The Camden Society

The Poplars

Inspection report

Drayton Road
Abingdon
Oxfordshire
OX14 5HY

Tel: 01235523630

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

his inspection took place on 14 and 15 January 2016. The inspection was unannounced.

The Poplars is registered to provide accommodation for up to six adults with learning disabilities who require personal care. At the time of the inspection there were five people living at the service.

The service did not have a registered manager. 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 service had management arrangements that included a service manager and a community support leader. The service manager had recently applied to be the registered manager and this application was now with the Care Quality Commission.

People were not always supported in line with the principles of The Mental Capacity Act 2005 (MCA). Staff were not always clear about how they would support someone in line with the principles of the MCA and care plans did not always contain Mental Capacity Assessments where necessary.

Records showed that staff had been trained in the MCA. Some staff we spoke with had an understanding of the principles of the MCA. However, some staff told us that they were unsure what the MCA was.

Some staff told us they did not receive regular meetings with their line manager (Supervision). However, documents relating to supervision demonstrated that staff did receive this.

People were safe. Staff understood how to recognise and report concerns. People received their medicines safely as prescribed. Staff assessed risks associated with people's care and took action to manage the risks.

Relatives told us, and we observed people benefitted from caring relationships with the staff who knew how to support them. Staff understood the needs of people and provided care with kindness and compassion. Staff took time to talk with people and provide activities.

We observed there were sufficient staff to meet people's needs. The service had robust recruitment procedures in place which ensured staff were suitable for their role. Background checks were conducted to ensure staff were of good character.

The service had systems to assess the quality of the service provided in the home. Learning was identified and action taken to make improvements which improved people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

People received their medicines as prescribed. Staff administering medicines checked each person's identity. Medicine records were completed accurately.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we took and what action we told the provider to take at the back of the full version of the 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. People told us they felt safe. Staff knew how to identify and raise concerns.

There were sufficient staff on duty to meet people's needs.

People received their medicines as prescribed. Staff carried out appropriate checks before administering medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported in line with the principles of The Mental Capacity Act 2005 (MCA).

People were supported by staff who had the skills and training to carry out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

Staff were very kind and respectful and treated people with dignity and respect.

People benefitted from caring relationships with the staff.

Staff had a caring approach to their work and clearly enjoyed supporting people.

Is the service responsive?

Good

The service was responsive. People received person centred care.

People were supported to avoid social isolation by engaging in a wide range of meaningful activities.

The service sought the advice from other professionals and took practical action.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a registered manager in post.

Staff gave a varied response to how the service was managed.

The manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

There was a whistle blowing policy in place that was available to staff around the home. Staff knew how to raise concerns.

The Poplars

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 checked whether the provider was 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 the on 14 and 15 January 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR, previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

We spoke with two people, two relatives, six care staff, the director of services, service manager, team coordinator and one healthcare professional. We reviewed five people's care files and records relating to the management of the service. 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 were safe. One person we spoke with told us "Yeah I'm safe here". This person then told us "I don't need to r(behaviour) here". When we checked with staff about what this meant to this person we were informed that the "[Person] (displays behaviour) when they are not happy or feel un safe". This person's care records confirmed this.

Relatives we spoke with told us people were safe. Comments included: "[Person] is looked after there", "I have no concerns", "People are safe there" and "[Person] would tell us if they were not happy".

People were supported by staff who could explain how they would recognise and report abuse. They told us they would report concerns immediately to the manager. Staff comments included "Report to line manager", "If I was unsure I would seek advice", "I would complete an incident form and tell my manager", "I would take it further if I had to", "First I would go to my manager", "I would first explain to the person that they were safe and not in trouble", and "I would go above my manager if I had to".

The service manager told us "If we had concerns about someone's safety then we would carry out additional observations. Everyone has one to one support. There are observations on this support as well as random spot checks". Staff were also aware they could report externally if needed. Staff comments included; "I would go to CQC (Care Quality Commission)", "I would consider reporting it to the police", "I would also inform the learning disability team" and "I would report it to the safeguarding team and CQC if I had to, or the police".

People were protected from risks. Individual risks to people were managed and reviewed daily. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person was at high risk of having seizures. Guidance for staff included the use of a personal monitoring device that alerted staff of the person's movement. We observed that staff followed this guidance and carried this device around with them. Further guidance on what action staff should take if this person had a seizure included 'give reassurance, stay calm and move objects out of the way'. Staff we spoke with were aware of these plans and followed this guidance.

Another person who had requested to attend a social event that may become unsafe for them had a specific risk assessment put in place. The risk assessment included advice and input from other professionals. The service took practical action to mitigate the risk to this person. This included having transport available to collect this person and bring them back to the home if they felt unsafe.

At the time of our inspection we observed that there were sufficient staff on duty to meet people's needs. Staff we spoke with gave a mixed response when asked if there was enough staff. For example, some staff we spoke with told us "There is three staff on at any one time, it's enough to get around everyone", "Yes there is enough staff" and "We don't have any issues with staffing". Another staff member told us "If we have any shortfall, then we ask our bank staff, they pick up most of it, If they can't then we ask staff. Failing that we use agency. This has only happened once since I have been here".

However, other staff we spoke with told us "There's not enough staff at the moment, most of the time it's really difficult to get staff cover", "From six o'clock there is only two staff members, if [person had a seizure] and [person] was not in bed then we would struggle. This was raised at a staff meeting, they said this would be looked into but they said they didn't think they would get the funding" and "We have a new service user coming at the end of the week. We need more staff".

We spoke with the provider about this and they informed us these concerns were being addressed. However, the staffing levels matched the care needs of the residents. During the day we observed staff were not rushed in their duties and had time to chat with people and engage with them.

The service manager told us "There's not enough permanent staff but we have excellent bank staff", "We've never had a reduced staffing level, you simply could not run a shift and give people quality support" and "Staffing levels are matched to the client's needs". We saw evidence the provider was currently recruiting two bank staff to permanent positions. The staff rota confirmed planned staffing levels were consistently maintained.

Records relating to the recruitment of staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identified if prospective staff had a criminal record or were barred from working with children or vulnerable people. We spoke with one member of staff who told us "You can't work with anyone until the checks come back".

People received their medicines as prescribed. Staff administering medicines checked each person's identity and explained what was happening before giving people their medicine. This ensured people received the right medicine at the right time. Medicine records were completed accurately. Medicines were stored securely in a locked cabinet and in line with manufacturer's guidelines. We saw evidence that the provider carried out weekly medication checks and spot checks on staff competencies.

Medicines administered 'as and when required' included protocols that identified when medicines should be administered. Staff had a clear understanding of the protocols and how to use them.

The home had personal evacuation plans in place for each person. This ensured people were protected during untoward events and emergencies. We spoke with staff who were aware of these plans and what action to take in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

People were not always supported in line with the principles 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. Staff were not always clear about how they would support someone in line with the principles of the MCA.

Care plans did not always contain Mental Capacity Assessments where information indicated people may lack capacity to consent to their care. For example, we were informed one person lacked capacity to make time specific decisions. However, there was no mental capacity assessment in this person's records to demonstrate this.

Records showed that staff had been trained MCA. Some staff we spoke with had an understanding of the principles of the MCA. Comments included: "It's about making the right decisions", "You must give people choices", "If we had concerns then we would have a best interest meeting", "It's about making certain decisions and not all decisions", "As long as their decision is safe and appropriate then that's fine". However, some staff told us that they were unsure what the MCA was, comments included. "I am not sure what you mean by mental capacity" and "I don't really know what it means".

These concerns are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us they did not receive regular meetings with their line manager (Supervision). However, we observed records that demonstrated that staff did in fact receive supervision that was in line with the provider's supervision policy.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provide legal protection for people who lack capacity and are deprived of their liberty in a person's own best interests. Records demonstrated that applications had been made to the supervisory body. At the time of our inspection three people were subject to a DoLS.

Relatives we spoke with told us staff were knowledgeable about people's needs and supported them in line with their support plans. Comments included; "The staff have the right knowledge and skills", "I have no concerns with the staff", "(Staff) have the right knowledge and they know [person]" and "There has been a lot of staff change, I don't really know the new staff but certainly my feeling is that they are knowledgeable".

People were supported by staff who had the skills and training to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. We saw evidence that the Induction was matched to the competencies of a national certificate. This included:

safeguarding, manual handling, health and safety, equality and diversity, fluids and nutrition, mental health, infection control, person centred approaches and health and safety. On completion of these competencies staff were signed off by their manager. One staff member we spoke with told us their induction "Was very effective and helped me to get to know the guys".

Staff told us and records confirmed that they had access to training that included Risk Assessment, Fire Safety, First Aid, Epilepsy awareness, Medication, Autism, MCA, Dignity in Care and Falls Prevention.

People had sufficient to eat and drink. Where people needed assistance with eating and drinking they were supported appropriately. Care records showed people's choices and preferences were identified and recorded. There were weekly meetings with people who were able to identify dishes in magazines that were matched to people's preferences. These pictures were then selected and put into weekly menus. Where people decided they wanted an alternative on the day then they had access to a kitchen and were able to select a meal of their choice.

Where people had been identified as having swallowing difficulties referrals had been made to Speech and Language Therapy (SALT). Care plans contained details of recommendations made by SALT and we saw staff were following these recommendations. For example, one person was referred to SALT and as a result was prescribed thickeners. The service acted on this advice and followed the guidance provided.

People's healthcare needs were regularly monitored. People had access to health care professionals where needed, such as doctors and specialists. Concerns about people's health had been followed up and there was evidence of this in people's care plans. For example, care files contained a 'medical appointment records form' which was used to highlight outcomes of appointments and follow up action.

Good

Is the service caring?

Our findings

We observed that people benefitted from caring relationships with the staff. For example, during our inspection one person became agitated. They reached out for the hand of a staff member. The staff member held hands with the person. The person looked at us and told us "I'm chilled now". Relatives we spoke with told us "It's going very well, [person] is very happy there, they have a life", "Yes, the staff are caring", "It has struck me on the whole as a thoughtful and practical service", "The staff are sympathetic and affectionate" and "The staff show great generosity and spirit".

Staff told us they enjoyed working at the service. Comments included; "I enjoy my job, I like helping people", "It's nice knowing you're helping someone to live a normal life" and "I really enjoy my job and supporting people with their needs".

Staff had a caring approach to their work and clearly enjoyed supporting people. Staff spoke with kindness and compassion when speaking with people. During our inspection we saw many gentle and considerate interactions. For example, when staff were addressing people they knelt down to people's level and made eye contact. Where appropriate, staff used gentle touch to engage with people.

Interactions were kind and caring. People were treated as individuals. For example, we observed how one person had been referred to an independent mental health advocate in order to support this person with their individual needs surrounding advanced decisions and ongoing medical care.

Staff treated people with dignity and compassion. When staff spoke about people to us or amongst themselves they were respectful. All the records we looked at used respectful language. Staff knocked on people's doors and waited to be invited in before entering. Where they were providing personal care, doors were closed. Staff we spoke with told us "It's important that we make sure doors are closed and no one is around, It's important that you follow (people's) routines, I treat people as I would want to be treated", "We always knock on doors", "We always knock first" and "We make sure doors are shut and we always make sure people have a gown".

Care records highlighted people's faiths and religious practices. For example, ones person's care records highlighted the significance of religious festivals and how the person enjoyed them. We spoke with a member of staff about this person and they confirmed this.

Relatives told us that they felt people were involved in their care. Comments included; [Person] has input into their care and the home gives us updates" and "Yes [person] is involved as much in their care as they can be". This was evidenced further in the persons care records.

People had their own rooms which enabled them to maintain their privacy. Staff we spoke with told us people were encouraged to personalise their rooms. Every person's room had been personalised and made to look homely. Staff we spoke with told us "It's important people feel at home, this is their space. We ask them what they like and support them to get it" and "What we do is ask what they would like to do to their

rooms or any changes they want to make".
Information relating to people and their care was held in the office. The office had a locked door ensuring people's information remained confidential.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to ensure the service could meet their needs. Care records contained details of people's medical histories, allergies and on-going conditions. Care plans had been developed from the information people provided during the assessment process. Care plans were updated regularly to ensure the information was accurate. Care plans provided staff with clear guidance on each person's individual care needs and contained sufficient information to enable staff to provide care effectively whilst responding to people's needs. For example, one person who was at risk of seizures had guidance on how to support them during a seizure and what steps staff should take directly after the event. Staff we spoke with were knowledgeable on how best to support this person and were aware of the guidance in the persons care records. Records confirmed that people had their care reviewed every six months. However, this information was not always easily accessible in the care records.

We observed the service had in place daily handover meetings. These meetings were designed to review people's care and respond to changes in people's support needs. We saw evidence that actions from these meetings were recorded.

People were kept up to date with changes to the home. For example, the provider is planning on making significant changes to how it delivers its service and care in the future. We observed evidence that house meetings had taken place to keep people informed of the changes whilst seeking people's views and concerns.

Care records included guidance on how to support people who may demonstrate behaviour that challenges others. For example, one person's records stated 'Staff to be clear and firm and reinforce positive behaviours'. Another person's care records highlighted de-escalation techniques that could be used. For example, playing certain music and asking the person to support staff with household jobs around the home. Staff we spoke with were aware of and followed this guidance.

People received personalised care. For example one person who had difficulties communicating through conventional methods such as sign language and Makaton and they had created their own sign language. Pictures of this person signing and what the signs meant were available in their care records. We spoke with one member of staff who was responsible for this person's one to one care and they were able to demonstrate the signs to us. This matched those in the person's care records.

People's care records demonstrated they were supported to avoid social isolation by engaging in a wide range of meaningful activities. For example, going to day centres, going out for walks, shopping trips, feeding the ducks, doing puzzles, watching trains, walks to see horses, art and eating out. All the care plans held personal information about people including their care needs, likes, dislikes and preferences. For example, one person's plan highlighted that they liked watching television, going to the pub and shopping for toiletries Another person's care records highlighted they loved to dance and going out for meals. Staff we spoke with were knowledgeable about the people they supported.

We saw evidence of how the service sought the advice from other professionals and took practical action. For example, one person's care records highlighted they had become unwell. The service took action and arranged an appointment for this person to see their GP. The service then supported the person to attend the appointment and supported them to follow the GP's advice in relieving the symptoms and monitoring the person's condition.

Another person's care records demonstrated that the service had responded to a person's changing medical need. The service sought advice from the GP and followed this guidance.

The service had a complaints policy displayed in the home. This policy was in both standard and easy read formats. There had been no complaints since our last inspection. The team coordinator told us "We encourage people to make complaints so we can improve our service". The service had in place monthly residents meetings were people's views were obtained and acted upon.

Requires Improvement

Is the service well-led?

Our findings

here was not a registered manager at the 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. We observed that this is being addressed by the provider. The service had management arrangements that included a service manager and a community support leader. The service manager had recently applied to be the registered manager and this application was now with the Care Quality Commission. However the service had been without a registered manager since November 2014.

Staff we spoke with gave a varied response to how the service was managed, Comments included "The team are good but the service doesn't feel organised or efficient", "The current manager is supportive but the service could be better managed higher up", The management of the service is O.K." and "Things are always changing you never get use to something".

Staff were confident the management team and organisation would support them if they used the whistleblowing policy or raised a concern. Staff felt able to approach the service manager and the seniors at any time for help and guidance. One member of staff said "The manager is approachable".

The service manager told us the visions and values of the home were that "Everyone should have a good life and live as independently as they could". It was evident from speaking with staff they shared the same visions and values. Staff and seniors told us that regular staff meetings were held. The service manager told us these were used to "Staff to raise problems, "discuss training and improvements to the service" and "To provide a safe space for staff to talk".

Accidents or incidents were documented and any actions were recorded. For example, at the time of our inspection there was an incident that involved a person missing an evening dose of their medicine. The service took immediate action by contacting the person's GP to seek medical advice. Following the incident the service manager arranged for additional support for staff to prevent this from happening again. The service manager informed us that this would be raised at the next team meeting where learning from the incident would be shared. Records confirmed that the service had raised this with Oxfordshire County Council Safeguarding Team.

There were effective systems in place to assess the quality of the service. Regular audits were conducted to monitor the quality of service and learning from these audits was used to make improvements. For example, a recent medication audit highlighted a person was at risk of not receiving their medication due to a formality in the procedure of obtaining the medicine. The service took immediate action by finding a solution. The service then followed this up with healthcare professionals. The service manager had identified the concerns with regards to the mental capacity act and staff supervisions and had an action plan in place to address this. However this was not in operation at the time of our inspection.

The provider carried out an annual quality satisfaction survey. The survey was given to people and staff supported people to complete it. The results of these recent surveys demonstrated that people felt supported and listened to. The provider sought to improve the service to deliver consistent, high quality care. The service manager had recently carried out a full audit of service. Where improvements had been identified action had been taken or was in progress.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The service manager had informed the CQC of reportable events.

Records confirmed that the service worked in partnership with visiting agencies, particularly the NHS and local authority. The service had links with local community mental health teams.

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 did not take formal enforcement action at this stage. 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 provider had not acted in accordance with the principles of the mental capacity act 2005 and associated code of practice.