

The Camden Society

West Oxfordshire Supported Living

Inspection Report

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Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask about services and what we found	4
What people who use the service and those that matter to them say	9

Detailed findings from this inspection

Background to this inspection	10
Findings by main service	11
Action we have told the provider to take	20

Summary of findings

Overall summary

West Oxfordshire Supported Living is a community service providing care and support to people living in their own homes. It provides services to adults with a learning disability. At the time of our inspection it was providing personal care to 28 people for a varying number of hours each week.

The service had a registered manager in post based in the service's head office. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. A locally-based "service manager" had been appointed to manage this service on a day to day basis and was in the process of applying to register with the CQC. They told us they also managed other services and spent an average of two days a week at this service.

We found risks were identified, assessed and managed in a way that protected people effectively. The care plans we viewed contained risk assessments together with actions designed to reduce the risks appropriately. However, we found medicines were not managed safely. Medicine audits were not conducted and care plans were not in place to inform staff when 'as required' medicines should be given.

We saw health action plans had been developed so people were able to see doctors or other healthcare professionals when they needed to. One person told us "If I am not well staff help me to sort it out and make an appointment to see someone." However, the management of people's epilepsy was not always safe as not all staff were appropriately trained and people who displayed behaviour that challenged others did not always receive appropriate care and support. There was no care plan in place to manage one person's behaviour.

Staff did not always receive supervision and appraisal so were not appropriately supported to provide care safely and to a suitable standard. Some staff had not been trained in epilepsy or the Mental Capacity Act, 2005 (MCA), although they were providing care and support to people who suffered from epilepsy and had varying levels of

mental capacity. This meant staff may not have been able to provide safe care when people had a seizure and may not have been able to support them appropriately to make decisions.

However, we saw training in the Mental Capacity Act, 2005 (MCA) was planned to be delivered to all staff in the near future. The manager also told us of plans to develop new 'essential life plans' for people, which would include assessments of their mental capacity to make specific decisions. This would provide staff with the necessary knowledge and information to enable them to protect people's rights appropriately.

We identified that some care plans were not up to date and did not reflect people's current needs. We saw decisions had been made about people's ability to manage their own medicines. However, it was not clear how those decisions had been made or whether the process used had complied with the principles of the MCA and its code of practice.

We observed the support coordinators trying and find staff to cover shifts to provide all the necessary support that was required. They told us this was a constant challenge due to staff shortages.

People told us they were not always aware of which staff were supporting them on a daily basis. One person said, "I don't get a rota and I don't know what day or what times or who is coming. My days and times change every week and I don't like all the swapping around." Whilst staff were deployed in a way which ensured people received their allocated number of support hours, staff shortages meant people did not always experience care and support from a staff team that was consistent.

We found the quality assurance system was not operating effectively. Support coordinators were required to conduct checks of each house to assess and monitor the quality of care provided by staff. They told us these were not being conducted because they did not have time to do them. One said, "Our backs are against the wall just trying to cover basic shifts." This meant the service was unable to demonstrate they were providing safe quality care.

Summary of findings

People we spoke with told us they felt safe being cared for by the staff. They said they were confident they could raise any concerns with members of staff and that these would be dealt with. People told us they received the care and support they needed and were happy with the service. One person said, “Living independently for the first time in my life has been a big success.”

People were treated with dignity and respect and were listened to. One person said, “The staff always treat me with respect and speak to me nicely.” We observed staff spoke to people respectfully and in a friendly way; they adapted their vocabulary appropriately, took time to listen and called people by their preferred names.

Each person had a key worker who knew them well and whom they had developed positive relationships with. People told us they felt staff listened to them and we saw

time was set aside each week for people to meet their key workers to discuss their care and wishes. One person told us “I feel staff listen to me and we have lots of meetings to talk about the things I want.”

Staff told us there was an open culture in the service. An experienced member of staff said, “The Camden Society are doing a good job, there isn’t a big hierarchy so communications are more direct.” We found the manager was open and accepting of the identified improvements that were required at the service and had clear ideas about how they could be achieved.

The concerns identified meant there had been breaches of the relevant regulations (Regulations 9, 10, 13, 20 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Whilst people told us they felt safe being cared for by the staff, we found not all aspects of the service were safe.

We found medicines were not managed safely and published guidance was not being followed. The quantity of medicines in stock was not recorded on the medication administration records (MAR). This meant the provider was unable to properly account for all medicines or demonstrate that medicines had been administered appropriately and in accordance with people's prescriptions. Care plans were not in place to inform staff when 'as required' medicines should be given and arrangements were not in place to ensure topical creams had not exceeded their 'use by' date and would be safe to use.

We looked at the service's policies on safeguarding and whistle blowing. We saw these were up to date and appropriate for this type of service. Records showed staff had received training in safeguarding and staff were clear about how to identify, prevent and report abuse.

We found risks were identified, assessed and managed in a way that protected people effectively. The care plans we viewed each contained risk assessments together with actions designed to reduce the risks appropriately.

Are services effective?

We found not all aspects of the service were effective.

We saw care plans contained assessments of people's needs, together with plans showing how those needs would be met. However, we found the plans did not provide detailed information about how each person should be supported according to their individual needs.

The management of people's epilepsy was not always effective as the care plan for one person was out of date and staff were not able to administer a rescue medicine to another person.

People who displayed behaviour that challenged others did not always receive appropriate care and support. In one case, there was no care plan in place to manage the person's behaviour.

Staff did not always receive supervision and appraisal so were not appropriately supported to provide care safely and to a suitable standard.

Summary of findings

Staff training was not adequate to ensure staff had the necessary knowledge and skills to support people effectively. Some staff told us they had not received training in epilepsy or the Mental Capacity Act, 2005 (MCA), although they were providing care and support to people who had epilepsy and had varying levels of mental capacity. This meant staff may not have been able to provide safe care when people had a seizure and may not have been able to support them appropriately to make decisions.

Opportunities were provided for staff to develop professionally. Some staff told us they had been supported to obtain vocational qualifications in the past. Others told us about a budget that had recently been obtained to support staff to obtain such qualifications in the coming year.

We saw health action plans had been developed to ensure people were able to see doctors or other healthcare professionals when they needed to. One person told us “If I am not well staff help me to sort it out and make an appointment to see someone.”

Are services caring?

We found the service was caring although improvements were needed.

Staff told us that people were not proactively asked who they wished to provide their care and support and whether they preferred a male or a female staff member, although we saw people had made this choice and in some cases this was respected. One person’s care plan said they did not like receiving care from young female care staff but we saw a young female care worker providing personal care to them. This meant people’s preferences were not always respected.

People were treated with dignity and respect and were listened to by staff. One person said, “The staff always treat me with respect and speak to me nicely; they don’t shout at me and are kind and caring. They respect my privacy if I want to spend time alone in my room. If I am in my room and they want to talk to me they always knock on my door.”

During conversations with people, we observed staff spoke respectfully and in a friendly way; they adapted their vocabulary appropriately, took time to listen and called people by their preferred names. We saw staff knock and wait for permission before entering people’s houses or their rooms.

Summary of findings

We found all staff knew enough about the people they supported to enable them to provide care and support in an appropriate way. In addition, each person's key worker knew them well, including their preferences and personal histories, and had developed positive relationships with them.

Some people received care and support during the day at a day centre. Staff told us they had a good working relationship with the day centre and had arrangements in place to exchange information where necessary for people's safety.

Are services responsive to people's needs?

We found the service was responsive although improvements were needed.

We found people had their individual needs regularly assessed although people were not aware of their care and support plans. One person told us they "do not really feel involved" in the writing of their support plan and said they "could not remember ever seeing one, but there might be one in the office." Another person told us they couldn't see their support plans because it was "locked away." We noted in two houses that care plans were kept in locked cabinets, to which only staff had keys, which meant people may not have been able to access them when they chose to.

We looked at five care plans and identified that some were not up to date and did not reflect people's current needs.

We saw decisions had been made about people's ability to manage their own medicines. In all but one of the care plans we viewed, we saw the service managed people's medicines on their behalf. However, it was not clear how those decisions had been made. There was no evidence that people had given consent to, or had been consulted about this and their mental capacity had not been assessed. This meant the process used may not have complied with the principles of the Mental Capacity Act, 2005 (MCA) and its code of practice.

People told us they were not always aware of which staff were supporting them on a daily basis. One person said, "I don't get a rota and I don't know what day or what times or who is coming. My days and times change every week and I don't like all the swapping around." An experienced member of staff told us they felt the lack of consistent staff was not helpful to the people they were supporting.

We saw two people had received appropriate support to make decisions in relation to financing holidays. In one case an advocate

Summary of findings

had supported the person to make a decision. People told us they were also supported to take part in a wide range of activities, including paid employment and voluntary work. They were encouraged to keep busy and active.

People were encouraged to make their views known about their care and support. People told us they felt staff listened to them and we saw time was set aside each week for people to meet their key workers to discuss their care and their wishes. One person told us “I feel staff listen to me and we have lots of meetings to talk about the things I want.”

The service had a complaints policy and information was available in a suitable, pictorial format. People were aware of how to make a complaint. One person said they would, “ring the office or go and see the staff in the office” and were confident their concerns would be dealt with satisfactorily.

Are services well-led?

We found not all aspects of the service were well-led.

The service had a registered manager in post based in the service’s head office. A locally-based “service manager” had been appointed to manage this service on a day to day basis and was in the process of applying to register with the CQC. They told us they also managed other services and spent an average of two days a week at this service.

We found the quality assurance system was not operating effectively. Support coordinators were required to conduct checks of each house to assess and monitor the quality of care provided by staff. They told us these were not being conducted because they did not have time to do them. One said, “Our backs are against the wall just trying to cover basic shifts.” This meant the service was unable to demonstrate they were providing safe quality care.

We observed the support coordinators trying and find staff to cover shifts to provide all the necessary support that was required. They told us this was a constant challenge due to staff shortages.

Whilst staff were deployed in a way which ensured people received their allocated number of support hours, staff shortages meant people did not always experience care and support from a staff team that was consistent.

Staff told us there was an open culture in the service; for example, managers did not have their own offices, but worked in open-plan offices so staff could approach managers for information and advice. We found the manager was open and accepting of the identified

Summary of findings

improvements that were required at the service and had clear ideas about how they could be achieved. An experienced member of staff said, “The Camden Society are doing a good job, there isn’t a big hierarchy so communications are more direct.”

We looked at the system used to manage accidents and incidents. We found this was being used effectively to capture details of concerning incidents or accidents which had occurred. We saw each house had an ‘essential information’ file which contained emergency information, such as environmental risks and fire evacuation procedures.

Summary of findings

What people who use the service and those that matter to them say

People told us they were not always aware of which staff were supporting them on a daily basis. One person said, “I don’t get a rota and I don’t know what day or what times or who is coming. My days and times change every week and I don’t like all the swapping around.” Another person told us “I don’t know which staff will be coming. I have to wait and see.” This meant people received care and support from a more staff than they would have preferred.

One person we spoke with was very clear about the contents of their care and support plan, told us they looked at it regularly and that they “have a review every year.” However, other people were not aware of their care and support plans. One person told us they “do not really feel involved” in the writing of their support plan and said they “could not remember ever seeing one, but there might be one in the office.” Another person told us they couldn’t see their support plans because it was “locked away.” We noted in two houses that care plans were kept in locked cabinets, to which only staff had keys, which meant people may not have been able to access them when they chose to.

People told us they received the care and support they needed and were happy with the service. One person said, “Living independently for the first time in my life has been a big success.” Another person told us staff were “good and help to clean up the flat and make nice

dinners.” A further person said “I tell my staff what I want support with and they work with me to decide when and what I do each shift; I am much more independent here than I was when I lived at home and I go out a lot.”

People told us they were supported to take part in a wide range of activities, including paid employment and voluntary work. One person said they were able to “tell staff what they want support with on each shift.” Another person told us they could change the days and times they received support to fit in with their activities; they said, “The staff are good at doing this.” A third person told us “I get all the help I need, like doing shopping and going dancing. I like swimming when it’s time for swimming.”

People felt they were treated with dignity and respect and that they were listened to. One person said, “The staff always treat me with respect and speak to me nicely; they don’t shout at me and are kind and caring. They respect my privacy if I want to spend time alone in my room. If I am in my room and they want to talk to me they always knock on my door.” Another person told us “Staff are respectful to me and nice to me as well.” A further person said, “I feel staff listen to me and we have lots of meetings to talk about the things I want.”

People told us they could see a doctor or other healthcare professional when they needed to. One person said, “If I am not well staff help me to sort it out and make an appointment to see someone.”

West Oxfordshire Supported Living

Detailed findings

Background to this inspection

Before our inspection we reviewed the information we held about the service. At our last inspection in November 2013 we had not identified any problems with the service.

The inspection team consisted of a lead inspector and an Expert by Experience who had experience of receiving care and support in their own home.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We visited the service on 7 and 8 May 2014. We spent time in the service's office looking at records, including five people's care records, staff training records and records relating to the management of the service. We spoke with nine members of staff and the manager. We also visited eight people in their homes where we talked with them and observed the way staff interacted with them.

Following the inspection we spoke with staff from the local safeguarding authority.

Are services safe?

Our findings

We viewed the care plans for five people using the service and saw they did not include assessments of people's mental capacity to make decisions, such as decisions relating to their finances or the management of their medicines. However, we saw training in the Mental Capacity Act, 2005 (MCA) was planned to be delivered to all staff in the near future. The manager also told us of plans to develop new 'essential life plans' for people, which would include assessments of their mental capacity to make specific decisions. This would provide staff with the necessary knowledge and information to enable them to protect people's rights appropriately.

With people's consent, we looked at the arrangements for managing medicines in two houses where people relied on staff to manage their medicines on their behalf. We saw most medicines were supplied pre-packed by the pharmacy. However, some medicines, such as paracetamol and sedatives, which were administered 'as required', were supplied in boxes; other medicines, such as anti-psychotic medicine and eye drops were supplied in bottles. We found the quantity of these medicines, was not carried forward on the medication administration records (MAR) from one month to the next. This meant it would be difficult for the provider to properly account for all medicines in stock or confirm that medicines had been administered in accordance with people's prescriptions.

We also found not all 'as required' medicines had care plans or other guidance in place to inform staff how and when such medicine should be administered. This meant people may not have received their 'as required' medicines in a consistent way and as prescribed. In the case of a sedative, we found limited guidance was in place, which required staff to speak with the duty support coordinator before administering it. However, records showed, and the staff member confirmed, that the duty support coordinator had been informed after the person had been given the sedative and not before. This meant the care plan had not been followed.

Staff were unable to find a MAR chart for one of the 'as required' medicines shown as being used by one person; a dental medicine that had been prescribed to be used twice a day was only recorded as having been given once a day; hand written entries on MAR charts were not signed by the

staff member making the entry or counter-signed by a second staff member; and the date of opening of topical creams was not recorded, so staff were unable to confirm that creams had not exceeded their 'use by' date.

We discussed our findings with the manager, who told us the management of medicines by the service was not currently audited by staff. We looked at the service's medicines policy, and saw it did not require audits to be conducted. Consequently, we could not be assured the service had appropriate arrangements in place to manage medicines safely on behalf of people.

The above concerns about the management of medicines meant there had been a breach of the relevant regulation (Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

People we spoke with told us they felt safe being cared for by staff, felt confident to raise any concerns with them and that they would be dealt with.

We looked at the service's policies on safeguarding of vulnerable adults and whistle blowing. We saw these were up to date and appropriate for this type of service. Staff records showed most staff had received training from the provider in safeguarding. Staff who had not been trained by the provider had received appropriate training from a previous employer. We were told this was verified when staff were recruited. We saw a training schedule which showed refresher training in safeguarding adults was planned for all staff in the near future. This would ensure staff knowledge was up to date and appropriate.

We spoke with six members of staff about the safeguarding of vulnerable adults. They were clear about how to identify, prevent and report abuse, although one staff member told us they had only received training (from a previous employer) in relation to protecting children, not adults. Staff told us they had recently received written guidance about safeguarding adults, which had provided them with appropriate advice.

We looked at the arrangements for safeguarding people's money. We saw that where a person was unable to manage their own finances, due to a lack of understanding, appropriate arrangements were in place for staff to manage

Are services safe?

them safely. All money spent on behalf of people was properly recorded, receipts were obtained and audits conducted. The system protected people effectively from the risk of financial abuse.

The service followed safe recruitment practices. We discussed the procedures used to recruit new staff with one of the support coordinators. They told us the service employed a member of staff to undertake all staff recruitment. They, in turn, had access to support and advice from the provider's head office to ensure potential recruits were vetted correctly. We looked at the staff files for three people who had been recruited recently. The files included application forms, records of interview, appropriate references and records showing that checks had been made with the Disclosure and Barring Service to make sure people were suitable to work with vulnerable adults. Records were also seen which confirmed that staff members were entitled to work in the UK. The service carried out appropriate checks to make sure staff were suitable to work with vulnerable people.

Risks were identified, assessed and managed in a way that protected people effectively. The care plans we viewed each contained risk assessments together with actions designed to reduce the risks appropriately. These included the risks of travelling, presenting behaviour which challenged others and taking part in activities. Another care plan contained an assessment for a person who was at risk when cooking in the kitchen. We saw arrangements had been put in place to support the person to help with the cooking safely. When we spoke with them, they said, "I peel the potatoes, but I'm not allowed to put the cooker on as I might burn my hand." This was an appropriate safeguard given the risks identified.

We looked at the risk assessment for another person, who had epilepsy. We saw equipment had been put in place to alert staff automatically if they had a seizure during the night. Staff were aware of these arrangements which ensured the person's condition could be monitored without any intrusion and action taken if needed.

Are services effective?

(for example, treatment is effective)

Our findings

We looked at care plans for five people. We saw these contained assessments of people's needs, together with plans showing how those needs would be met. However, we found the plans did not provide detailed information about how each person should be supported. For example, one person's care plan said, "[The person] needs help to put creams on areas they can't reach", but did not specify what creams or what areas this related to; it added that the person "needs to be encouraged to help with preparing meals" but did not detail their capabilities. The manager told us they were planning to change care plans to an "essential life plan" format, which would better focus on people and their needs.

The management of people's epilepsy was not always effective. The risk assessment and care plan for one person was not up to date. It said they had not had a seizure "for many years". However, their daily care records showed they had had four seizures in April 2014. Staff told us they did not consider the seizures to be real seizures and described them as "attention seeking episodes" as the person had recovered from them quickly. Staff had not arranged for the person's care to be reviewed by a doctor so could not confirm the person was receiving safe and appropriate care. The care plan for another person specified a rescue medicine which was to be used in the event of a seizure. We spoke with two staff members who regularly supported this person, but neither was aware of how this medicine should be used. One of the support coordinators told us that no staff member at the service was trained to administer the medicine, but the person had not suffered a seizure for "some years. The person would not have been able to receive their medicine if they had experienced a seizure, which could have had a detrimental effect on their recovery. Following our inspection we alerted the local safeguarding authority to our concerns about the management of epilepsy.

People who displayed behaviour that challenged others did not always receive appropriate care and support. Staff told us about one person who sometimes became anxious and displayed behaviour which challenged others. However, the person's care plan did not contain a plan to show how the person should be supported to manage their behaviour. Records showed they had experienced episodes

of such behaviour recently; staff told us they used techniques to distract people to calm them down, but these techniques were not recorded in the person's care plan.

When we visited one person, they told us they had fallen at home six few days earlier and were in pain and discomfort as a result. Whilst this was recorded in the person's records, their injuries had not been examined by a healthcare professional and no pain relief was recorded as having been offered. A care worker offered to rub some "magic cream" on their bruises and when we asked what cream this was they told us it was "eczema cream." This would not have been effective in relieving the person's pain. There was a lack of assurance that the person had not sustained an injury. The service had not ensured the welfare of this person.

The lack of effective care plans and the failure to provide appropriate care and support meant there had been a breach of the relevant regulation (Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

We looked at records of daily care that had been provided to five people. We saw these had not been completed for every person on every day. For some people, no entry had been made in their records for up to three days. Entries that had been made were not always comprehensive and did not show all the care and support that staff told us had been given. Consequently, the provider was unable to confirm that care and support had been provided effectively or in accordance with people's care plans. The manager told us they had identified the lack of daily notes and were addressing it. This meant there had been a breach of the relevant regulation (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

Not all staff received appropriate support, supervision and appraisal. We spoke with six members of staff who told us they had received sessions of supervision recently. However, none of the staff we spoke with reported having had an appraisal and records confirmed that not all staff employed by the service for more than a year had received an appraisal in the past year. The three support coordinators told us they had not had an appraisal for "several years." One of them added "that's why I haven't

Are services effective?

(for example, treatment is effective)

done appraisals for my staff.” The manager told us they had not had an appraisal since starting work at the service in 2012. This meant staff were not appropriately supported to provide care safely and to a suitable standard.

There were no formal arrangements in place for supervising and monitoring staff performance. The manager told us that this was done informally by support coordinators spending time working with care and support staff on shifts. However, there was no system of spot checks or formal observations of staff who worked alone, supporting people on a one to one basis. A new staff member told us they had not received any form of direct supervision or spot checks since starting at the service. The service was, therefore, unable to demonstrate that staff were appropriately supervised to make sure they delivered care and support safely and to an appropriate standard.

We spoke with two new staff about their induction training. They told us this consisted of one day in the office, where they learnt about the service, its values and some of its policies. This was followed by a day’s medicine training and undertaking a number of shadow shifts with experienced members of staff. They were then allowed to work on their own. One member of staff told us they had spent two weeks shadowing other staff, during which time they supported people in 13 houses. They told us they had not received training in epilepsy or the Mental Capacity Act, 2005 (MCA), although they were providing care and support to people who had from epilepsy and had varying levels of mental capacity.

We found staff training was not adequate to ensure staff had the necessary knowledge and skills to support people effectively. The manager told us the service had suspended all training in September 2013 due to financial constraints. This meant new staff, employed after this date, had to rely on training they had undertaken with previous employers, rather than training designed to meet the individual needs of people using this service.

Two other staff members we spoke with also demonstrated a lack of knowledge about MCA. One said they were “unsure” about it and “wanted more training.” The other was unable to describe the purpose of the Act. Consequently, they would not be able to support people appropriately to make decisions.

We found other staff who cared for people with epilepsy had also not received training in epilepsy. We looked at the provider’s policy relating to the management of epilepsy and saw this required all staff who cared or supported people with epilepsy to have received appropriate training. The provider’s policy was therefore not being followed and staff had not received training to enable them to support people safely.

The lack of appraisals, supervision and essential training meant there had been a breach of the relevant regulation (Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

Opportunities were provided for staff to develop professionally. Some staff told us they had been supported to obtain vocational qualifications in the past. Others told us about a budget that had recently been obtained to support staff to obtain such qualifications in the coming year. The manager told us of three staff members they had identified as having the potential to progress to supervisory roles within the service; they said they were currently exploring ways in which these staff members could be supported to realise their potential.

We saw health action plans had been developed so people could see doctors or healthcare professionals. Records showed referrals to dentists, psychologists, and speech and language therapists had been made for specialist advice. One person said, “If I am not well staff help me to sort it out and make an appointment to see someone.” This showed that other people had received appropriate healthcare support.

People told us they received the care and support they needed and were happy with the service. One person said, “Living independently for the first time in my life has been a big success.” Another person told us staff were “good and help to clean up the flat and make nice dinners.” A further person said of the staff, “they come every day, help make dinner, go shopping and sort out my money.”

Are services caring?

Our findings

Staff told us that people were not proactively asked who they wished to provide their care and support and whether they would prefer a male or a female staff member, although we saw people had made this choice and in some cases this was met. The support coordinators told us it was not always possible to match people with preferred carers due to shortages of staff. For example, we saw that one person, whose care plan said they did not like receiving care from young female care staff, was receiving personal care from a young female care worker on the second day of our inspection. This meant people's preferences were not always met.

We found people were treated with care and respect. One person said, "The staff always treat me with respect and speak to me nicely; they don't shout at me and are kind and caring. They respect my privacy if I want to spend time alone in my room. If I am in my room and they want to talk to me they always knock on my door." Another person told us "Staff are respectful to me and nice to me as well."

During conversations with people, we observed staff spoke respectfully and in a friendly way; they adapted their vocabulary appropriately, took time to listen and called people by their preferred names. We saw staff knock and wait for permission before entering people's houses or their rooms. In one case, where a staff member needed to enter a person's bedroom, they went downstairs to find the person and seek their permission first. Records in homes where more than one person was living were kept in locked cabinets. This ensured confidentiality and showed respect for each person's privacy.

In one house, where staff provided 24 hour care and support, we noted that people's bedrooms did not have locks on the doors. We asked people living there if they wanted to be able to lock their doors. One person told us they were very keen to have a lock on their door and

immediately asked staff if this could be arranged. Staff told us they had concerns about lockable doors, in case they needed access in an emergency and the manager told us the housing association which owned the house might not agree to locks being fitted. However, we found the staff room in the house did have a lock, which was thought to have been authorised by the housing association, and the manager confirmed that locks were available which could be overridden from the outside in an emergency. Such locks would provide people with the privacy they sought without compromising their personal safety.

We found all staff knew enough about the people they supported to enable them to provide care and support in an appropriate way. In addition, each person's key worker knew them well, including their preferences and personal histories and had developed positive relationships with them. For example, the staff member supporting one person knew they liked to be independent and said they only provided support when requested. The person told us "I tell my staff what I want support with and they work with me to decide when and what I do each shift; I am much more independent here than I was when I lived at home and I go out a lot." This showed people were supported to be as independent as they wanted to be.

Some people received care and support during the day at a day centre. Staff told us they had a good working relationship with the day centre and had arrangements in place to exchange information appropriately, such as what medicine people had received or whether they had been showing any anxiety. We saw the provider's policies supported such an exchange of information where necessary for people's safety. The manager told us they had had a "big drive" on information sharing following concerns identified at our last inspection. In addition, the service used a 'hospital passport' system which provided key information which could be shared with hospital staff if people were admitted to hospital.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found people had their individual needs regularly assessed. We saw care plans were in place for each person and records showed plans were updated yearly or when changes were required. One person we spoke with was very clear about the contents of their support plan, told us they looked at it regularly and that they “have a review every year.” However, other people told us they were not aware of their support plans. One person told us they “do not really feel involved” in the writing of their support plan and said they “could not remember ever seeing one, but there might be one in the office.” We noted in two houses that care plans were kept in locked cabinets, to which only staff had keys, which meant people may not have been able to access them when they chose to.

We looked at five care plans and identified that some were not up to date and did not reflect people's current needs; for example, one person's care plan said they “like to walk round the pond”, but staff told us their mobility had decreased and they were and they now only went on short walks. Another care plan said records should be made of when a person spent time with someone living in the community, but staff told us the person had chosen not to spend time with that person any more. A third care plan said the person had not experienced a seizure for several years, but records showed they had had recent seizures. Therefore, people could not be assured of consistent, personalised care that met their current needs. This meant there had been a breach of the relevant regulation (Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

We saw decisions had been made about people's ability to manage their own medicines. In all but one of the care plans we viewed, we saw the service managed people's medicines on their behalf. However, it was not clear how those decisions had been made. There was no evidence that people had given consent to, or had been consulted about this and their mental capacity had not been assessed. This meant the process used may not have complied with the principles of the Mental Capacity Act,

2005 (MCA) and its code of practice. The manager told us training in MCA was planned and care plans were to be amended to an “essential life plan” format which would include assessments that complied with the legislation.

We saw two people had received appropriate support to make decisions in relation to financing holidays. In one case the person was supported by a lay advocate to help them understand the consequences and risks involved; this had enabled them to make the decision for themselves. In another case, a best interests decision was made on behalf of the person, with the involvement of people who knew the person well, as they lacked the capacity to make such decisions. Another person told us their mother acted as their advocate and “that is what I like.”

People told us they were not always aware of which staff were supporting them on a daily basis, other than when they had their weekly “talk time” sessions with their key workers. One person we visited did not know the name of the person that was providing them with support at the time of our visit. People using the service told us they found this unsettling. Another person said, “I don't get a rota and I don't know what day or what times or who is coming. My days and times change every week and I don't like all the swapping around.” Another person told us “I don't know which staff will be coming. I have to wait and see.” The manager told us they were planning to introduce colour-coded calendars, linked to photographs of staff, to provide this information, but this was not yet in place.

Whilst some people told us they had regular staff, others said this varied. One person told us “I have regular staff and some new ones.” An experienced member of staff told us they felt there was a lack of consistent staff, which was not helpful to the people they were supporting. They said, “People have had to adapt to more staff than before. They're not happy.” This meant people did not always receive support from a consistent team of staff.

People told us they were supported to access a wide range of activities, including paid employment and voluntary work. We saw people were also supported to attend a day centre and to do shopping and cooking. One person said they were able to “tell staff what they want support with on each shift.” Another person told us they could change the days and times they received support to fit in with their activities; they said, “The staff are good at doing this.” A

Are services responsive to people's needs?

(for example, to feedback?)

third person told us "I get all the help I need, like doing shopping and going dancing. I like swimming when it's time for swimming." This showed people were encouraged to lead active lives.

People were encouraged to make their views known about their care and support. The provider undertook annual surveys of people using the service. We saw the results of the survey were analysed and action taken to address any concerns identified. For example, we were told some key workers had been changed following feedback from people during the last survey.

People told us they felt staff listened to them and we saw "talk time" was set aside each week for people to have one to one meetings with their key workers. People said they enjoyed these meetings which they found useful. One person commented, "I feel staff listen to me and we have lots of meetings to talk about the things I want." Another person said "If I have problems I can talk to the staff and I can go to the office when I want." A third person told us they "discuss care plans from time to time and talk about going out." This showed people were actively involved in making decisions about their care and support.

One person told us they wanted to move back to their "old house" as they were not happy living where they were. We saw this had been noted by the service and plans were in hand to explore the options available to this person. Another person told us staff used to check their medicines. They said, "I didn't want that so it changed and now I do it all on my own." This showed the service responded to people's wishes.

The service had a complaints policy and information was available in a suitable, pictorial format. People were aware of how to make a complaint. One person said they would, "ring the office or go and see the staff in the office" and were confident their concerns would be dealt with satisfactorily. A log of complaints was maintained, which we viewed. We saw examples of individual complaints that had been made and responded to appropriately. We saw the person concerned had been informed of the findings of the investigation promptly, which demonstrated the provider responded appropriately to people's concerns.

Are services well-led?

Our findings

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The registered manager was not based locally, but visited when required and took decisions about the way the service was run. A “service manager” had been appointed to manage this service on a day to day basis and was in the process of applying to register with the CQC. They told us they also managed other services and spent an average of two days a week at this service. Supporting the manager were three support coordinators who were responsible for the allocation and supervision of support workers. When the manager was on leave, they told us management cover was provided by the manager of another service within The Camden Society.

The manager told us about the service’s quality assurance system, which was based on ‘house checks’ undertaken by support coordinators. However, they said the checks were only being completed “informally” at the time of our inspection as support coordinators were “having to spend 30% of their time on shifts due to staff shortages.” The support coordinators confirmed that ‘house checks’ were not being conducted because they did not have time to do them. One said, “Our backs are against the wall just trying to cover basic shifts.” Consequently, the system designed to assess and monitor the quality of services provided was not operating effectively. For example, the concerns found during this inspection had not been identified. This meant there had been a breach of the relevant regulation (Regulation 10(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

A new member of staff told us they felt well supported. They said, “I like the company and the communications are really good. I have contact numbers, out of hours numbers and a buddy system”, However, other staff told us morale was low and staff turnover was high. The manager confirmed that staff turnover had been high but was now improving. We observed the support coordinators trying to

find staff to cover shifts to provide all the necessary support that was required. They told us this was a constant challenge and that things were particularly difficult due to staff shortages.

One member of staff said “Things are not good at the moment.” Another staff member told us “Morale is low and people are leaving. The company has not delivered what they promised in terms of training and development of the service.” When talking about their experience of working for the service, a further staff member told us “The main problem is the hours; they want your life. It’s not a family friendly place; hence why there is a high turnover.” An experienced member of staff said of the way staff were allocated to people, “The system works for some people, but not others. I now work in many houses and support 12 people.”

Whilst staff were deployed in a way which ensured people received their allocated number of support hours, staff shortages meant people did not always experience care and support from a staff team that was consistent. Therefore, people could not be assured of consistent, personalised care from staff that understood their individual needs well.

The service provided care and support to people based on budgets that had been allocated to each person. This varied from a few hours a week to 24 hour support. In some cases, the budget provided for ‘shared support’ between two or more people and in other cases people had access to emergency support when needed from staff working nearby.

Care and support was provided by 23 permanent staff, together with a bank of 10 staff on flexible contracts. Additional cover was provided by an agency which supplied a small number of staff on a regular basis. The manager told us they were actively recruiting staff and had reduced the number of agency hours worked on a weekly basis from 106 hours in March to 18 hours in April. This meant people received support from more regular staff who they could get to know.

We looked at the system used to manage accidents and incidents. We found this was used effectively to capture details of concerning incidents or accidents which had occurred. For example, we saw a medicine error had been

Are services well-led?

reported appropriately to the local safeguarding authority, and action taken to prevent a recurrence. Systems were in place to identify patterns or trends of incidents so remedial action could be taken.

Emergency plans were in place and understood by staff. We saw each house had an 'essential information' file which contained emergency information, such as environmental risks and fire evacuation procedures. This included personal evacuation plans for all people, and emergency contact numbers for other services. The service also operated an on-call rota for supervisory staff to ensure someone was always available for advice or to attend in the event of an emergency.

The manager told us the service was "going through an organisational change process." They said the senior

management team had been reduced to create a "flatter structure" which made communication more effective. Staff told us there was an open culture in the service; for example, managers did not have their own offices, but worked in open-plan offices with the staff. We saw this model working effectively in the service's office during our inspection. An experienced member of staff said, "The Camden Society are doing a good job, there isn't a big hierarchy so communications are more direct." We found the manager was open and frank about improvements that were required at the service and was clear about how they would be achieved. They were also supportive of staff on the days of our visit, taking time to check they were alright. The service also operated a whistle blowing policy, which staff were aware of. This encouraged staff to raise concerns in a way that protected them from discrimination.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	<p>Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of people who use services.</p> <p>The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of the planning and delivery of care that met service users' individual needs and ensured their safety and welfare.</p>

Regulated activity	Regulation
	<p>Regulation 10(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.</p> <p>The registered person had not protected service users against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of services provided.</p>

Regulated activity	Regulation
	<p>Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). Management of medicines.</p> <p>The registered person had not protected all service users against the risks associated with the unsafe use and management of medicines.</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Compliance actions

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). Records.

The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in relation to the care and treatment provided to each service user.

Regulated activity

Regulation

Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers.

The registered person did not have suitable arrangements in place to ensure persons employed for the purposes of the regulated activity were appropriately supported by receiving appropriate training and appraisal.