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	Good

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

Summary of findings

Overall summary

We undertook an unannounced inspection of The Poplars on 9 February 2017.

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 three people living at the service.

At the previous inspection on 14 and 15 January 2016 we found the provider had not acted in accordance with the principles of the Mental Capacity act 2005 and associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014, which relates to consent.

At this inspection we found that the home had made significant improvements to address the areas of concern. The registered manager and staff understood the Mental Capacity Act (MCA) 2005 and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves.

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. However, the community support leader of the service had submitted an application to become the registered manager.

Staff understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse. Staff had completed safeguarding training.

The service sought people's views and opinions and acted upon them. Relatives told us they were confident they would be listened to and action would be taken if they raised a concern. Where risks to people had been identified risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe.

People received their medicines as prescribed. Records confirmed where people needed support with their medicines, they were supported by staff that had been appropriately trained.

Staff spoke positively about the support they received from the community support leader. Staff had access to effective supervision.

People were supported by staff who had the skills and training to carry out their roles and responsibilities. People benefitted from caring relationships with the staff who had a caring approach to their work. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff and the community support leader shared the visions and values of the service and these were embedded within service delivery. The service had systems to assess the quality of the service provided. Learning from audits were used to improve the service.

People were supported to maintain good health. Various health professionals were involved in assessing, planning and evaluating people's care and treatment. People had sufficient to eat and drink. Where people needed assistance with eating and drinking they were supported appropriately.

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. Relatives told us people were safe.

There were sufficient staff to meet people's needs.

Staff understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had been trained in the MCA and applied it's principles in their work.

Staff had the training, skills and support to meet people's needs.

The service worked with other health professionals to ensure people's physical health needs were met.

Is the service caring?

Good

The service was caring.

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

People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed to ensure they received personalised care.

Staff understood people's needs and preferences.

Staff were knowledgeable about the support people needed.

Is the service well-led?

Good

The service was well led.

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. Staff knew how to raise concerns.

The visions and values of the service were embedded within service delivery.

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 9 February 2017. The inspection was unannounced. This inspection was conducted by one inspector.

Before the inspection, the 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 previous inspection reports and notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. This ensured we were addressing any areas of concern.

We spoke with two relatives, three care staff, one team coordinator, one community support leader and the director of services. We looked at three people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service.

Good

Is the service safe?

Our findings

Relatives told us people were safe. One relative told us "Yes [person] is safe there". Another relative told us "I admire the staff and I am glad he is in such safe hands".

Staff were aware of types and signs of possible abuse. Staff had completed safeguarding training and understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse. Staff we spoke with told us that if they had any concerns they would report them to the manager. Staff comments included "I would contact my manager straight away", "If I wasn't taken seriously then I would go to their manager" and "I would inform [community support leader] straight away and record what I needed to".

Staff were aware they could report externally if needed. One staff member told us "If someone was at immediate risk then I would contact the police". Another staff member said "I would contact the safeguarding team and the care managers".

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 assessed as 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. This persons care records gave further guidance for staff on what action to take when responding to this person's needs. Staff we spoke with were aware of these plans and followed this guidance.

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. The provider carried out regular medicine 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. For example, one person's care records gave guidance on what staff should do if the person had difficulties taking their medication. We observed staff administering as and when required medicine for this person. During the administration the person had difficulties taking the medication. Staff followed the guidance in the persons care plan. As a result this person received the appropriate medicine when they needed it.

We observed, and staffing rotas confirmed, there were enough staff to meet people's needs.
A staff member we spoke with told us "I feel that staffing is fine. We seem to have enough numbers". We saw evidence that staffing levels were reviewed by the management team. During the day we observed staff having time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role.

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.

Good

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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.

At the previous inspection in March 2016 we found the provider had not acted in accordance with the principles of the MCA and associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. At this inspection we found significant improvements had been made.

For example, one person's care record identified they lacked capacity to make particular decisions in areas that related to ongoing medical treatment. This persons care records included a mental capacity assessment in relation to the decision and professionals involved in this person's ongoing care had been involved in a best interests meeting. The outcome of this was that the person received the medical treatment they needed and that this was carried out in the least restrictive way.

Records showed that staff had been trained in the Mental Capacity Act (MCA). All staff we spoke with had a good understanding of the principles of the MCA. Staff comments included: "Just because someone makes a decision that we don't agree with does not mean they lack capacity", "We must assume capacity until proven otherwise" and "It's about the ability to make specific decisions, small or large".

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 their own best interests. At the time of our inspection the service had made DoLS applications for three people.

Relatives we spoke with told us staff were knowledgeable about people's needs and supported them in line with their support plans. One relative told us "I feel they have the right skills". Another relative told us "I feel the staff understand [person] well".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff completed training which included: Person centred planning, safeguarding adults, moving and assisting, supporting people with complex needs, medication, positive risk taking and epilepsy.

Staff told us that the training supported them in their roles. Staff comments included "The training is good and seems to have got better", "The training is good I enjoy it" and "We get regular training and we are also encouraged to read the policies". Staff told us and records confirmed that staff had access to further training and development opportunities. For example, staff had access to national qualifications in care. One staff member we spoke with told us "I am planning on doing my NVQ level 3".

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one staff member told us "We discuss my support needs, any staff problems or training needs". Staff told us they felt supported. Comments included "I can always go to [senior] if I need something", "[Senior] is brilliant, she is very supportive", "They are good at giving advice and guidance" and "I feel very supported, I can go to my seniors anytime with anything".

Staff were also supported through spot checks to check their work practice. Senior staff observed staff whilst they were supporting people. Observations were fedback to staff to allow them to learn and improve their practice. Observations were also discussed at staff supervisions.

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.

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 records contained a 'medical appointment records form' which was used to highlight outcomes of appointments and follow up action.

Where healthcare professionals provided advice about people's care this was incorporated into people's care plans and risk assessments. For example, 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 the recommendations.

Good

Is the service caring?

Our findings

Relatives were complimentary about the staff and told us staff were caring. Relative's comments included; "[Person] is well looked after there", "[Staff] is brilliant and really caring" and "They look after my son very well with great consideration and affection".
Interactions were kind and caring. People were treated as individuals and supported with their independence. For example, two people had been referred to an independent mental health advocate in order to support them with an upcoming change to the service.
Throughout our visit we saw people were treated in a caring and kind way. The staff were friendly, polite and respectful when providing support to people. Staff took time to speak with people and reassure them, always making sure people were comfortable and had everything they needed before moving away. For example, one person was being supported to put on their footwear. The staff member informed the person of what they were doing throughout the care task. When the staff member had carried out the task they asked the person if they were "O.K." and "comfortable". The person responded non verbally to the staff member. Records confirmed that the nonverbal communication demonstrated that the person was 'happy'.

We asked staff how they promoted people's dignity and respect. Staff comments included "It's about giving choice", "We always explain what's going on. It promotes dignity but it's also important because it keeps people safe", "You must ensure that dignity is protected in everything you do. Like making sure doors and windows are closed" and "At the end of the day it is a basic human right, our service users are no different to anyone else. Some people see people with learning disabilities differently. That doesn't happen here. Our service users have the same rights and choices as anyone else". A relative we spoke with told us, "They promote his dignity".

Staff spoke to people with respect using their preferred name. When staff spoke about people to us or amongst themselves they were respectful. Staff called out to people if their room doors were open before they walked in, or knocked on doors that were closed. For example, people's medicines were kept in locked cabinets in people's rooms. We needed to access these cabinets. Without exception all staff that supported us with this knocked and called out to gain peoples permission, prior to the inspector entering their rooms.

Relatives told us they felt involved in peoples care. One relative told us "They are always getting in touch and updating us with things". Another relative told us "We have a meeting every year. Yes I feel involved".

People's independence was promoted. Care plans guided staff on how to promote people's independence. For example, one person's care plan highlighted that the person liked to remain independent and carryout personal care tasks by themselves. The person's care plan highlighted the different levels of support and prompts that a person required when carrying out specific care tasks for themselves. Staff we spoke with told us how they supported people to do as much as they could for themselves and recognised the importance of promoting people's independence. One staff member we spoke with told us "We encourage people to do what they can for themselves, whilst keeping a watchful eye on them".

People's advanced wishes were recorded. We looked at people's records and where there were instructions

on 'Do Not Attempt Cardio Pulmonary Resuscitation' and it was evident that discussions had taken place with people's families and healthcare professionals surrounding end of life care.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care plans contained details of people's preferences, likes and dislikes. For example, care plans contained a document that captured specific information on people's favourite pastimes and activities, personal care preferences and important people in their lives. Staff we spoke with were knowledgeable about the the information in people's care records. For example, one member of staff told us about a person's favourite activity. The information shared with us by the staff member matched the information within the person's care records. During our inspection we observed this person enjoying their favourite activity.

The service was responsive to people's changing needs. We noted the service had responded to one person's changing needs surrounding an ongoing medical condition. Following this change in need the home liaised with healthcare professionals. The result of this was that the person received a specialist appointment with the relevant team at the local hospital. A relative we spoke with told us "They are always on the ball and let me know things, if there are any changes in (person's) needs". Another relative told us "They keep me up to speed with what's going on".

All care records that we looked at contained a 'Hospital passport' which people took with them to healthcare appointments. This included guidance for healthcare professionals on how to support people appropriately following changes to people's care needs. For example, one person's hospital passport detailed signs of agitation and steps that healthcare professionals could take to address the situation and support the person if they became agitated. This supported people to have positive experiences within other services.

People received personalised care. For example, one person had difficulties communicating through conventional methods such as sign language and Makaton. As a result the person 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 two members of staff on duty and they were able to demonstrate and explain the signs to us. This matched the pictures in the person's care records.

Care records included guidance on how to support people who may demonstrate behaviour that may appear challenging to others. For example, care records highlighted de-escalation techniques that could be used to appropriately support people. Staff we spoke with were aware of and followed this guidance.

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 shopping trips, listening to their favourite music, going to the pub and doing puzzles. During our inspection we observed people engaged in activities that were matched to their individual preferences.

Care records included people's faith and religious practices. For example, one 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.

People were kept up to date with changes to the service. For example, the provider had recently made significant changes to how it will deliver its service in the future. For example the provider is moving its premises. We saw evidence that house meetings had taken place to keep people informed of the changes whilst seeking people's views and concerns. The service had also sought the support of independent advocates to ensure that the people's views were recorded.
The home sought people's views and opinions through satisfaction surveys. People were supported to complete these by staff and professionals involved in their care. Responses to the recent survey were positive.

The service had a complaints policy displayed in the home. This policy was in both standard and easy read formats. There had been four complaints since our last inspection. These had been dealt with in line with the provider's complaint procedure. One relative we spoke with told us "I would not have a problem with raising a concern, I feel they would generally want to know if there was a problem, so they could put it right".

Good

Is the service well-led?

Our findings

Staff spoke positively about the community support leader. Comments included, "She is very calm", "She emits calmness", "If she doesn't know the answer then she will find it out for you" and "If she refuses something then she will always let you know why".

The community support leader told us their visions and values for the home were, "For people to live as independently and be able to access the community when they want to and for people to be safe". They also told us "There are no barriers here and people are included in everything we do". There was a positive and open culture in the office and the management team was available and approachable.

Regular audits were conducted to monitor the quality of service. These were carried out by the community support leader and the provider. Audits covered all aspects of care including, care plans, person centred care, risk assessments and medication. Information was analysed and action plans created to allow the community support leader and provider to improve the service. For example, following a recent audit of care records the audit identified the need for information within the records to be more person centred. As a result care records were updated to include further information that supported a person centred approach to care planning. This demonstrated that the service was continually looking to improve.

Accidents and incidents were recorded and investigated. The registered manager used information from the investigations to improve the service. For example, following a minor medication error the provider took the appropriate action and ensured that the staff involved underwent medication refresher training and had their competencies checked. The provider also ensured that the person's G.P was informed.

The service had introduced a system to ensure that staff completed documentation that captured their thoughts and feelings of the incident and what learning they could then take from it in order to continuously improve the quality of care that people received. For example, following an incident that involved a person needing reassurance from staff, staff felt that although the person received a good level of reassurance this could have been delivered differently. This was included within the documentation on strategies that the staff should try if the incident happened again.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice.

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

The service worked in partnership with visiting agencies and had links with G.P's, the local learning disabilities team and other healthcare professionals. Records of referrals to healthcare professionals were maintained and any guidance was recorded in people's care records.