Possability People Limited

Montague House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 10 April 2018 and was announced. The provider was given 48 hours' notice because the location provides a care at home service. We wanted to be sure that someone would be in to speak with us.

Montague House is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and provides a service to adults. On the day of the inspection the service was supporting fifteen people with a range of health and social care needs, such as people with a physical disability, sensory impairment or people living with dementia. Support was tailored according to people's assessed needs within the context of people's individual preferences and lifestyles to help people to live and maintain independent lives. Staff who supported people using the service were also known as personal assistants.

At the last inspection on5 July 2016, the service was rated as good in the areas of Effective, Caring, Responsive and Well-led. The service was rated as requires improvement in the area of Safe but the overall rating for the service was Good. At this inspection we found the evidence continued to support the overall rating of Good and there was no evidence or information from our inspection and on going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The new manager had been monitoring the quality of the service by the use of visits to people's homes and internal quality audits they had introduced. Where these had been recently introduced by the manager they were not fully completed and information was not consistent. People and staff felt that they were not receiving effective communication about any changes that had been, and were, taking place. We identified this as an area of practice that needed to improve.

People and relatives told us they felt the service was safe. The provider had made improvements to their systems for recruitment to ensure that staff were suitable to work with people. People remained protected from the risk of abuse because staff understood how to identify and report it. People continued to receive their medicines safely. The provider had arrangements in place for the safe administration of medicines. People were supported to maintain good health and had access to health care services

Staff considered peoples capacity using the Mental Capacity Act 2005 (MCA) as guidance. People's capacity to make decisions had been assessed. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported at mealtimes to access food and drink of their choice. Some people's food preparation at mealtimes was supported by staff or themselves, staff ensured meals were accessible to people.

People's individual needs were assessed and care plans were developed to identify what care and support they required. People were consulted about their care to ensure wishes and preferences were met. Staff worked with other healthcare professionals to obtain specialist advice about people's care and treatment when required.

Staff continued to have the knowledge and skills to support people. There was an induction process and a training plan in place for essential training such as, safeguarding and health and safety. Staff also received training updates when required and supervision.

People and relatives felt staff were kind and caring. Staff spoke warmly about the people they supported and provided care for. Staff were able to detail people's needs and how they gave assurance when providing care.

Further information is in the detailed findings below

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 improved to Good.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Requires Improvement

The service has deteriorated to Requires Improvement.

Systems of quality assurance had been introduced but not fully implemented and required to be embedded to ensure good oversight.

People and staff felt that they were not communicated to enough by the new manager and any changes that had been and were taking place.

Montague House

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 10 April 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We wanted to be sure that someone would be in to speak with us.

The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we held about the service. This included notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted six health and social care professionals involved in the service for their feedback and received feedback from two regarding the service.

During our inspection we spoke with six people and three relatives over the telephone, four personal assistants, an administrator, the co-ordinator, branch manager and the integrated services manager. We observed the managers and staff working in the office dealing with issues and speaking with people over the telephone.

We reviewed a range of records about people's care and how the service was managed. These included the care records for five people, medicine administration record (MAR) sheets, five staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

The service was last inspected on the 5 July 2106 and was awarded the rating of Good. At this inspection the

service remains Good.

Good

Is the service safe?

Our findings

At the last inspection on 5 July 2016 we found not all aspects of the service were safe. The provider had not undertaken the required pre-employment checks to ensure that staff were suitable to work with people and we identified this as an area that requires improvement. At this inspection we saw the provider had taken action to improve pre-employment checks following our last inspection.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or adults. The provider had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form.
This meant the provider could be sure that staff employed were suitable to work with people and of good character and not put people at risk of harm.

Staff continued to receive training in safeguarding adults with regular updates. They were able to describe how they would recognise the types of abuse and what actions they would take should they be told or suspect that abuse had taken place. There were safeguarding and whistleblowing policies in place in the office and in people's support folders in their homes. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation or directly to external organisations. Personal Assistants we spoke with confidently knew about safeguarding and gave clear examples on how they would deal with any concerns. They said they would not hesitate to raise a concern should it be necessary. One personal assistant told us "I see the same person on a regular basis and have built up a good rapport and would notice if anything was wrong and would hope they would open up to me as well. I would report any concern to the office straight away".

People and relatives told us that they felt safe using the service. One person told us "I've always felt safe with my carer, they call out when they arrives I know it's them, I trust them in my home I'm not sure why, I've just never doubted them".

There were sufficient staff employed to meet the needs of people. Each person had a team of dedicated staff to support them, with their own rota. Sufficient staff were allocated to each person to ensure that there was cover. Rotas were flexible and person centred to support independence and choice. One person's rota demonstrated members of the team covering each other's shifts to allow for staff holidays and training. The rota also showed where extra members of staff had been made available to support people to go out and take part in their chosen activities or attend appointments.

People remained supported to receive their medicines safely. We saw policies and procedures had been drawn up by the provider to ensure medicines were managed and administered safely. Audits of medicine administration (MAR) were undertaken to ensure they had been completed correctly. Any errors were investigated, for example, if a missing signature had been highlighted for the administration of a medicine.

The manager would investigate and the member of staff would be spoken with to discuss the error and invited to attend further training if required. People told us they received appropriate support with their medicines.

Personal assistants remained taking appropriate action following accidents and incidents to ensure people's safety and this was recorded in the accident and incident book. We saw specific details and any follow up action to prevent a reoccurrence. Any subsequent action was updated on the person's care plan and then shared at staff handover meetings. The management team analysed this information for any trends and action put in place where required

People were protected by the prevention of infection control. Personal assistants had good knowledge in this area and attended regular training in this area. PPE (personal protective equipment) was used when required including aprons and gloves. The provider had detailed policies and procedures in infection control and observations in people's homes incorporated infection control to ensure staff were following the guidelines. One personal assistant told us "We have a good supply of gloves and aprons in the person I support, it is never a problem".

Detailed risk assessments had identified hazards and how to reduce or eliminate the risk. For example an environmental risk assessment included an analysis of a person's home inside and out. The condition of pathways and access to a person's home considered whether a risk of trip, slip or fall for either the person or the staff member and if there was adequate lighting. Other potential risks included the equipment people used and how personal assistants could ensure they were used correctly and what to be aware of. For example one care plan detailed that a person used a walking aid and how personal assistants needed to make sure the person was encouraged and supported the person to use the aid. This meant that risks to individuals were identified and managed so staff could provide care in a safe environment.

Good

Is the service effective?

Our findings

People and relatives felt confident in the skills of the staff and felt they were trained well and also felt staff had been well matched. One person told us "I have had the same person since the start its good as now we are just like friends, I think we are matched very well". Another person said "I see the same member of staff since the start I like that, we get on".

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. Staff had good knowledge and an understanding of the (MCA) because they had received training in this area. People were given choices in the way they wanted to be cared for where possible. People's capacity was considered in care assessments so staff knew the level of support they required while making decisions for themselves. Staff told us how people had choices on how they would like to be cared for. One personal assistant told us "People have capacity to make their own decisions and choices and we support these. If we have a concern about someone's capacity or a choice they are making then we would contact the office and discuss this".

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity and faith. Some of these needs were recorded in care plans and staff we spoke to knew the needs of each person well. Staff also attended equality and diversity training. People using the service also commented on how well their individual needs were met.

Personal assistants were given a job description which outlined the expectations of them and their role and had access to a range of policies and procedures to guide and support them in their role. Staff undertook a variety of essential training which equipped them with the skills and knowledge to provide safe and effective care. Training schedules confirmed staff received training in various areas including moving and handling, medicines and infection control. Staff completed their training on induction and updates in a classroom setting. One member of staff told us "I have regular training updates, last month I did safeguarding and got a few coming up next month to attend".

Staff received support to understand their roles and responsibilities through supervision these consisted of individual face to face and telephone meetings where they could discuss any concerns, training and development. The manager showed us a supervision plan on how he was ensuring he was meeting with each member of staff individually. They told us "I have my plan and met with some staff already and this is on going. Being new in my role I want to meet everyone individually, so we can get to know each other".

Personal assistants supported people to eat and drink by helping them with shopping and preparing food. One person said "If I have not had my breakfast they will look in the fridge tell me what I've got in there, maybe eggs, bacon, and they will cook something for me". Another person said "My personal assistant will take me out for lunch it's good for me to mix with other people, they will encourage me to order the food, it's

all good for my confidence". Staff were knowledgeable about people's preferences and dietary requirements and gave examples of how they needed to remind and encourage some people to eat and drink sufficiently. For example one person had to follow a specific diet and needed food presented to them in a certain way. Staff were able to describe how they supported the person and this support was reflected in the person's individual support plan.

People remained supported to access and attend routine health care appointments such as visits to the GP, dentist and chiropodist. One person told us "My personal assistant will always take me to any appointments I have". Staff monitored people's health and wellbeing and supported them to access or request referrals to services as and when required. One person was supported to manage a complex health need. There was detailed guidance for staff in place and staff clearly understood this person's condition and were able to confidently describe the actions they would take should they become unwell and gave examples on how good professional relationships had been built up with regular contact with other health professionals.

Good

Is the service caring?

Our findings

Staff spoke with great compassion for the people they supported and gave examples of how rapport had built up and they worked closely with the same people. One personal assistant told us "I have worked with one person for a long time and know their needs inside out. I know how they like things done and it is great they have that continuity all the time".

People and relatives felt all staff were caring and kind. Comments from people included "My carer is very caring we have a laugh and I feel that she listens to me, I feel like she is my friend. Whilst we are doing things she will chat to me" and "I feel we are a good team we work together to make things better, he's funny and there is good banter between us". A relative told us "All the staff are very caring. They can have a hard job sometimes but they are lovely".

Staff spoke with affection and warmth in their approach towards people. They gave examples of how over time, rapport had built up with people and their relatives. This was down to seeing the same people on a regular basis. One member of staff told us "I spend a lot of time with one person and we have built up great rapport with one another. I know what their likes and dislikes are and how to meet their needs to ensure they can live the life they want to in their own home".

Relatives and people told us they could express their views and were involved in making decisions about their care and treatment for their relative receiving care and support from the service. They confirmed they had been involved in designing their care plans and felt involved in decisions about their care and support.

Staff remained aware of the need to preserve people's dignity when providing care to people in their own home. Staff we spoke with told us they took care to cover people when providing personal care. They also said they closed doors, and drew curtains to ensure people's privacy was respected. People we spoke with confirmed dignity and privacy was always upheld and respected. One personal assistant told us "I ensure the person I am supporting with personal care is covered with a towel and if another health professional is visiting I support them to make sure they are dressed and they don't come into their room and until they feel ready to see them".

People's confidentiality was respected. Personal assistants understood not to talk about people outside of their own home or to discuss other people whilst providing care to others. Information on confidentiality was covered during staff induction, and the provider had a confidentiality policy.

Personal assistants told us how they promoted people's independence. In one care plan it stated that a person required support out into the community. Staff told us that wherever possible people were encouraged to maintain their independence and undertake their own personal care. Where appropriate staff prompted people to undertake certain tasks rather than doing it for them. One personal assistant told us "Due to the health condition my person has, they can differ from day to day. I know their capabilities and when appropriate I will encourage them to maybe brush their own teeth if they feel they can". One person told us "I couldn't manage without them they keep my spirits up and encourage me to do things I probably

wouldn't do".

Good

Is the service responsive?

Our findings

People and relatives told us they always received a service that was responsive to their needs. One person told us "My carer goes by my mood they will adjust what we do and how they approaches me with things, like they will say perhaps we won't go out today would you rather we stayed in and watch TV". Another person said "We get on really well now, there are no awkward silences. They have taken me out a few times which I wasn't doing before they came".

A health professional told us "All workers knew my client well and were able to build up a positive working relationship with them. They knew their preferences for food and drink and social activities and worked hard to ensure her needs were met on a day to day basis".

Information for people and their relatives could be created in a way to meet their needs in accessible formats, to help them understand the care available to them. This could include large print and the manager also told us "We don't currently have anyone that requires a care plan in a different format but if this was needed we would be able to arrange this".

We saw that people's needs were assessed and detailed plans of care were developed to meet those needs, in a structured and consistent manner. The manager had recently started to update the care plans into a new format that was more structured for people and personal assistants to read and understand. The manager told us "So I get to know each person I am meeting them personally and updating their care plans into a new format. I have found this very beneficial of getting to know people and their families and ensuring we are meeting their needs". One person told us "At the start the old manager set up my care plan with the case manager and me, it all went well. There is a new manager now and he came out and gave me a copy of the care plan and we talked about what I was hoping to get out of having the support of a personal assistant". Records confirmed people where possible and their relatives were involved in the formation of the initial care plans and were subsequently involved in any care plan reviews. Care plans contained detailed personal information, which recorded details about people and their lives, likes and dislikes. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us "I think the care plans hold the right information and details. If there are any changes then we would call the office to discuss this".

Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's clinical needs and the support required meeting those needs. Care plans also contained detailed information on a person's daily routine with clear guidance for staff on how best to support that individual. For example one care plan stated how a person's bed should be positioned and how like it to be left with personal items accessible. This included photos for staff to ensure it was dealt with in line with the person's wishes. There was evidence of reviews of care, which also involved relatives or other healthcare professionals if appropriate. The reviews discussed the suitability of the person's care package, and whether or not any changes were required.

Personal assistants told us that there was always enough time to carry out the care and support allocated for each person. Staff stated that people had long hours of care which included working nights. The manager told us that the hours needed for care would be changed on review if needed to ensure people received a quality service and how the service was flexible to people's needs. We spoke with the member of staff who completed the staff rotas and discussed the scheduling with them. The staff member told us "Each client has regular members of staff for continuity. This is recorded on the system, for when I complete the rotas. Rotas remain the same for clients and all the staff know them really well".

People and relatives were aware of how to make a complaint and all felt they would have no problem raising any issues. The complaints procedure and policy were provided to them at the start of using the service. Complaints made were recorded and addressed in line with the policy and included a detailed response. Most people we spoke with told us they had not needed to complain and that any minor issues were dealt with informally.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager. The current manager had been in post for two and a half months and was currently going through the process of registering with us to become the registered manager. The service was currently in a transitional period due to the new management. We found areas of improvement and variable experiences were had by people and staff.

The new manager had been monitoring the quality of the service by the use of visits to people's home and internal quality audits they had introduced. The audit records covered areas such as training, staff files and care records. Where these had been recently introduced by the manager they were not fully completed and consistent of information. Although the latest feedback survey sent to staff and people was mainly positive, the absence of detailed and recorded auditing meant the manager could not yet be assured of the quality of service delivered. The manager told us this was an area they knew that needed to improve when they took on the role as manager and showed us examples of action plans and systems they had created to address this, however these still needed to be completed fully and embedded into practice. Although the manager was aware of the issues and was taking steps to manage getting the audits up to date, this is still an area that we have identified that is in need of improvement.

People and staff felt that they were not communicated to enough by the new manager and any changes that had been and were taking place. People's comments included "Seems they have a high turnover in managers. I think the one now is called [managers name] but I've not met or heard from him" and "I don't know them in the office. I just speak to whoever is there but I don't really have to call the personal assistant will sort any problems". Comments from staff included "I have not really met him yet. I have spoken to the new manager briefly and we have a supervision meeting set up for next week" and "There was a meeting but I couldn't go, I think there will be more but I am not sure". We spoke with the manager around communication and engaging with people and staff and they told us "I do have a plan in place to visit every person who is using the service, I have met some already and the same for staff. Unfortunately the time did not allow me to meet all of them yet. I have held a team meeting but not all staff were able to attend but these will be on going. I also have supervision meetings booked with all staff and planning for more team building meetings". This is an area that we have identified that is in need of improvement.

People's and staff feedback was remained sought and used to improve people's care. Feedback came from meetings with people and their relatives and annual surveys for people and staff. Comments were mainly positive and any suggestions made had been taken on board by the provider and acted on. From a recent staff survey, staff had identified they would benefit from career progression opportunities within the organisation and this was being looked into by the provider.

Management and staff work closely with stakeholders such as the local CCG and health specialists when required. The manager showed commitment in keeping up to date with best practice and updates in health and social care. They were also aware of our revised Key Lines of Enquiries that were introduced from the 1st November 2017. They told us "I am currently completing a diploma in health and social care and then plan to go on to complete my level 5 Diploma".

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The manager and integrated services manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.