The Camden Society

Short Term Breaks - 69 Neithrop Avenue

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

We undertook an announced inspection on 9 March 2018. Short Term Breaks - 69 Neithrop Avenue is a service where people receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service offers people with a physical or learning disability short term breaks throughout the year. At the time of the inspection the service was providing short term breaks to 33 people throughout the year. At the time of our inspection three people were staying at the service.

The care service had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service did not have a registered manager at the time of the inspection. The provider was proposing to register an existing registered manager at another service to oversee 69 Neithrop Avenue. In the meantime the service was overseen by a service manager, a Community Support Leader and a deputy manager. Support was also provided from the nominated individual (a nominated individual is responsible for supervising the management of the regulated activity provided) and a registered manager from another service. 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.

Rating at last inspection: Good

At our last inspection in October 2015 we rated the service as Good overall. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service is rated Good:

The provider was not fully following the principles of the Mental Capacity Act 2005. We have made a recommendation about the provider ensuring all guidance is referred to.

The service had not always notified the Care Quality Commission about changes that affected the service. We have made a recommendation that provider reviews their internal processes to ensure that all notifications are submitted as required.

The service was being managed, in the absence of a registered manager, by staff in the service that were supported by a service manager and the nominated individual.

People remained safe at the service. Staff knew how to recognise safeguarding concerns and what to do if they suspected any abuse. Risk assessments were carried out to promote people's well-being and recognise people's individual abilities. There were enough staff to keep people safe and the provider followed safe recruitment procedures. Medicines were administered in line with guidance.

People continued to receive support from effective staff. People's needs had been fully assessed to ensure that staff had guidance to meet these needs. Staff were knowledgeable, skilled and had the relevant skills and experience. Records confirmed staff received regular supervision sessions and they told us they were well supported.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People were supported to access health professionals when needed and staff worked closely with various external professionals to ensure people's health needs were met. People were given choice about what they ate alongside appropriate support to ensure a balanced diet.

The service continued to support people in a kind and caring way. People were treated with kindness and as individuals. People were involved in decisions about their care needs and the support they received. People's dignity, privacy and confidentiality were respected, and they received person centred care that included access to information that met their needs.

The service remained responsive to people's needs and ensured people's changing needs were recognised and appropriate changes to support were implemented promptly. People were supported to raise concerns if necessary.

The management team were keen to ensured staff put people at the forefront of the service delivery. There was an open and positive culture that valued and engaged people, relatives and staff. There were systems in place to monitor the quality of the service provided. The service worked well with various external professionals to ensure people received the input they needed from all sources.

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 remains safe.

Is the service effective?

Good

The service remains effective.

The service had not consistently applied the principles of the Mental Capacity Act 2005 (MCA). We have made a recommendation about the provider ensuring that guidance is consistently followed and adhered to.

Is the service caring?

Good

The service was caring.

Staff were caring and knew people well.

People's choices and preferences were respected.

People were treated with dignity and respect.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in post and this had not been reported as required by the provider.

A PIR had been requested but had not been returned.

There were systems and processes in place to monitor and improve the service.

Management and staff were committed to providing people with

a good quality of life in line with the values of the provider.

Short Term Breaks - 69 Neithrop Avenue

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 comprehensive inspection took place on 9 March 2018. We gave the service 48 hours' notice of the inspection visit because the location provides short term breaks. Therefore, we needed to be sure that staff would be in and there were people receiving support when we visited.

The inspection was carried out by one inspector and one Expert by Experience who telephoned relatives for their views on the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We also reviewed statutory notifications that the service had sent to CQC. A notification is information about important events which the service is required to send us by law. Before the inspection, we had asked the provider to complete a Provider Information Return (PIR). The provider had not completed the Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

We spoke with two people who used the service, eight relatives, the nominated individual (responsible for supervising the management of the regulated activity provided), the service manager, the acting manager and deputy manager and two members of staff. We looked at records including three care plans, two staff files including recruitment information.

Good

Is the service safe?

Our findings

People continued to be supported safely at the service. We telephoned relatives of those who visited for short breaks to gain their views. All relatives we spoke with said they felt confident that their loved ones were safe when they were having their breaks at the service. One person's relative said, "Once there was an incident with my [relative] where another service user became challenging and hurt my [relative]. I was informed straight away and the incident was dealt with appropriately. I feel my [relative] is safe there." Another commented, "I feel he is safe because he always has 1:1 when he is there and has been going there for 14 years."

Staff had completed safeguarding training and understood their responsibility to identify and report any concerns related to abuse. Staff were confident action would be taken if they raised any concerns. A member of staff told us, "If I was worried about anything I know I have to report to management. I have done this before and it was acted upon. If they didn't act upon it, I know I can take it higher." Records showed that all concerns had been reported, investigated and appropriate action taken to keep people safe from abuse.

People's care plans contained risk assessments and where risks were identified there were plans in place to manage the risks. Any risks present, such as epilepsy, had plans in place to ensure people were kept safe. A member of staff said, "We get to know what risks people have by reading their support plan. We are given all the information and I also read people's plans to refresh myself before they visit for respite each time. This helps me to make sure I have up to date information." Risks were regularly reviewed and any changes identified.

Relatives told us they felt there were enough staff to meet people's needs. A relative said, "I think my [relative] is safe there because there is enough staff on duty." The service continued to recruit to some vacancies. In the interim, bank and agency staff were used, and the provider ensured they were suitably skilled and were always paired with more experienced staff. Staff told us, "We could do with more permanent staff. At times, we are using agency staff and it would be better if we had our own staff. However, I feel on the whole people are safe with the staffing we have." The provider had safe recruitment and selection processes in place.

Medicines were managed safely and people received their medicines as prescribed. A relative told us, "All medication is checked in and out when I drop my [relative] off." Staff were provided with training and their competency checked to ensure they were safe to administer medicines. Medicine administration records (MAR) were fully and accurately completed. Where people were prescribed 'as required' medicines (PRN) there were protocols in place identifying when the person may require the medicine.

The provider had effective systems in place to monitor accidents and incidents to identify trends and patterns. A member of staff said, "We complete incident forms and these are then given to our manager. For example, a person supported was experiencing poor mobility which was a risk. I reported it to the manager and we got increased support agreed to keep them safe." Team meetings had de-briefs after incidents and discussed 'near misses'. This meant lessons were learnt and acted upon following incidents to keep people

safe and avoid similar incidents in the future.

Staff were clear about their responsibilities to follow infection control procedures to minimise the risk of infection. Records had been kept to evidence action was taken to keep the premises and equipment safe. Any issues were addressed and resolved promptly.

Good

Is the service effective?

Our findings

The service continued to provide effective care and support to people. People's needs were assessed gathering information from the person themselves and those who knew them well both personally and professionally. These assessments were used to develop care plans to guide staff in how to support people to achieve effective outcomes for people.

People were supported by staff that had the skills and knowledge to carry out their roles and responsibilities. For example, staff had training delivered by health personnel to ensure they understood techniques such as Percutaneous Endoscopic Gastrostomy (PEG). This is used when people are unable to eat orally and food is delivered via a tube into the stomach. A relative said, "They only have trained staff for my [relative] because he is peg fed. Most of the staff have been with him for some time, but understandably some do leave. I do know if a new member of staff assists my [relative], they shadow a permanent member of staff first."

Staff told us they had received induction and completed training when they had started working at the service. A member of staff told us they were well supported through supervisions (a one-to-one meeting with their line manager). A member of staff told us, "My manager is supportive and listens. We can ask for training and this is arranged."

People were not consistently supported in line with the principles of the Mental Capacity Act 2005 (MCA) which ensured their rights were upheld. The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. We found that an assessment had been undertaken on someone who had capacity to make decisions and had not objected to support. Therefore, an assessment had not been necessary. We also saw a consent form had been signed by a relative who did not have Power of Attorney. A best interest decision had been made about the use of a listening monitor but there was no capacity assessment completed prior to the best interest decision. This meant we were not assured that the principles of the MCA were consistently applied across the service. We spoke with the service manager and acting manager who demonstrated that they understood the principles of the MCA. We also saw that the quality assurance audit in September 2017 had identified the concerns around correct completion of forms relating to MCA. However, at the time of this inspection we found some records were still not accurate.

We recommend that the provider seek advice and guidance on ensuring compliance with the MCA 2005.

Staff understood they needed to gain consent and to give people choices. A member of staff told us, "I have had training on the MCA and am aware that we presume capacity and if not, an assessment is required around a decision."

People can only be deprived of their liberty (DoLs) when this is in their best interests and legally authorised under the MCA. We saw DoLS applications were being made and reviewed when the service felt they may be restricting people's liberty to ensure their safety.

People were fully involved with choosing which food they liked to eat and were involved in developing menus. A member of staff said, "I ask the person what they would like to eat and sometimes go to the fridge to show what is available. We make people what they like and always cook food freshly." A relative said, "My [relative] loves her tea visits. She enjoys the food there, especially cooked dinners. She's not too keen on the pudding."

People were supported to access health professionals if needed during their stay. The service also sought the advice of occupational therapists, psychologists, psychiatrists and other professionals as needed to ensure people remained well in their care.

Good

Is the service caring?

Our findings

At the inspection in October 2015, we received feedback to reflect that caring achieved an outstanding rating. At this inspection, we had positive findings and feedback that supported a rating of Good.

People were treated with care and kindness when they visited the service. People and their relative's feedback consistently reflected this. One person said when asked what they liked about the service said "I love everything about it." Comments from relatives included, "My [relative] is very happy to go there, and staff are always very much interested in the family too. Always ask about family, nieces and nephews", "I don't see the staff because I don't drive and they don't have transport but I think they are caring because my [relative] enjoys going there."

People were supported by staff that cared about them. Staff had been selected and trained to ensure they had the right skills to ensure that people received compassionate support. A relative said, "Staff are brilliant and some of them are a real treasure and I know my [relative] is happy there." Staff were given enough time to get to know people, including having enough time to refer to records to understand what care and support needs, wishes, choices and any associated risks people had.

We saw that where families had a different opinion to the person who used the service, staff tried to help all involved to understand their decision and see things from their point of view. For example, a person was resistant to some care tasks during their stays. The management were balancing the requests from the relative but ensuring that the person's rights were respected as they had capacity to refuse consent for these care tasks.

Staff used accessible means of communication whenever needed. Support plans had guidance for staff. For example, if someone refused their medicines the guidance suggested, 'Try saying okay, can you let me know when you are ready to have meds?' It then stated the person would let them know when they were ready. There was also guidance about a person having good verbal communication and understanding. However, they could be repetitive. Advice was given about managing this to provide the person with consistency. The provider had policies to ensure their information met the Accessible Information Standard in order that people had every opportunity to be involved and informed.

People were given choice when they visited the service. They chose the room they wished to stay in and had been involved with some elements of the design, such as carpeting. People were supported to maintain and develop their relationships with those close to them, their social networks and community. When breaks were being arranged, staff tried to ensure that people with particular friendships visited at the same time. A relative commented, "The home avoids grouping together clients who don't get on. My [relative] likes this [person], like a "[partner]" so staff gave them both a "special meal" together and they accommodate them at the same time." Another said, "My [relative] is taken out regularly to places like the theatre. They do birthday parties, and celebrate other occasions like Christmas. The home tries to book special friends together whenever they can, especially peers or friends from the day centre."

People were treated with dignity and respect. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. For example, we saw guidance in a care plan stating 'Stand just outside the door so you can observe me to make sure I am safe.' This was important as the person had seizures but to maintain privacy and dignity this was a way of ensuring they remained safe at the same time. Staff referred to people by their chosen name, listened to people, and took time to find out what they wanted. Staff were aware of the importance of confidentiality and we saw people's confidential information was stored securely.

People benefited from a service that respected the importance of equality and diversity. The provider had a policy with the vision: 'Helping people to live to their full potential'. This included with protected characteristics such as disability, sexual orientation, religion or beliefs were treated equally and free from discrimination.

Good

Is the service responsive?

Our findings

The service continued to be responsive to people's needs. The support plans were detailed and provided guidance for staff on how peoples' physical, emotional and social needs should be met. Staff knew people well explaining people's likes, dislikes and preferences. Each person had a quick reference support plan on their file to ensure their needs could be understood quickly in the event there may not always be time to review the whole support plan.

There was information on what routines people liked with detail such as having the lights dimmed and choosing to have two stories before they slept. This meant staff could maintain some continuity for the person during their short breaks at the service.

People who used the service could stay between one day and two weeks. The service would also take unplanned stays in the event on an emergency. The deputy manager who arranged the bookings said they would always try and accommodate particular requests for dates and also try to arrange bookings for people at the same time who got on well. A relative commented, "We have re-arranged respite at short notice and the manager has always been very accommodating in changing times and dates. On very rare occasions we've had cancellations by the home. We do understand that emergencies can occur." Another relative said, "Staff are very accommodating, they are flexible, they supported us when I couldn't get there on time to collect my [relative]. I had a hospital appointment and would have been late so they didn't force me to collect him on time."

People had opportunities to engage in activities during their stay at the service that were meaningful to them. We saw from people's records that their interests and preferences had been recorded so they could continue these during their stays in the service. For example, we saw that one person enjoyed crafts, going out, baking and going into town. We saw that people continued to attend local clubs they belonged to in the evenings. A member of staff said that the service had been without a vehicle for some time. We were told the service was having a new vehicle arranged and it was expected imminently. This would help ensure that staff could assist people to activities that required transport.

People's communication needs were recognised and accommodated by the staff. Staff had received advanced communication training, basic Makaton (a way of communicating by using signs and symbols alongside speech) and the use of body language in non-verbal communication. A member of staff said, "We can use pictures to aid communication if needed."

People and their relatives felt confident to raise concerns and felt any issues were dealt with in a timely manner. However, none of the relatives we spoke with had any reason to make a complaint. One relative said, "Communication is good so if we did have any concerns we are confident they would be dealt with straightaway." Complaints records showed that the manager had investigated all complaints and resolved them to the satisfaction of the complainants.

People were encouraged to give their feedback about the service. A staff member said, "We have meetings

with people to seek their opinions and check if they are happy with everything." Relatives were also invited to meetings. A relative said, "Previously, there used to be carers meetings on regular basis when the old manager was in place. We've had one since the new manager came but I suppose he needs time to settle in."

Requires Improvement

Is the service well-led?

Our findings

Providers are required to submit a notice of absence if a registered manager proposes to be absent from carrying on or managing the regulated activity for a continuous period of 28 days or more. The registered person must give notice in writing to the Commission informing of the expected length of absence, the reason for it, arrangements made for the management of the service and who would be responsible for the regulated activity during that absence. The registered manager left the service in October 2017 and submitted their cancellation to the Commission. We contacted the nominated individual in December 2017 to enquire why a notification had not been submitted to inform the CQC about how the service would be managed in the absence of the registered manager. We had no reply to this and when followed up in January 2018, we were informed that the service manager was supporting a manager and deputy in the service and had been asked to make the notification. We did not receive any notification following this. We subsequently heard that an application had been made to the CQC to register a new registered manager but this had been withdrawn. At the time of the inspection, we were informed that the provider had plans to register an existing registered manager from another service to 69 Neithrop Avenue; however this was still to be actioned.

Before the inspection, we had asked the provider to complete a Provider Information Return (PIR). The provider had not completed the Provider Information Return.

The provider continued to use a quality assurance system for monitoring all aspects of the service. This helped to identify where the service was doing well and the areas it could improve on. For example, the need to improving records on MCA. As we described earlier in the report, although this issue had been identified there were improvements needed to ensure compliance. We also found the quality assurance system had not identified that not all statutory notifications were being submitted as required.

We recommend that the provider reviews their internal processes to ensure that all notifications are submitted as required.

The auditing system was linked to the five domains used by the CQC. The provider regularly scrutinized incidents and accidents, complaints and safeguarding issues to identify where any trends or patterns may be emerging. This information was used to support and evaluate performance to ensure safety and to drive improvement. This included audits in areas such as care plans, medicines, training and health and safety. Findings from audits were analysed and action plans created to drive continuous improvement.

The management team were working well together to deliver care which helped people who visited the service to enjoy their lives, make their own choices and keep them safe. A member of staff commented, "Since the registered manager left we have been a bit in limbo. However, the new staff are starting to settle in." One relative of a person told us, "The service was managed well by the previous manager but feel my [relative] still get support needed.

Staff told us they felt well supported by the management team, were involved in making decisions regarding

care delivery and worked well as team. Staff we spoke with were confident about their responsibilities and stated that they felt comfortable approaching the management team with any concerns. We saw team meetings with staff had taken place and that information of importance discussed. For example, at one recent meeting communication guidelines from the Speech and Language Therapist (SALT) was discussed in respect of a person who used the service. A member of staff told us, "Yes we have team meetings and our views are listened to."

A regular survey was organised to gather opinion of people who use the service. At the time of the inspection, the provider was in the process of evaluating feedback. A relative told us, "Sometimes, there is a questionnaire, asking about the food, service, the trips etc."

Records showed and staff confirmed that the service worked in partnership with a number of health and social care professionals such as GPs and social workers to ensure people's health and well-being were maintained.

The service understood and complied with their responsibilities under duty of candour. The service had their CQC rating displayed on the website and in the premises.