Tawnylodge Limited

Poplars Nursing and Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Poplars Nursing and Residential Care Home is a care home that was providing personal and nursing care to 44 people aged 65 and over at the time of the inspection.

People's experience of using this service:
The systems in place to monitor the quality of care were not effective and actions were not driving improvements. This was the third time the service had been inspected and had failed to achieve a good rating; people had been exposed to poor care for too long. The provider did not have robust strategies in place that enabled them to identify when staffing levels were not meeting people's needs. Audit systems were in place but identified trends were not always acted upon. Regulatory requirements were understood and CQC notifications were submitted in accordance with the law.

People were not supported by sufficient numbers of suitable staff to meet their needs. People were not always supported to stay safe as staff did not always have time to follow people's risk assessments. People's medicine records were not consistently completed by staff. Systems were in place to safeguard people and staff understood how to protect people from abuse.

People's needs and choices were assessed but staff did not always have the time to deliver support in line with people's needs. Staff had the skills and knowledge to deliver effective care.

People's dignity was not always respected. People were treated with kindness and compassion by staff. People's privacy was respected and staff promoted people's independence.

People were not always supported to follow their interests. People contributed towards the planning of care but personalised care was not always received. People's concerns and complaints were encouraged and responded to.

The service met the characteristics of Inadequate in most areas. More information is in the full report.

Rating at last inspection: At the last focused inspection (report published 11 October 2018), the service was rated as Requires Improvement overall and Requires Improvement in the key questions of Safe and Well-Led. At the last comprehensive inspection (report published 28 April 2018), the service was rated as Requires Improvement overall with ratings of Requires Improvement in the key questions of Safe, Effective, Responsive and Well-Led. At the last two inspections, we asked the provider to make improvements.

Why we inspected: This was a planned inspection based on the rating at the last comprehensive inspection and to make sure improvements had been made.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found and

appeals is added to report after any representations and appeals have been concluded.

Follow up: The overall rating for the service is inadequate and the service will be placed in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. We will continue to monitor intelligence we receive about the service until we return to visit.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Poplars Nursing and Residential Care Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
The Poplars Nursing and Residential Care Home accommodates up to 60 people. At the time of our inspection, 44 people were using the service. People were accommodated in one adapted building with support provided over two floors with five communal lounges for people to use.

People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The current manager informed us that they would be registering with the Care Quality Commission imminently. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection, we spoke with six people who used the service and six relatives. Some people who used the service were not able to speak to us about their care experiences, so we observed how the staff interacted with people in communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight staff members including care assistants and nurses and we also spoke with the manager.

We reviewed the care records of six people. We looked at two staff files, which included pre-employment checks and training records. We looked at records relating to the management of the service. For example, rotas, complaint logs, accident reports, monthly audits and medicine administration records.

After the inspection, the manager sent us additional information that we had requested during the site visit.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Staffing and recruitment

- At our last focused inspection in August 2018, we found there were not enough staff available to meet people's needs and they were not always deployed effectively to ensure people received support when they needed it. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection, we found the provider had not made the required improvements and there were still not enough staff to meet people's needs safely.
- One person told us, "There's never enough staff." Another person told us, "I used to go downstairs but I couldn't cope seeing people wanting help and not being helped." A relative told us, "People have to wait too long."
- The provider had failed to ensure there were sufficient staff to respond to service users and meet their needs at the time they required it. One person told us, "One staff came in at 11:30pm last night to turn me. I should be turned twice in the night. They didn't come back. I woke up and I was cold and wet. I pressed the call button and it was the day staff that came." Staff confirmed they were not always able to reposition people and attend to their personal care needs as regularly as their care plan indicated. Repositioning charts showed people were not always repositioned as they should have been. For example, repositioning charts showed one person required repositioning every four hours during the night but the repositioning chart recorded they had not been turned on five consecutive nights.
- Following the inspection, the provider told us that staff had recorded some repositioning on activity of daily living logs rather than the repositioning charts. The provider provided us with the activity of daily living logs for this person which showed they had been repositioned regularly on four of the five nights. However, there was no evidence to show that on one night, the person had been repositioned at all and the records indicated they had not been repositioned for over 15 hours. This meant that people were at risk of skin breakdown and their safety was not being maintained.
- Staffing levels were not sufficient to maintain people's safety. We saw one person trying to mobilise using a walking frame that was back to front. A member of the inspection team was required to intervene to prevent the person from falling as no staff were present. Incidents and accidents logs and notifications submitted to CQC confirmed that a high number of unwitnessed falls had occurred whilst staff were not present.
- People were at increased risk of abuse by other service users due to staffing levels not being sufficient. A relative told us, "Sometimes there is falling out, people slap each other. The staff aren't here when that happens." Incidents and accidents logs and notifications submitted to CQC confirmed that a number of unexplained bruising incidents had occurred. We saw one person get up unsteadily and snatch a cup off another resident. We checked care records and identified that there had been incidents where this person presented with behaviour that challenged but action had not been taken to ensure staffing levels were appropriate to reduce risk to people.

● The provider had failed to ensure there were sufficient staff to respond to service users and meet their needs at the time they required it. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Safe recruitment practices were followed to ensure people were supported by suitable staff. We saw that Disclosure and Barring Service (DBS) checks were undertaken and gaps in employment history were checked prior to staff commencing employment.

Assessing risk, safety monitoring and management
● Risks to people were assessed and reviewed but action was not always taken to manage risk when needed. For example, one person had experienced seven unwitnessed falls in one month. The person's risk assessment had been reviewed and it had been identified a referral to the falls team was required but the manager confirmed a referral had not been made. The person was left at risk of harm.
● Staff understood risk assessments in place but did not always follow them. One staff member told us, "We have quite a few people who need two people to support them. If we had two staff to support all of these people, we wouldn't get to the end of the corridor so we have to do it on our own sometimes." This meant that people's safety was not being maintained in accordance with their risk assessment and they were placed at risk of harm.
● Systems were in place to monitor accidents and incidents but these were not effective. This information was analysed to identify any trends but appropriate action was not always taken to reduce future risk.

Using medicines safely
● People's medicines were not always administered safely. We saw Medicine Administration Records (MARs) were not completed for topical creams. This meant the provider was unable to evidence that people had their topical creams when they needed them.
● Protocols were in place for 'as required' medicines but these were not detailed and did not guide staff on what to look for and when to administer 'as required' medicines. This meant people may not have received their 'as required' medicines as prescribed.
● Staff were trained to ensure they were competent in medicine administration. Medicines were stored safely in locked trollies.

Learning lessons when things go wrong
● Lessons were not always learnt when things went wrong.
● Some improvements had been made since the last inspection to improve the service. However, concerns regarding staffing levels had not been adequately addressed so people's safety could not always be maintained but we saw other areas, such as staffing, had not been addressed.

Systems and processes to safeguard people from the risk of abuse
● At the last focused inspection in August 2018, we found people were not consistently safeguarded from harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● At this inspection, we found the provider had made improvements and were no longer in breach of regulations.
● Staff completed behaviour charts and incident forms when they witnessed people displaying behaviours that challenge. These were monitored by the manager and CQC notifications were submitted and safeguarding referrals made to the local authority when needed.
● Staff knew how to recognise the signs and symptoms of potential abuse and how to report and record their concerns. A staff member told us, "If there is any harm or risk of harm, we report it to a senior or manager, document it and file an incident report."

● People and their relatives told us they felt safe. A person told us, "I feel safe. The staff are not too bad at all."

Preventing and controlling infection

● The home was clean and tidy. Staff were cleaning the premises throughout the day and were quick to address any odours.

● Staff followed infection control procedures and people were protected from the risk of infection and cross contamination. We saw staff wore aprons and gloves when taking meals to people. One staff member told us, "I have done infection control training. We have to wear personal protective equipment. I make sure I keep changing my gloves and wear aprons."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People and their relatives had been involved in developing their support plans, which identified their preferences and guided staff on how people would like to be supported. However, staff told us they did not always have time to read care plans or to provide care in the way people would like it so people's needs were not always met in their preferred way.

● People's assessments were stored using an electronic record management system and staff used hand held devices to view documentation and input details of the care given. A staff member told us this was good as it alerted them to what tasks were still required. However, staff told us there were still some issues with the system so they had to find a laptop to remove the alerts once the tasks had been completed.□

● People's needs were assessed before they started to use the service. People's diverse needs and protected characteristics were considered within assessments, in line with the requirements of the Equality Act 2010.

Staff support: induction, training, skills and experience

● People were supported by staff who were appropriately trained and had the skills to provide effective support. People and relatives told us staff were good. Staff members told us they did online and face to face training. We saw that staff had the skills to support people safely.

● Training records were in place which identified training that had been undertaken by staff and any gaps in learning. Where gaps were identified, the manager took action to ensure training was up to date.

● Staff told us they received supervision and felt supported by the manager.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not always able to choose where to eat their meals. Staff told us there were not always enough staff to offer people their meal in the dining room.

● Most people enjoyed the food. A person told us, "The food is very good. I don't like to be faced with a plate full, they do the right amount for me."

● People were given a choice of meals but people's communication and dementia needs were not always considered when offering choice. Meal options were displayed on the wall in the communal lounge and the regional manager told us people were offered meal choices by being shown plates of food. However, we found staff were not consistently using this system to support people with choice.

● People's dietary needs, including specialist diets, were assessed and managed effectively by staff. One staff member told us, "[People's names] have pureed diets because they are at risk of choking. We have to feed most people on a pureed diet. Some people also have thickened drinks."

● People's fluid, food intake and weights were monitored. However, the provider did not always take action

where records showed people's weight had fluctuated so concerns regarding people's diet were not always addressed.

Adapting service, design, decoration to meet people's needs

● People's dementia needs were not always met by the signage used in the home. People had pictures on their doors with their name and room number on but each room in the same unit had the same picture on the door sign. This meant that people could have difficulty with identifying their own rooms.

● People's rooms were personalised to their taste and they had personal items in their bedrooms.

● The design of the building met people's needs. People who used wheelchairs could access other floors of the building through the lifts and people were able to walk around with or without staff support as needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were not always supported in a timely manner to access therapy services when needed. For example, the manager told us a referral to the falls team had not been made when it had been identified as a required action.

● People were supported to access GP and nursing services when required. Records showed district nurses visited daily to administer insulin to people who needed it. The manager regularly communicated with the local GP practice to try to access healthcare support for people. A staff member told us, "[Person's name] had an episode yesterday so we called the paramedic in ."

Ensuring consent to care and treatment in line with law and guidance

● 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.

● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Mental capacity assessments had been undertaken when needed.

● Staff understood the principles of the MCA and knew how this applied to supporting people. Staff asked people for their consent before they supported them. Staff told us about how if people lacked capacity, a best interests' decision may be made with the involvement of family and other professionals.

●The manager made appropriate DoLS referrals where people's liberty was being restricted and had met the conditions on authorisations.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always respected as the provider failed to ensure staff had time to support people with personal care in their preferred way. One person told us, "It can be a couple of months for a proper shower." One staff member told us, "We are not washing people as we would want to. I haven't got time to give them what they need, it shouldn't be like this."
- However, people confirmed when staff supported them they were respectful. One person told us, "You have your shower. They go just around the corner and say, 'just shout if you need me'. They respect my dignity."
- People were encouraged to maintain their independence. One person told us, "I can use my wheelchair on my own, it gives me independence. Staff guide me to use the lift."
- People could be visited by their relatives at any time which people and relatives appreciated. A relative told us, "I can bring our dog in to see [person's name] which they really like."

Supporting people to express their views and be involved in making decisions about their care

- People were supported to express their views and staff encouraged people to make decisions about their care where able. One person told us, "You can choose where you sit." We observed staff downstairs asking people what they wanted to eat and drink and which room they would like to sit in.
- However despite a system in place to offer choice at meal times, we saw staff were not using this to show people plates of food to support with choice.

Ensuring people are well treated and supported; respecting equality and diversity

- We observed positive interactions between staff and people and relatives told us staff were caring when they were supported. One person told us, "I haven't come across one that isn't nice – they are always smiling and have a fab sense of humour." One relative told us, "the staff are brilliant, so friendly, so helpful. They always know where my relative is and they know who I am too."
- People were given emotional support by staff when needed. We observed one person become anxious. A staff member knelt by them and spoke to them whilst holding their hand which calmed and reassured the person.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● At the last comprehensive inspection in February 2018, most people said that more activities would be welcomed.

● At this inspection, we saw further improvements were still required. A relative told us, "No one comes into [Person's name]'s room to just chat or do activities with them." One staff member told us, "There's not enough activities for people to do. The activities co-ordinator is brilliant and does lots of work but there's not enough activities co-ordinators." We saw some people enjoying an activity with a ball in the main lounge during the inspection. However, this was not consistent as others were sitting alone for long periods of time without engaging in any activities or stimulation from staff.

● People and relatives were involved in assessments and care planning. A relative told us, "Before [person's name] moved in, we came to look round and they asked lots of questions about their needs and the things they like."

● However, care was not always provided in line with people's wishes and preferences. A person told us, "Sometimes staff put their head round the door, but don't speak to me and that worries me because I don't know who it is." Our observations showed there was sometimes no engagement or conversation between staff and the person, for example when supporting with meals.

Improving care quality in response to complaints or concerns

● Concerns and complaints were encouraged and responded to.

● People and their relatives told us they knew how to complain. One relative told us, "If I had concerns, I would talk to the manager."

● A complaints policy was in place and followed by the manager. Where a formal complaint was made, we saw the manager had arranged meetings to discuss the concerns, had investigated the concerns and then provided feedback.

● The management acted on concerns to improve the quality of care for people. We saw a "You said, we did" display board which was visible to visitors so they could see how the provider had responded to any concerns.

End of life care and support

● People's end of life wishes had been considered. Do Not Attempt Resuscitation (DNAR) orders had been discussed and were in place for people to ensure their end of life wishes were known.

● Relatives confirmed they had spoken with staff regarding end of life care for their relative. One relative told us, "We did a care plan with the senior. They asked questions about their needs but also about their life including end of life care."

● End of life care plans were in place documenting people's wishes and preferences at that stage of their life.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- At this inspection, the overall rating is Requires Improvement . This service has been rated as 'Requires Improvement' in Well-Led on three consecutive inspections and 'Requires Improvement' overall on three consecutive inspections. This shows that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved. This also shows the provider did not always learn from feedback given to improve the delivery of care to people.
- Due to the provider's consistent failure to adequately address concerns regarding sufficient staffing levels, despite being rated as 'Requires Improvement' by the CQC, we cannot be assured that feedback will be acted on to improve staffing levels and care provided to people.
- At the last focused inspection in August 2018, we found there were not always effective systems in place to monitor the service and mitigate risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection, we found that effective systems were still not in place to monitor the service and mitigate risks to people.
- For example, the staffing tool used was not effective in ensuring sufficient staff were deployed based on people's dependency levels. The systems did not identify where people's dependency scores had not been updated to accurately reflect their needs.
- The provider's systems had not ensured staff were following agreed risk assessments to keep people safe. For example, systems in place failed to identify people that required assistance of two staff were not always supported safely as they did not have sufficient staff to meet people's needs in accordance with their risk assessments. This left people at risk of harm.
- The provider's systems had not ensured action was taken to prevent further incidents. For example, we saw a high number of unwitnessed falls and incidents of service user on service user abuse. Despite analysis being undertaken and trends being identified, no action was taken to improve staffing levels to reduce risk to people.
- The provider promoted a vision regarding high quality care but the staffing strategy was inadequate to fulfil this vision and achieve good outcomes for people. A staff member told us, "The manager is encouraging of person centred care. It's the intention of everyone in the building to provide this but it is not always possible due to staffing levels." We observed staff trying to provide person centred care but this was not provided consistently due to the provider's consistent and continuing failure to ensure sufficient staffing levels were in place.
- People and their relatives told us the provider engaged with them but action was not always taken as a

result of their feedback. A relative told us, "They send us a survey through the post and you fill it in and give it back. The last one was a few weeks ago." Another person told us they had spoken to the manager about the number of physical incidents between people and they had said it was because there wasn't a third staff member on shift but this was 6 weeks ago and staffing levels had not improved. This meant that although people and their relatives were encouraged to give feedback, action was not taken by the provider to improve the service.

● Staff told us they had raised concerns about how inadequate staffing levels were negatively impacting upon people, but nothing had been done to address this. This meant that the provider had continually failed to act to address legitimate concerns by staff.

● This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● At the last focused inspection in August 2018, we found the provider had not notified the CQC of incidents as they are required to do by law. At this inspection, we found the provider was now submitting CQC notifications as required by law and was no longer in breach of Regulation 18 of the Care Quality Commission (Registration Requirements (Regulations) 2009.

● Services that provide health and social care to people are required to tell us about important events that happen in the service. We use this information to monitor the service and make sure the service is keeping people safe.

● The last inspection rating was displayed at the home, as required.

● The provider did not have a registered manager in post. The manager told us they would be registering with the CQC in due course. We will continue to monitor this.

Working in partnership with others

•□The manager told us they worked in partnership with other professionals to improve the service. For example, a senior staff member was present when professionals visited people and they would both be involved in developing effective care planning. Records we saw supported this.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had been rated as 'Requires Improvement' on 3 consecutive inspections and had failed to take action to make improvements to the service. Effective systems were not in place to monitor the service and mitigate risks to people.

The enforcement action we took:

We restricted new admissions and the provider is required to send a report to the Commission within 7 days of the condition coming into effect and on the first Monday of the month thereafter, detailing staffing levels and how these are sufficient to meet people's dependency needs safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by sufficient numbers of suitable staff to meet their needs and maintain their safety.

The enforcement action we took:

We restricted new admissions and the provider is required to send a report to the Commission within 7 days of the condition coming into effect and on the first Monday of the month thereafter, detailing staffing levels and how these are sufficient to meet people's dependency needs safely.