Tawnylodge Limited

Poplars Nursing and Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 29 August 2018 and was unannounced. We carried out an unannounced comprehensive inspection of this service on 26 February 2018.The service was rated as requires improvements and there was a breach in Regulation because the provider had not ensured staff were deployed effectively to meet people's needs.

After the inspection on 26 February 2018, we received concerns in relation to staffing levels, recruitment practices, risk management and governance systems. As a result, we undertook a focused inspection to consider those concerns. This report only covers our findings in relation to the concerns raised. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Poplars Nursing and Residential Care Home on our website at www.cqc.org.uk.

The Poplars Nursing and Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Poplars Nursing and Residential Care Home accommodates up to 60 people. At the time of our inspection 48 people were using the service. People were accommodated in one adapted building with support provided over three floors with five communal lounges for people to use.

There was a registered manager at the service who was present at the inspection. 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.

People were not safeguarded from harm because incidents of abuse had not always been identified and reported.

The registered manager had not always notified us (CQC) of incidents that had occurred at the service as required by law.

Improvements were needed in the way staff were deployed to ensure that people received the support they needed, when they needed it.

Improvements were needed to ensure the systems in place to monitor the service were effective in mitigating people's risks.

Medicines were administered and managed safely. People's risks were planned and managed to keep people safe. Staff followed infection control procedures which meant people were protected from the risk of

infection and cross contamination.

People, relatives and staff were able to approach the registered manager who was supportive and acted on feedback provided. The registered manager worked in partnership with other agencies to ensure consistent care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see 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?

Requires Improvement

The service was consistently safe.

Improvements were needed to ensure staff recognised and reported incidents of alleged abuse. Staff were not always deployed effectively to meet people's needs.

There were systems in place to learn when things went wrong. The provider had acted on feedback received and started to implement changes to the service where issues had been identified.

Medicines were managed safely and staff understood how to support people to mitigate their risks . Safe recruitment procedures were followed to ensure staff were suitable to provide support to people and people were protected from the risks of infection.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Incidents of alleged abuse had not always been reported to the commission as required by law. Improvements were needed to the systems in place to monitor the service to enable risks to be identified and mitigated.

Feedback was gained from people and their relatives, which was acted on to make improvements to people's care.

People, relatives and staff were able to approach the registered manager and staff felt supported to carry out their role. The registered manager worked in partnership with other agencies to ensure people's needs were met.

Poplars Nursing and Residential Care Home

Detailed findings

Background to this inspection

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

We carried out an unannounced focused inspection on 29 August 2018. The inspection team consisted of three 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 service.

The inspection was completed due to concerns we been made aware of with regards to staffing, risk management and the management of the service. The inspection focused on the key questions of Safe and Well-led. This report only contains details of our findings in these areas.

Before the inspection we reviewed the information, we held about the service. This included notifications that we had received from the provider about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries and safeguarding concerns.

We spoke with eight people, six relatives, five staff, the registered manager and the regional manager. We observed care and support in communal areas. We viewed eight records about people's care and medication administration. We looked at how the service was managed which included eight records for staff employed at the service and audits to show how the service was monitored.

Requires Improvement

Is the service safe?

Our findings

People were not consistently safeguarded from harm. Staff told us that they understood how to recognise and report suspected abuse to protect people from harm. However, incidents that had occurred at the service had not always been reported to the local authority as required. Behaviour charts had been completed by staff when people had displayed behaviour that challenged. We viewed the behaviour charts for June 2018 and July 2018. The behaviour charts showed there had been five incidents in this period where people had been put at risk of harm by other people that lived at the home. For example; one person had been verbally abusive to another person. Another person had thrown items at another person in the communal lounge, which escalated to the other person throwing items back in retaliation. Another person attempted to hit a person with a book and was verbally aggressive towards this person. These incidents had not been recorded on an incident form. The registered manager was unaware of these incidents and there were no systems in place to monitor behaviour charts. Therefore, these incidents had not been investigated by the registered manager or reported to the local safeguarding authority to consider and investigate if required. The regional manager told us there was a plan to monitor behaviour charts. However, this was not in place at the time of the inspection. This meant people were not always safeguarded from harm.

The above evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that there were not enough staff available to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements were still required.

We received mixed feedback from people and their relatives with regards to the availability of staff. One person said, "I have a buzzer and staff generally come when I buzz for them". Another person said, "I think there is enough staff". A relative said, "My relative has been hit by another person a few times. There isn't enough staff to prevent things like this happening". Another relative said, "Residents are left on their own in the lounge unsupervised. Once I was in the lounge when there was no staff. A person got up who was very unstable on her feet and they were wandering around. I was worried that they might fall and so I pressed the buzzer. Staff did not come to help so I had to help the person to sit down again".

During the inspection we saw there was not always staff available to monitor people and to support them when needed. For example; one person was supported by a member of staff into the dining room for their breakfast. This person told us they were "starving". This person waited for 42 minutes before they were served their breakfast, whilst other people at the table had been provided with their breakfast. A staff member told us that this person was unable to have their breakfast because they were waiting for the nurse to check their blood sugars and administer their medicine before they could eat. Another person was observed in the upstairs lounge shouting for assistance for a period of 12 minutes. After four minutes a member of staff walked towards the lounge and then walked back along the corridor without speaking to the person or asking what the person needed. This person started to display signs of agitation and began to bang a paint brush on the table whilst continuing to shout until a member of staff approached the person

and asked what they needed. This meant that staff were not deployed effectively to meet people's needs when they required support.

We feedback our concerns to the registered manager and regional manager who told us that since the last inspection they had implemented a check sheet in the lounges at the front of the home. They explained that people who used these lounges needed less support as they were more independent and staff ensured that they checked on people in these lounges on an hourly basis. We saw that staff were allocated certain people to support during their shift. However, the allocation sheet stated that all staff to monitor the lounges. This meant that staff did not have clear direction, which meant people were at risk of being left without support if their allocated worker was supporting a person in their room. The registered manager and regional manager stated that they would re-assess the allocation and deployment of staff to ensure staff had clear guidance on their responsibilities. We will assess this at out next inspection.

The above evidence demonstrated that staff 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.

People were supported with their medicines in a dignified and caring way. Staff explained to people what medicines they needed to take and gave people time to take their medicines. Medicines were administered and managed through an electronic system. We saw that where people needed 'as required' medicines these contained detailed guidance for staff to follow. Staff showed us how they recorded when people had received their medicines and how they recorded when medicines were refused or not required. Medicine Administration Records (MARs) we viewed showed the medicines people needed, the frequency and the amount and we saw the MARs had been completed accurately by staff. We saw that people's medicines were stored securely and checks had been completed to ensure medicines were stored at the correct temperatures. This meant that medicines were managed safely.

People told us they felt safe when staff supported them. One person said, "I feel safe here. The staff help me safely". A relative said, "I like the fact that my relative has a pressure mat in the bedroom because my relative had a bad fall in the bedroom. This alerts staff if they are moving in the bedroom which keeps them safe". We saw that people who were able to walk independently were able to move freely around the service because the environment was clear of any hazards that could be a risk to people such as trips and falls. We observed a person being supported to move with the use of equipment in a safe way. An explanation was given to the person of how staff were supporting them to move and the person was reassured whilst they were being moved. The person's care plan and risk assessment documented the support they needed to move which reflected what we observed. We also saw that people were protected from risks to their skin. We observed people who needed specialist pressure cushions were supported with these in place to ensure their skin integrity was maintained. Care plans contained information to give staff guidance on how to support people to maintain their skin. This meant that people's risks were planned and managed to protect them from harm.

Staff had been employed using safe recruitment procedures. Staff told us and we saw that they had received checks of their character and references from previous employers. The registered manager had carried out checks with the Disclosure and Barring Service (DBS). DBS carries out criminal record checks to ensure staff are suitable to work with vulnerable people. This meant people were supported by staff that were of suitable character and had been recruited safely.

People and relatives told us that the service was always clean. We saw that the environment and equipment were clean and there was a cleaning schedule in place. We saw domestic staff cleaning all areas of the

service throughout the inspection. We observed staff wearing disposable gloves and aprons when they supported people and staff told us that these were always available for them to use. The registered manager explained how they ensured that staff prevented the risk of cross contamination. We saw an infection control audit was in place to ensure that any risks to people were mitigated. This meant people were protected from the risk of infection and cross contamination.

People, relatives and staff felt involved in the service and told us they felt the management were approachable and acted on issues if things went wrong. The regional manager told us they had learnt from issues identified the provider's other services. For example; a management meeting had been held to discuss the implementation of new systems at Poplars Nursing and Residential Care Home. The provider had recognised these new systems needed to be implemented across their services to make improvements. The provider had started to implement some changes from the feedback received at our last inspection and we will assess whether learning had been taken from the areas that we identified as requiring improvement at our next inspection.

Requires Improvement

Is the service well-led?

Our findings

The provider has a duty to notify us (CQC) of any incidents that had happened at the service, which enables us to monitor the service, for example; expected and unexpected deaths, serious injuries, Deprivation of Liberty Safeguards (DoLS) and alleged abuse. During the inspection we identified from the provider's safeguarding file that three referrals of alleged abuse had been made to the local safeguarding authority. However, we had not been notified of these safeguarding incidents by the provider prior to our inspection. We also identified that five incidents of alleged abuse that had been recorded on behaviour charts which the registered manager told us they had not reported because they did not know about the incidents. We had not been notified of these incidents, which meant we did not have a clear view of the incidents that had occurred at the service because these had not been reported as required by law. The registered manager told us that they would ensure incidents of this nature would be shared with us in the future. We will continue to monitor to ensure that incidents are reported appropriately.

The provider had not notified the commission of incidents as required. This is a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009.

Improvements were needed to ensure effective systems were in place to monitor the service. The registered manager had undertaken some monitoring of the service such as; infection control audits, medication audits, pressure sore analysis and health and safety audits. These had had identified areas that needed improvement and action had been taken. However, we identified concerns with behaviour charts and food/fluid charts at the service. For example; one person's care plan stated that the person should have food and fluid monitoring. There was a daily fluid intake target recorded. The fluid records showed that this person had not reached their target on four occasions. Another person's record showed that they required fluid monitoring and there was a target set, which they were not regularly meeting. We asked the registered manager and regional manager how people's fluid intake was monitored to ensure people were drinking enough to maintain their health. We were told that people's fluid intake was discussed at each shift change. We observed the handover on the day of the inspection and people's fluid intake was not discussed. The registered manager told us that there was not a system in place to monitor people's fluid intake as the computerised system had not been developed to allow the electronic monitoring of fluids and a paper based monitoring system was not in place. The registered manager told us that they would put this in place. We will assess the effectiveness of this system at our next inspection.

There was not an effective system in place to ensure behaviour charts were monitored. Incidents on behaviour charts had not been reported as required by staff and the registered manager was unaware of these incidents because there was not a system in place to monitor the behaviour charts. This meant that the registered manager was unable to ensure that people's behaviour was being managed effectively. The registered manager had not identified that incidents of alleged abuse had not been reported as required, which put people had continued risk of harm. The regional manager told us and we saw a management meeting had been held on the 15 August 2018, which had identified that behaviour charts needed to be monitored. This had not been implemented at the time of the inspection and we were unable to assess whether this was effective. We will assess the effectiveness of this new system at our next inspection.

The above demonstrates that 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.

People and their relatives told us that the registered manager was approachable. One relative said, "The registered manager is very helpful. They are very approachable. If their door is open I can always go in and have a chat with him". During the inspection we saw people approach the registered manager who spoke with people and listened to what people wanted. There was a system in place to gain feedback from people/relatives about the service in the form of a survey. Results of these surveys had been placed on the noticeboard and contained the actions taken in response to the feedback. For example; the survey showed that issues had been raised about the quality of the food provided and the registered manager had changed suppliers to raise the standard of the food for people. People told us that they were happy with the quality of the food since the changes had been made. The registered manager and regional manager told us that a resident/relative meeting was scheduled in September 2018 to provide updates and to gain feedback from people/relatives about the care provided. This meant people were able to approach the registered manager and feedback was gained from people/relatives to inform service delivery.

Staff told us the registered manager was approachable and supportive. One member of staff said, "I feel the registered manager is very supportive and shows an interest in what I'm doing". Staff had received a supervision. A supervision is an opportunity for staff and management to discuss work related issues and areas of staff development. Staff told us they found supervisions useful to discuss any issues, raise any areas of development in their role and areas of their role they needed to improve on. One member of staff said, "We have regular supervision to discuss our performance and progression within the service. I've recently changed roles and I feel I've been really well supported". This meant staff felt supported in their role.

We saw that the registered manager had contact with other agencies on a daily basis. This included healthcare professionals such as G.P's, hospital staff and consultants. Records showed that the registered manager arranged for social worker visits when required to ensure that people's needs were met. This meant that the registered manager worked in partnership with agencies to ensure people received care that met their changing needs.

The rating of our (CQC) last inspection was on display at the service as required by law, which ensured that people and their relatives were aware of the improvements needed as a result of our last inspection.