while they provided support. However, we spoke with relatives of both people supported and received positive feedback. One relative told us staff were caring and that the person they supported regarded them more as a 'peer' than as carers. People were visited by regular staff members who also supported them at day services. This helped staff to develop relationships with people who used the service, some of whom could find this difficult. Another relative referred to staff as "Diamonds" and another staff member as "An absolute star" for their help and support during a particularly difficult period for the family.

A staff member told us that they had a good working relationship with the person and their family. We asked them about how they supported people to express their views and they told us, "[Name of person is very capable of making their own decisions so we always ask their opinion. We also review daily contact sheets on a regular basis to review what had worked well or needs to be amended."

We spoke with staff and reviewed records they kept about people who used the service. Staff spoke respectfully about people who used the service, and respectful person centred language was used when writing about people. Daily contact sheets were kept in which staff wrote about how people had spent their time, and the support they had provided. These were written in the first person, and they showed that people were supported in a way that promoted their independence taking into account of how they felt on a daily basis, for example, "I chose to have my teeth brushed in my room because I was sleepy."

We spoke with a relative who told us that their relation was well cared for; they said, "They get on very well with [name of person]; they look after them very well." They also told us that the staff who visited the service provided care in line with the plans in place, but would offer the person they were supporting opportunities to carry out some tasks on their own and to remain as independent as possible. They told us, "They give them opportunities to do things on their own. I like that they [staff] let them do a few more things; it benefits me as well as these are things that I can try too."

The privacy and dignity of people was maintained. Care plans we read detailed the amount of supervision that was required for bathing to maintain their safety, whilst affording the person as much privacy as possible. Policies and procedures were in place related to privacy and respect including a confidentiality policy and the use of staff personal mobile phones.

None of the people who used the service were accessing any form of formal advocacy at the time of the inspection. There was, however, a regional 'Sense users reference group' who could visit services and attended management meetings to represent the views of deaf and or blind people.
Information was provided in an easy read format where appropriate and used adapted communication methods to seek the views of people where possible. The non- verbal communication of people was also observed and taken into account when considering the views of people.

Good

Is the service responsive?

Our findings

A relative told us that staff were responsive to people's needs and that the times of visits could be adjusted to respond to changing needs. They said, "The staff are very flexible, and person centred." The registered manager told us, "We try to maintain staff consistency." This meant that regular staff visited people wherever possible to avoid disruption to their routines and preferences.

Each person had a support plan which was person centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning support Plans contained comprehensive information about people's likes and dislikes. These were broken down into 'Things I really like, things I like, things I dislike and things I really dislike.' It was important that staff were aware of these, particularly dislikes, due to the potential for these to cause a distress reaction which could result in behavioural disturbance. Due to the communication difficulties some people experienced, care records were explicit about how staff would recognise if a person liked or disliked something, through their facial expressions or gestures. There was evidence that support plans had been reviewed on a regular basis to ensure that the information was up to date and reflected the care and support required.

Records showed, and a relative told us, that they were regularly involved in reviews and discussions about support plans. They said, "We have regular reviews but if I have any concerns I can go to see the manager [day services manager] or they will come to see me and things are quickly resolved." Reviews were structured and contained headings which checked how family members and people found communication with staff and managers, and what they would change about the service and any improvements they would make. As it was difficult to ascertain the views of people who used the service, daily contact sheets were analysed thoroughly every six months to check for that was working well and any areas that did not appear to be working so well so these could be discussed during reviews.

We did not visit people in their homes but we saw from records that people were supported to take part in activities that they wished to. They were supported in their own homes and during the visit from the service; some people chose to spend some time on their own in their bedroom. At other times they sat with staff and did things they enjoyed such as colouring in. People attended day services so could be tired upon their return home so the level of activity staff engaged in with people was determined by their preferences.

A complaints procedure called 'Resolving issues' was in place but no formal complaints had been received. We spoke to a relative who told us that they had not had to make any formal complaints and that any minor concerns were quickly addressed. Complaints that had been investigated in other services nationally were shared locally. The registered manager told us, "There is always something to learn from these." Compliments were also shared and celebrated within the organisation.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. A staff member and a relative we spoke with told us that another manager was in charge and that they did not see the registered manager on a regular basis. One staff member told us, "X is my line manager, I wouldn't go to [name of registered manager] unless they couldn't help me or were unavailable. I did go to the registered manager once. He was lovely and sorted things out for me." The service was being managed by two day services managers.

Each person who used the domiciliary service attended day services and the staff that supported them at home worked there also. We spoke with the registered manager who told us they had taken on a wider regional operational role within the organisation and that they were aware that this meant they were unable to provide day to day management of the domiciliary service. They said it was explicit to front line staff that they were still the registered manager until changes took place. From our conversations with staff and a relative however this was not clear to people.

During our inspection, when we asked for specific information about the running of the service, the registered manager referred us to the day services managers to provide this. They were in day to day charge of the service and monitored care, line managed staff, held staff meetings, liaised with relatives and provided on call support for staff out of hours. The registered manager was knowledgeable and experienced, and was passionate about the services they provided. Staff and other managers told us they felt well supported by the registered manager, who could be contacted for advice and support if necessary but we observed that the registered manager did not have sufficient oversight of the service due to their other commitments. Systems for the monitoring of the quality and safety of the service were unclear. Although audits and checks of care records for example, appeared to be being carried out, they were not always formally recorded or carried out in a systematic way, and there was confusion about who was in charge of the service.

We recommend that the responsibilities of the registered manager and systems for monitoring the quality and safety of the service are more clearly defined.

No concerns about the quality and safety of the service and staff were raised with us and a relative told us people were safe and that the quality of the service provided was good. The day services managers observed the practice of staff while people attended day services. This avoided disrupting their routine at home, or potentially upsetting people by having too many staff visiting. The registered manager kept duplicate care records and copies of medicine administration records at the office which they told us they sampled on a regular basis. Quality assurance surveys or questionnaires were not in use so the views of people were monitored on a daily basis through documenting their reaction to the support provided and activities they engaged in, and through careful monitoring of their individual methods of communication. Relatives attended reviews on a regular basis and there were plans to meet with them on a three monthly basis to ascertain their views about the quality of the service.

The registered manager told us that there was regular contact with the senior management team, and

general management team meetings were held on a regular basis. These meetings had standing agenda items including finance and compliance with regulations. The provider monitored the financial viability of services and compared themselves to other providers that had been rated by CQC to see where they could make improvements and work towards having outstanding services.

We had not received any statutory notifications from the service. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We checked with the registered manager who told us that there had been no notifiable incidents, and that they were clear about what must be reported.

A number of benefits were available to staff working in the service including cheaper personal mobile telephones, health insurance and access to a counselling service for themselves and family members.