The Camden Society

Short Term Breaks - April Cottage

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Short Term Breaks-April Cottage on 17 and 18 June 2016. The inspection was unannounced. Short Term Breaks-April Cottage is a respite care home in Witney that provides care to people in and around Oxfordshire. At the time of this inspection, the home was supporting five people.

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

Staff had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. However, the registered manager was not clear on their responsibilities to ensure the service completed their own mental capacity assessments if it was thought a person may lack the capacity to make certain decisions. Where people were thought to lack capacity, assessments in relation to their capacity assessments had not been completed in line with the principles of MCA.

Staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety.

People who used the service felt safe. Staff had a clear understanding of how to safeguard people and protect them from harm. Staff had a good understanding of their responsibilities to report any suspected abuse. The home had sufficient numbers of suitably qualified staff to meet people's needs. People and staff were confident they could raise any concerns and these would be dealt with. The provider had systems in place to manage and support safe administration of medicines.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care.

People's needs were assessed and care plans enabled staff to understand how to support people. Changes in people's needs were identified through regular reviews. People's interests and preferences were discussed during assessments and these were used to plan their care. The service was flexible and responded positively to people's requests.

People felt supported by competent staff. Staff benefitted from regular supervision (one to one meetings with their line manager) and yearly appraisals to reflect on their practice and develop their skills. Staff received training specific to people's needs.

People and their relatives described the staff as good and providing very good care. People felt they were

treated with kindness and their privacy and dignity were always respected. Staff had developed positive relationships with people.

The registered manager informed us of all notifiable incidents. The service had good quality assurances in place. The registered manager had a clear plan to develop and improve the service. Staff spoke positively about the management and direction they had from the registered manager.

The registered manager had a clear vision for the service which was shared throughout the staff team. This was embedded within staff practices and evidenced through people's care plans. Staff felt supported by the registered manager and the provider.

Leadership within the service was open and transparent at all levels. The provider had systems to enable people and their relatives to provide feedback on the support they received. The feedback was acted upon when required.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we have required the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of suitably qualified staff to meet people's needs.

Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to reduce the risks and keep people safe.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005. However, the registered manager was not clear on their responsibilities to ensure the service completed their own mental capacity assessments if it was thought a person may lack the capacity to make certain decisions.

People who were being deprived of their liberty were being cared for in the least restrictive way.

Staff had the knowledge and skills to meet people's needs.

People were supported to have their nutritional needs met.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people time to express their wishes and respected the

decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

Is the service well-led?

Good

The service was well led.

The provider had systems in place to monitor the quality of service.

People knew the registered manager and spoke to them with confidence.

The leadership throughout the service created a culture of openness that made people feel included and supported.

Staff spoke positively about the team and the leadership

Short Term Breaks - April Cottage

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 18 June 2016 and was unannounced. The inspection team consisted of one inspector.

Before the inspection we reviewed the information we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We contacted social and health care professionals who had professional involvement with the service. This was to obtain their views on the quality of the service provided to people and how the service was being managed. We also contacted commissioners of the service.

We spoke with the registered manager, the deputy manager, a service manager and two members of staff. We reviewed a range of records relating to the management of the home. These included three staff files, quality assurance audits, minutes of meetings with staff, incident reports, complaints and compliments. We spoke with two people and three relatives. We looked at five people's care records including medicine administration records (MAR). We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People felt safe when staying and receiving care from Short Term Break-April Cottage. People were comfortable in approaching and interacting with staff. Relatives told us their family members were safe. One person's relative told us, "Definitely safe here. [Person] has been coming here for years". Another person's relative commented, "This is a very safe place and [person] looks forward to coming here".

Risks to people's safety had been assessed and people had plans in place to minimise the risks. Risk assessments included areas such as physical harm, safety when showering, accessing the community and financial abuse. Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. For example, one staff member told us they supported a person when they went out to ensure their safety. Ways of reducing the risks to people had been documented and staff knew the action they would take to keep people safe. Records showed people had Personal Emergency Evacuation Plans (PEEP) in place.

Staff were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding and whistleblowing procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us, if they had a concern, they would "raise a safeguarding alert with the local safeguarding team". Another member of staff said, "We report any concerns to the manager or senior staff".

We looked at the arrangements for safeguarding people's money. Where a person was unable to manage their own day to day pocket money and expenses due to a lack of understanding, appropriate arrangements were in place for staff to manage their finances. All money spent on behalf of people was recorded and receipts were obtained. The registered manager conducted audits of people's finances to check the services policy on handling people's money was followed. The system protected people effectively from the risk of financial abuse.

People were supported by sufficient numbers of staff to meet their individual needs. Staffing levels were determined by the people's needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The service used a dependency assessment tool at the beginning of care provision to assess the need for staff adjustment. The registered manager considered sickness and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels. One member of staff told us, "On the whole we have a good solid team. We use regular bank staff when needed and it provides consistency".

Safe recruitment procedures were followed before staff were appointed to work at Short Term Break April Cottage. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. For example, staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe

recruitment decisions and prevents unsuitable people from working with vulnerable people.

Medicines were stored and administered safely. There was an up to date medicine policy. People received their medicines when they needed them. Records showed staff administered medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. All staff who administered people's medicines had received training to do so and their competency was assessed yearly.

The environment was clean and there was a homely feel. Staff were aware of the providers infection control polices and adhered to them. Equipment used to support people's care, for example, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. Where people had brought in their own wheelchairs, checks had been conducted to ensure they were safe to use. We observed staff using equipment correctly to keep people safe.

Requires Improvement

Is the service effective?

Our findings

Staff had good knowledge of the Mental Capacity Act 2005 (MCA). 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. However, care plans did not always identify where people had been assessed as lacking capacity to make a specific decision and there were no details of best interest processes being followed. The registered manager was not clear on their responsibilities to ensure the service completed their own mental capacity assessments if it was thought a person may lack the capacity to make certain decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit the registered manager told us the provider had sourced support and guidance in line with completion of mental capacity assessments. However, we have asked the provider to forward an action plan to demonstrate continuous improvement as these concerns had not been identified by the provider prior to our inspection.

People's consent was sought before care or support was given. Staff told us they would explain care to be given and seek the person's consent to that care. We observed staff knocking on people's doors and seeking verbal consent whenever they offered support interventions. We also saw in support files that people, or family members on their behalf, gave consent for care they received. For example, all files reviewed showed consent for personal care and administering medicines. Staff told us consent was always sought and the response was not necessarily obtained verbally. Staff observed people's body language which determined if a person was happy with the support offered.

The provider followed the requirements in the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The registered manager had identified use of bed rails and locked doors as some of the areas where DoLS needed to be applied. They had discussed with people's relatives and were in the process of identifying people that needed to be referred to the court of protection for application of DoLS.

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. Staff comments included, "Induction included statutory training and the care certificate", "New staff can shadow more experienced staff for as long as they need depending on experience" and "We shadow other staff during induction. It's like a buddy system to support new staff". Staff were not expected to deliver care independently until they were prepared and confident to

do so.

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling, safeguarding, infection control medication administration and MCA as well as the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. Staff told us they had the training to meet people's needs. One member of staff said, "We are supported to get extra training. We have requested dementia training and it's been arranged".

Records showed staff had received additional client specific training from district nurses. The training included administration of buccal medicines and catheter care. This training was person specific and therefore could only be performed on the person whom the training was for. Staff also received training for different pieces of equipment before use. These included hoists and walking aids.

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. Staff told us they had regular two monthly one to one supervision meetings with their line manager which were helpful to their practice. Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process.

People's specific dietary needs were met. Staff had the information they needed to support people. Some people had special dietary needs and preferences such as diabetic diet and soft food where chocking was a risk. For example, a person's support plan indicated the person was to be supported to during meals to unsure they chewed their food enough to prevent choking. Another person had several food allergies and staff supported them to avoid certain foods during their respite care.

Good

Is the service caring?

Our findings

People and their relatives were positive about the care they received. Comments included, "I love it here", "I am happy to come here", "No problems with care. Carers are brilliant" and "Staff are genuinely caring. I am pleased with the care [person] receives".

We observed many caring interactions between staff and the people they were supporting during our inspection. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and laughter throughout our inspection. People were being supported in recreational activities. Staff engaged with people by listening and talking, and by using non-verbal communication including touch. Support staff had a good rapport with people. We spoke to one person who did not reply but made eye contact with us. They were smiling and clearly comfortable at the service.

Staff told us they enjoyed working at the service. One member of staff said, "I love respite. It's a privilege to work in this area". Another member of staff told us, "I love working here. I love the service we provide". Staff showed they cared for people by attending to them in a caring manner. We observed people being assisted in a patient way offering choices and involving people in the decisions about their care. People were given options and the time to consider and to make a choice. One member of staff commented, "We give information to make choices. We support them [people] to make unwise choices".

Each person's support plans detailed the importance of people maintaining their independence where possible. Staff told us people were encouraged to be as independent as possible. One member of staff told us, "We involve people to maintain independence". Records showed people's independence was promoted. For example, one person had prompts in their care plan to 'support to attend disco independently'. We saw records of the person using a reputable taxi company to attend discos independently.

Staff were respectful in their approach to ensure people were not distressed or worried by having inspectors in their home. The inspector was introduced to people throughout the day. Staff took time to explain the purpose of our visit to people and sought people's consent for us to speak with them. Staff told us how each person preferred to communicate and shared any special methods of communication such as by body language, hand signals and assistive technology to ensure we were able to obtain views from all people including those who could not communicate verbally. Understanding people's specific ways of communicating also meant staff ensured people were able to consent to and be involved in decisions about their care.

Staff were aware of people's unique ways of communicating. For example, if one person sighed loudly, staff knew this meant the person was not happy with what was suggested. We observed staff communicating with people using Makaton. This is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication.

People were treated with dignity and respect by staff and they were supported in a caring way. Staff ensured people received their care in private and staff respected people's dignity. Staff described how they treated people with dignity and respect. Comments included, "We shut doors and windows during personal care" and "We respect their [people] privacy".

Staff understood and respected confidentiality. Staff comments included, "We don't talk about clients outside work", "We don't give confidential information over the phone" and "We use secure emails for communication and only document people's initials rather than full names". Records were kept in locked offices only accessible to staff.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. The registered manager met with people and their relatives to do these assessments. The assessments were used to create a person centred plan of care which included people's preferences, choices, needs, interests and rights.

Care plans focused on people's personal history. The provider used a 'Getting to know me' document which captured people's life histories including social life, likes and dislikes enabling staff to provide person centred care and respecting people's preferences and interests. People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person did not like being in noisy environments. We saw staff asking this person if they wanted to go to another area when it was becoming noisy in the lounge. The care records reflected that care was centred on people's individual views and preferences. The provider had a key worker system in place which gave people and relatives a point of contact, allowing consistency and the establishment of meaningful relationships. People knew their keyworkers and worked very closely with them as well as relatives to ensure support planning was specific to each individual.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, one person was very unwell and the service facilitated their admission to hospital. When the person was discharged, the care plans and risk assessments were updated to reflect the changes.

April Cottage had good systems in place to ensure smooth transition between services. People had 'hospital passports' which had all the important information to allow continuity of care. These included important information on communication, likes and dislikes, health information and allergies. Some people had diaries which were completed with updates when people visited day centres or external activities.

Records showed where appropriate, people's relatives signed documents in care plans to show they wished to be involved in the plan of care. Relatives told us they had been involved in developing care plans and reviewing care. One person's relative said, "We discuss any changes and agree on care plans". Another person's relative told us, "We are involved in care planning.

People's wishes and preferences were used to identify activities of interest for people. This involved a number of social groups and activities of their choice such as swimming, shopping, puzzles and clubbing. We observed one person who liked helping with household chores being supported to do so safely. One person told us they, "I visit many places. I go with [person]".

Feedback was sought from people through regular meetings with their carers as well as quality assurance surveys. Records showed that some of the discussions were around what suggestions people had to make improvements to the service. For example, in one meeting people's relatives had requested for a reliable

minibus accessible with different wheelchairs to transport people to different activities venues. We saw the provider had bought a new minibus and were waiting for it to be collected. The provider also sought feedback following each person's respite stay. The feedback had been analysed monthly and action plans created.

People and their relatives knew how to make a complaint if required and were confident action would be taken. The provider had a complaints policy in place. There was also a complaints procedure for people in 'easy read' format (simple, clear English supplemented by photographs). One person told us if they were not happy with something, "I tell [person] manager". Staff were clear about their responsibility and the action they would take if people made a complaint. Any minor complaints raised were quickly dealt with. Any concerns received about the quality of support were investigated thoroughly and recorded. The registered manager discussed concerns with staff individually in supervisions and more widely at team meetings to ensure there was learning and to prevent similar incidents occurring.

Records showed complaints raised had been responded to sympathetically and followed up to ensure actions completed. Relatives spoke about an open culture and felt that the home was responsive to any concerns raised. One person's relative told us, "If I have concerns I can talk to the manager. I have given suggestions before and they are taken on board". Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Good

Is the service well-led?

Our findings

The service was managed by the registered manager who was supported by a deputy and service managers. The registered manager had been in post for over a year. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

People and their relatives we spoke with knew the registered manager. They told us, "The manager has a handle on everyone and knows who is who", "[person] is very nice" and "Manager is very open and transparent". Staff told us the registered manager knew people and relatives well. Comments include, "She works with clients and the clients know her well", "The manager practices what she preaches" and "Manager covers shifts often. Clients love her".

Staff we spoke with felt the service was well led. They told us they had good relationship with the registered manager. Staff comments included, "We have struggled with managers before but now we have a manager we do not want to let go", "Our manager is very supportive and knowledgeable", "She [manager] knows the service well" and "She is the best manager I have ever had".

The registered manager spoke with us about their vision for the service. They told us one of their greatest achievements had been to support a person who had never been able to use respite services before due to complexity of their needs. They had positively managed incidents involving this person used this to plan their care. The registered manager said, "We run a good service. We do lots of good work but there is a lot of room for improvement". The registered manager told us one of their challenges had been not having a bus and using public transport to access activities. This had now been addressed and they were waiting for the bus to be delivered.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. The provider had quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including medicine safety, environmental safety, care plans and levels of residents need. Although the manager had not undertaken MCA assessments, they were responsive at the time of the inspection and were taking action to address this.

Staff told us the registered manager and deputy manager had an open door policy and were always visible around the home and regularly worked alongside staff. People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. For example, family meetings were held regularly and relatives could drop in anytime to speak with the registered manager.

Staff described a culture that was open with good communication systems in place. Team meetings were regularly held where staff could raise concerns and discuss issues. Staff told us, "We have meetings every month and minutes are available for staff to read and sign" and "We have staff meetings on rota and we discuss current issues, ways to improve and share information". Records showed discussions were around suggestions on how to improve people's care.

The provider maintained strong links with the local community. These included family support network groups for people's relatives and community friendship groups. This allowed people to be involved in local community activities and be kept up to date with changes in surrounding areas.

There was a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people who used the service were documented, investigated and actions were followed through to reduce the chance of further incidents occurring. For example, a person was hit by another person without being provoked on more than one occasion. The registered manager put a strategy in place to reduce further incidents. They booked the people to come in on different days and this prevented father incidents. The registered manager discussed accidents and incidents with staff and made sure they learnt from them. One member of staff said, "We discuss incidents in team meetings". All accidents and incidents were audited and analysed every month by the registered manager. The registered manager told us this was to look for patterns and trends with accidents to see if lessons could be learnt and changes made where necessary.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff said, "I can raise concerns to my manager, head office or I can whistle blow to CQC or social services".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager did not have a clear understanding of their responsibilities in relation to completing mental capacity assessments. Where people were thought to lack capacity, assessments in relation to their capacity had not been completed in line with the principles of MCA. The registered manager relied on capacity assessments carried out by other health professionals. Regulation 11 (1)(2)