Midland Heart Limited

Poppy Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 June 2017 and was announced 24 hours before our visit to see if people who lived at the service would be available to speak with us.

Poppy Court provides an extra care service of personal care and support to people within a complex of 48 apartments and 10 bungalows. Staff provide care at pre-arranged times and people have access to call bells for staff to respond whenever additional help is required. The complex is spread over three floors with a lift and stairs to each floor. People have access to communal lounges and a dining room where they can have lunch or tea. At the time of our visit 45 people were in receipt of personal care from the provider.

We last inspected the service in July 2015. At our last visit we had rated the service as 'Good' overall. During this visit we found standards had fallen and the rating was now 'Requires Improvement' overall. We found however, that the provider was aware of most of the concerns found at this inspection, and had already started to take steps to improve 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 previous registered manager had left in March 2017 and the service was being overseen by the provider's operations manager, a locality manager and a temporary scheme manager, whilst recruitment for a new scheme manager and care staff was underway. A new scheme manager joined the service two weeks after our inspection visit.

In early 2017, there had been significant restructuring of the provider's management teams that supported the service. People told us they had found the recent changes in the management of the service unsettling and some felt the provider had not kept them fully informed. Some staff felt morale had declined and they had not felt supported by the provider. However others felt that the service was beginning to improve and that the new management team were approachable and supportive.

People received varying levels of support depending on their needs. Some people only required a minimal assistance with personal care. Others required assistance with administration of medication, continence care, nutritional support and with mobility.

People told us they felt safe living in their accommodation and with the staff who delivered their care. Staff were aware of the action they needed to take if they had any concerns about people's safety or health and wellbeing. However, risks related to people's health and well-being were not always fully or accurately assessed and care plans did not always include important information about risks to people's health. Staff

were however, able to talk confidently about how they managed those risks.

Medicines were not consistently administered correctly to people or managed well. The provider had identified this and was taking robust action to make improvements.

Staff allocation sheets showed there were sufficient staff to cover the scheduled calls to people. Some people told us there were occasions when they had to wait if they requested assistance between their scheduled calls. The provider employed agency staff to support staff numbers on each shift and was actively recruiting new staff to the service.

Staff received an induction and training when they started working at Poppy Court. Some training was out of date, but there were plans to ensure all staff completed the required training to ensure their work safely met people's needs. Staff received supervision meetings to discuss their work and training needs.

Care plans were not consistently kept up to date and information was difficult to find. The provider was reviewing all the care plans to ensure they were accurate, focused on the person, and supported staff to deliver care and assistance to meet people's individual needs.

People were mostly happy with the care they received and said staff were caring and friendly. Staff respected people's privacy and maintained people's dignity when providing care. The provider and staff understood the principles of the Mental Capacity Act (MCA) and gained people's consent before they provided personal care. Some care records lacked detail around people's capacity and best interest decisions, although staff we spoke with were knowledgeable about the people they supported.

All the people we spoke with clearly recognised that due to the support and care provided by staff, they were able to enjoy living relatively independently in their own homes. Staff supported people to maintain their independence where possible.

There were processes to monitor the quality of the service through feedback from people and a programme of checks and audits. The provider acknowledged these had not been consistently completed since our last inspection in 2015 and the quality of the service had not been monitored to the provider's standards. A full audit of the service had been undertaken and an action plan devised to address all areas of concern.

Some of the provider's policies and procedures had not been consistently adhered to and the provider had taken positive actions to address this.

The provider was open and transparent regarding challenges the service was facing and was taking proactive steps to improve the quality of the service provided. They had kept us updated regularly on developments and improvements at the service.

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 mostly safe.

There was a procedure to identify risks associated with people's care, but care plans did not always include important information on how to manage the identified risks. Staff understood their role in keeping people safe and their responsibility to support any concerns they had about people's emotional and physical wellbeing. Medicines were not always managed safely and some people did not consistently receive their medicines as prescribed. There were sufficient numbers of staff to support people safely. Recruitment practice reduced the risk of the service employing unsuitable staff.

Is the service effective?

Requires Improvement

The service was mostly effective.

New staff received training and an induction to make sure they could meet the needs of people safely and effectively. Some staff training was not fully up to date and the provider was addressing this. Plans were in place to update training so that care delivery reflected best practice and the staff team's skills were maintained. Staff understood about consent and respected decisions people made about their daily lives, but some people's capacity to make decisions had not been fully assessed. People's nutritional needs and healthcare needs were being met.

Is the service caring?

Good

The service was caring.

People told us staff were kind, respected their privacy and dignity, and promoted their independence. Staff were committed to provide good quality care. People were able to express their views and guide staff as to how they wanted their care to be carried out.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Care plans were not consistently detailed, or person-centred, to support staff in delivering care and assistance to meet people's individual needs. Recent concerns were acted on, and complaints investigated in line with the provider's complaint policy and procedure. However some complaints had not been formally recorded.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

There was no registered manager in post but senior managers were overseeing the service and had already identified areas where improvements were required. Systems and processes to monitor the quality of the service had not been consistently performed. People and staff had found the changes in the management team unsettling and staff morale had been affected. Policies and procedures had not consistently been followed. The provider was taking actions to support staff to carry out their roles and were motivated towards providing a quality service to people. A robust action plan was in place to address the issues of concern identified by the provider.

Poppy Court

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.

The inspection of Poppy Court took place on 8 June 2017 and was announced 24 hours before we visited to establish if people who lived at the service would be available to talk with us.

The inspection was conducted by 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.

We reviewed the information we held about the service. We looked at the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We contacted the local authority contracts team and asked for their views about Poppy Court. They informed us the provider had kept them informed of recent events at the service.

We spoke with eleven people during our visit and four relatives. We also spoke with the Director of Retirement Living and Care Services, the Operations Manager and the Locality Manager. We spoke to eight members of staff. This included care staff and the kitchen assistant.

We reviewed five people's care plans and daily records to see how their care and support was planned and delivered.

We looked at other records related to people's care and how the service operated including, medication records, staff recruitment records, the provider's quality assurance audits and records of complaints.

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Requires Improvement

Is the service safe?

Our findings

We looked at the management of medicines and found some people had not been supported to take their medicines as prescribed or received them on time, which could have affected their health and wellbeing.

Prior to our inspection visit the provider had made us aware of a serious medication error. This involved one person who did not receive their medicine, which was prescribed to treat a blood disorder, correctly for 94 days. Staff had not followed the correct procedures when new stocks of the person's medicine had been received into the home and medication charts indicating when the medicine should be administered were not accurate. The provider had taken robust actions to address these issues.

We saw that some people received their medicines at incorrect times. For example, one person was due to receive theirs at 07:00am; however we saw it was given to the person at 11:25am. When we asked why, the member of staff informed us that the person had been asleep. We asked if the next dose would be altered to ensure the person did not receive their next dose of medicine before the prescribed four hour gap. The member of staff told us the delay would have been recorded on the person's visit log so the staff coming on duty would know to adjust the time of the next dose accordingly. However when we looked at people's daily logs we saw several were out of date sequence and were not stored in an organised way. This meant there was a risk that staff may not have been able to see the last recorded visit and would be unaware that the person received their medicines late.

Another person told us, on one occasion, they had not received their medication which was prescribed to thin their blood. Their relative told us they had noticed staff had not given it and when they asked why, they were told the member of staff could not access their relative's medicine administration chart (MAR). As a result, in agreement with the person, their family member gave them their medicine and informed the staff they had done this. This potentially placed the person at risk as their medication dose may have changed which the persons' relative may not have been aware of. Staff told us they had located and checked the MAR chart the next morning and the prescribed medicine dose had not changed.

The provider had made us aware, prior to our inspection visit, that another person also receiving medicine to thin their blood, did not receive their correct dose for nine days. The person should have been receiving 5mg of their medicine but for four days only received 4mg. This could have placed the person at risk as they were not receiving their correct medicine dose to maintain their health and well-being.

Some people received their medicines in pre prepared packs and were dated to begin at the start of a specific week. We saw one person had received medicine from a pack that was not due to be opened until the following week. This placed the person at risk as there may have been a change in the dose of their medicine, or the times it needed to be administered. We checked and found there had not been any changes to the prescribed medicines and the provider told us they would take immediate action to ensure staff were using the correct weeks supply.

The provider acknowledged that auditing and monitoring of people's medicine charts had not been robust

and there had been inconsistency in some people receiving their medicines which placed their health and wellbeing at risk. Policies and procedures had not been followed when new medication had been received into the service.

This was a breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

The provider told us, "I don't think the standards around medications have been good and now only staff we have reassessed as competent will be administering them." They went on to tell us that all staff would be reassessed and daily audits would be conducted to check people had received their medicines as prescribed. 'Spot checks' were planned by the management team to check staff were safely administering medicines to people and procedures, for the correct handling of medicines into the service, were followed.

We asked people if they received their medicines on time and we had mixed views, one told us, "Staff are responsible for my tablets. I like that. But they are not always on time." A relative who ordered their family member's medicines told us staff did not give sufficient notice that the person's medicines were running out. However one persons' relative told us the person had come to live at Poppy Court especially to receive support in taking their medicines and they had no concerns.

One person we spoke to told us there were delays on occasions when they were receiving their medicines. They told us this was because the provider had reduced the number of care staff who were able to administer medicines in light of the recent medication errors. The provider had taken this action to ensure that all staff were re assessed for their competency.

The provider had taken robust actions to improve the management and administration of medicines. They had carried out a detailed medication audit and an action plan was implemented to address the issues of concern. This included improved staff training; correct handling and recording of medicines received into the service and improved monitoring of stock levels of medicines. The provider wanted to encourage staff to report medication errors so that these could be discussed during team meetings and individual supervisions (one to one) meetings and lessons learned shared with staff.

Everyone we spoke to said they felt safe at Poppy Court. Comments included: "I feel very safe… I like living in a community." And, "I do feel safe". One person told us they felt secure because staff had a 'fob' key which allowed them entry into their flat if they needed assistance.

There was a procedure to identify risks associated with people's care, but care plans did not always include important information on how to manage the identified risks. This is important as staff would need to know about the risks to people and how they could take the necessary actions to reduce them. For example, some people who needed assistance to move around, or take their medicines, had care plans to manage or reduce those risks. However, there was no care plan for a person who was at risk of skin damage due to immobility. The person's records indicated they were able to mobilise with a walking frame, however this was out of date as the person was no longer able to walk independently. We did not see an updated risk assessment on how this person should be safely moved, or how often, to prevent their skin becoming sore.

Another person's care plan indicated they were 'confused' at times, however there was no further information on how this might place the person at risk. We saw they had fallen on the floor recently, but there was no detailed information on how staff could reduce their risk of falling.

The staff we spoke with were aware of risks to individuals and were able to talk confidently about how they supported people's needs relating to skin breakdown, falls and behaviours. This included both the

prevention of risk and risk management methods. The provider used 'impact statements' which documented changes in people's risks or needs. These were shared at staff handover to ensure staff were aware of any new risks or changes in risk so they could meet people's support needs safely.

The provider acknowledged to us that people's risk assessments were not up to date and accurate and this had been identified prior to our inspection visit following a provider audit of the service. As a result an improvement plan had been implemented by the provider. This had clear actions in place for a 'risk and needs' assessment to be carried out for people, and a system for monitoring when reviews were required. This was to ensure that information about risks to people and their health and well-being was up to date.

We asked staff how they made sure people remained safe and were protected from abuse. Staff had completed training in keeping people safe and understood abuse could take many different forms. One told us, "It could be about their wellbeing, if a resident refuses to have a wash, I'd report it to the office staff to follow up. Abuse could be financial, sexual, neglect, emotional abuse. If I needed to go higher I could go to the managers... Or I could report it to CQC, the Police or social services." Another told us, "If I did have concerns I would bring it up. We talk to the residents about what abuse is as well."

Staff were aware of the action they should take if they had any concerns. There was a policy and procedure for safeguarding people and the provider understood their responsibility, and the procedure, for reporting allegations of abuse to the local authority and CQC. Information was displayed in communal areas to enable people, visitors and staff to report any concerns of abuse directly to the local authority.

The service had experienced a significant turnover in staff in the early part of 2017 and this had led to an increased number of agency staff being employed to meet the needs of people using the service. We asked people if they felt there were enough staff to provide support. Everyone we spoke to told us they received their care at the time it was due and most were happy with the care and support provided. However some told us they were unhappy with the use of agency staff as this meant they received care and support from staff who were not familiar with their likes and dislikes and how they preferred to receive their care. One person told us, "There are too many [agency staff] and they don't know me or my relative."

The provider told us to ensure continuity of care to people they employed regular agency staff and recruitment for new staff was taking place. Staff we spoke with told us the changes had been unsettling, however they felt there were enough staff on duty to safely support people. Comments made were, "There is a lot to handle with agency staff. Trying to keep the agency consistent… I think the staffing levels are fine." And, "I definitely think there are enough staff."

The provider told us the complexity of people's needs had increased at Poppy Court and this had created pressure on staff to support people safely. They had discussed their concerns with the local commissioning group and had not accepted some people into the service as they were unable to meet their needs. The operations manager told us, "The dependency needs of some people do not match the ethos of Extra Care with housing." They went onto explain that supporting people to live independently was a key objective of the service. As a result new admissions to the service would be carefully assessed to ensure there was a balance in the amount of support people required.

Staff files indicated that safe recruitment processes were followed including a DBS (Disclosure Barring Service) and reference checks. One new member of staff told us, "When I first started they took references from my previous employer. I had to have a DBS check before I could start."

Requires Improvement

Is the service effective?

Our findings

People told us most staff were competent when providing their care and support. One person told us, "The staff are very good and efficient. They do the job well." Two relatives told us staff had been 'brilliant' in safely supporting their relative when they had fallen and took appropriate actions. However another relative told us staff did not seem confident in using a piece of equipment designed to support their relative who had fallen.

The management team told us, "Training has not been kept up to date and some is out of date. We are now block booking training three months in advance." They went on to tell us training would be held locally to make access easier for staff to attend.

Staff told us they received an induction into the service that made sure they could meet people's needs when they started work. This included training and working alongside a more experienced staff member (shadowing) before they worked on their own. One new member of staff told us, "I had an induction and lots of training, a full week. There was moving and handling, health and safety, safeguarding. Then, two weeks of shadowing, it was very good."

Staff told us they had received training in areas the provider considered essential to delivering care safely and effectively. One commented, "With training I learned about dignity… it's a refresher. Things change and there are new policies and procedures to understand. I also did palliative (end of life) care training."

The provider told us training was linked to the Care Certificate which sets the standard for the fundamental skills, knowledge, values and behaviours expected from staff within a care environment. In addition all new staff, including temporary staff such as agency or bank staff (occasional staff employed by the provider), were required to undertake a five day course which provided training in all areas consider essential such as moving and handling people and safeguarding.

Staff told us they had not received regular supervision in recent months; however the provider had taken steps to improve the frequency of these meetings and we saw a list of dates planned for individual staff meetings. One staff member told us, "I had my last supervision a few months ago." They went on to say, "If I had any issues though I could raise it with the manager."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

DoLS makes sure people who lack capacity to make certain decisions do not have their liberty restricted unless specific safeguards are in place. The provider informed us no one was subject to a DoLS however they were clear what their responsibilities were if they had concerns about a person.

We found staff had a basic knowledge of the MCA but worked within its requirements. Staff understood people were assumed to have capacity to make decisions unless it was established they did not. They told us this could fluctuate if a person's health deteriorated, for example if they became unwell with a urine infection. One member of staff we spoke with told us, "If someone started to refuse care that's their choice, but if I became concerned I would monitor them closely and tell the manager." The operations manager informed us training for staff to update their knowledge of the MCA and their responsibilities was planned for the week following our inspection visit.

Some care records did not contain sufficient information about people's capacity or when a best interest decisions had been made. For example, we found one person, who lacked capacity, did not have any best interest decisions recorded in their care records. The person was receiving pain medicine but on occasions was refusing to take it. The operation manager had identified this and had organised a best interest meeting with the relevant healthcare professionals, however we could not see this recorded in the person's care plan. Another person's records did not contain up to date information about their capacity and ability to make decisions. This would be important information for staff so they could be aware of when the person may need best interest decisions made for them. However we found staff we spoke with were knowledgeable about the person and how to support them. The operations manager told us these omissions would be looked at as part of the care plan reassessments that were underway.

Some people prepared all their own food and drinks; others made their own breakfast and bought a lunchtime meal and evening meal from the restaurant within Poppy Court. Other people told us that staff prepared their food and drink for them or supported them to make their own meals.

When visiting people in their homes, we saw they had a drink near to them, where they could easily reach it. People we spoke with confirmed they had enough to drink throughout the day.

People's medical appointments were arranged by themselves, their relatives or staff. Staff checked people's health during their calls and took appropriate action when a need was identified. One person told us on one occasion they had become unwell suddenly and staff had responded immediately and called for an ambulance. Staff were also able to arrange for healthcare professionals such as opticians, chiropodists and dentists to visit people in their own home.

Good

Is the service caring?

Our findings

People lived in their own flats so we were unable to directly observe the care and support they received, but most people told us staff were caring and treated them with respect. Comments included, "They (the staff) ooze care... I get far better care here than in a rehabilitation [unit] or a hospital." And, "The staff are alright. They are friendly."

Some people commented that the recent changes in staff meant they did not receive care and support from staff they were familiar with and they found this unsettling at times. Comments made were, "The agency staff don't know me." And, "It's all gone to pot (due to staff changes)."

Staff told us they were aware of the impact on some people with recent staff changes but one told us, "With the [people], they are friends; it is a shame, they feel it too. I believe it will get back up to scratch though." Another told us, "I think the priority has been the care, above and beyond anything else. If anything [people] have had more time from staff."

Staff told us they were committed to providing high standards of care and had developed meaningful relationships with people living at Poppy Court. One told us, "I am happy when I see the rapport between people and staff, some people living here adore the staff. I always care for people like they were my mum or dad." Another commented, "I love working here, the [people] are just lovely."

People appeared relaxed and happy in the company of care staff and we heard friendly banter between them. Staff recognised the individual needs of people they provided care and support to and listened to what they had to say.

People we spoke with told us due to the support and care provided by staff, they were able to enjoy living relatively independently in their own homes. Comments made were, "I can't dress or undress myself but they let me do what I can." One person told us they had moved to Poppy Court after coming out of a rehabilitation unit where they had been receiving support to improve their mobility. They commented, "When I came out of rehab they asked if I wanted to use a stick and they walked behind me as I walked round my flat getting used to it."

Staff confirmed they promoted independence, with one staff member telling us, "If I am helping with personal care, I tell the person I will wash where they can't reach." The operations manager told us they were keen to promote independent living for people, they commented, "We need to rebalance Poppy Court and I want there to be more of a community feel for people living here."

We asked people if they were involved in the planning of their care and choosing options regarding their care. Overall, people were satisfied that they received their care, how and when they needed it and at times they preferred. People could also choose whether to have their care provided by staff at Poppy Court or from another service provider.

People confirmed staff respected their homes and knocked on the door and waited for a response before entering and we saw this on the day of our inspection visit. On occasions when staff could not hear the person responding they opened the door and then asked the person if they could enter their flat.

We had mixed views from staff we spoke when we asked had they felt cared for by the provider in recent months following the staff changes. Some staff told us they had not; however others told us they felt the management team were approachable and supportive.

Requires Improvement

Is the service responsive?

Our findings

All the people we spoke with were able to identify someone who they would talk to should they wish to make a comment or complaint. However several told us following the recent staff and management changes they did not feel confident to raise concerns, one told us, "I don't know who the manager is now."

Some people told us they had recently visited the main staff office to discuss concerns but had found the door had been closed. Until the recent managerial changes people told us they had felt able to walk into the office to speak with staff. One told us, "I get the feeling we are not wanted in the office. We can look at the expression in their faces." Another person told us, "There are that many managers you don't know who to talk to. Before the office door was always open but now it's closed. You feel as if you are imposing."

We discussed this with the management team who told us that private and confidential information was held in the office and protecting this information was a priority. We saw the minutes of a group meeting involving people who used the service held in April 2017 where this had been discussed. The provider had informed people of the reasons for the office door being closed, but assured them they could still attend the office and request to speak with a member of staff in a private room. During our inspection visit we saw people and relatives visiting the reception area and asking to speak to a member of staff and we saw staff were available to speak with them.

We looked at the complaints log and could only see two recorded complaints which the new management team had dealt with in accordance with the provider's complaints procedure. The operations manager told us complaints had not been formally recorded since our last inspection visit, however they said this was being addressed and staff would be reminded to record all complaints so that actions and outcomes could be monitored. We saw the provider's complaints procedure was displayed on in the main reception area at Poppy Court. Staff members told us they would record any complaints or concerns and direct the person to the management team.

People we spoke with told us staff were responsive to their needs. There were occasional instances of a delay in receiving their care, but people told us this was usually because of urgent needs of other people and was rare. One person we spoke to told us on occasions they had experienced a wait of over 30 minutes to receive support using the bathroom. However most people told us staff responded quickly if they needed assistance outside of their call times. The staff allocation sheets showed there were sufficient staff to cover the scheduled calls to people.

We asked the provider how they monitored to ensure staff were responding to people's needs at the correct time. They told us staff recorded their visits to people on a daily care and support form. The information written was then scanned onto an electronic pen and the information downloaded on to the provider's computer system at the end of the staff members shift. This enabled the provider to electronically monitor that people were receiving their care at the correct times. Staff also signed their daily schedule sheets to record they had carried out the person's visit. The team leaders also liaised with staff during the shift to ensure people's calls had been attended.

We looked at the daily visit sheets for four people and found several were out of date order and it was difficult to see when people had received their care call. This meant that new staff coming on shift would find it difficult to see what care the person had received prior to them coming on duty. The provider told us they had already identified this and were considering introducing a new system. They told us they would remind staff again to make sure daily visit logs were in the correct date sequence and stored correctly in people's flats.

We looked at the care files of four people who used the service. We found there was conflicting information in the care plans and some had not been updated to reflect people's current needs. For example, one person records informed staff they were able to mobilise with a frame, however when we visited the person staff told us the person was no longer able to walk and required the assistance of staff to transfer with the use of a hoist. There was no information in the care plan to inform staff how the person should be moved safely using the hoist, or what the appropriate size of hoist sling should be used. This is important to ensure the person is safely supported whilst being moved.

We also found some information in the care plans was difficult to find. This means that new staff unfamiliar with the service would not be able to find information easily to ensure they were aware of the person's preferences, risks and how they liked to receive their care.

The operations manager told us they were not satisfied with the standard of some people's care plans. They told us, "I am not happy with the care plans, and how often they have been reviewed. I don't feel they are person centred enough and may not reflect the needs of people." They told us care plans were currently being reviewed and updated. To ensure people's needs had been accurately assessed, the provider had employed registered nurses for a four week period to carry out assessments of each person's needs and a plan of care.

Team leaders provided staff with allocation sheets that contained essential information about people's care call times, care needs and any changes. The operations director told us following the care plan updates the team leaders would be responsible to ensure the call schedules accurately reflected each person's plan of care and support.

We spoke with staff and found they were knowledgeable about people and their care needs, they were also able to tell us, in detail, how people liked to receive their care. We observed the staff handover meeting and the change of shift and found staff were well informed of changes in people's needs.

Some people we spoke with were not aware of what their care plan contained even though some plans showed people, or their relative, had been involved in the reviews. The operations manager told us as part of the review process discussions would be held with people or their nominated representative to ensure they were fully involved in the planning of their care. Staff told us they would frequently speak with the person, or their family, to discuss their care needs, one told us, "I know a lot of the families and we chat and they ask questions."

However some relatives did not feel they received sufficient information regarding their relative's care and support. One relative was concerned they had not been kept fully informed of changes to their relatives care and had expressed their concerns directly with the provider and a healthcare professional supporting the person. We spoke with the healthcare professional following our inspection visit and they informed us the person's family had not been satisfied with the response given to their concerns. This was being addressed with a planned meeting with the provider.

Requires Improvement

Is the service well-led?

Our findings

Since March 2017 the service had undergone significant managerial changes. The registered manager and three experienced staff members had left Poppy Court; prior to this the locality manager had also left. People told us they found this unsettling, comments made were, "It's brilliant here but if I could change one thing I would have my old care workers back." And, "There are different people here but we have not been introduced. It has been a bit haywire of late."

Prior to our inspection visits some people had contacted us to express their concerns at the impact these changes were having on the care of people and staff morale. Some relatives contacted us to say their relations were unhappy with the care provided and the on- going use of agency staff. Other information we received related to staff feeling unsupported by the provider and some feeling 'bullied' and overworked.

Some people and relatives told us they had not felt the provider had effectively communicated with them about the changes the service was undergoing. Some people told us, "It feels like a different place," and, "No one knows what's going on." One person described the service as not feeling 'happy' anymore.

The providers' new Director of Retirement Living and Care Services had contacted us and the local commissioning team, in March 2017 to inform us of the changes taking place within the scheme. They told us policies and procedures within the service had not been followed and robust action had been taken to address the concerns identified. They also told us a new management team were in place at Poppy Court and what actions were being taken to provide stability to the service.

The Director of Retirement Living and Care Services told us at our inspection visit, "Unfortunately there has been a long period of mismanagement and poor adherence to our policies." They were open and transparent with us that provider audits previously conducted, were not detailed enough and issues of concern had not been highlighted and addressed, for example errors occurring with people's medicines.

The provider had taken positive action and had deployed senior managers to the service to conduct a full, detailed audit of the care and support people received. This identified that systems and processes had not been consistently followed to ensure the quality of the service was monitored and maintained. A new scheme manager had also been employed and started working at the service two weeks after our inspection visit.

Following this a 'service improvement plan' was drawn up which outlined areas of improvement required and who was responsible for completing the actions within specific time frames. For example, we saw the plan highlighted a need to recruit new members of staff and as a result a staff recruitment fair had been held. To address the concerns regarding medication issues a separate medication action plan had been devised to reduce the incidence of medication errors. Staff performance was now being monitored to ensure a high quality of care was being delivered to people living at the service. The operations manager told us there was a new process
in place to ensure the quality assurance audits would be carried out to the standards expected by the

provider.

To address the concerns expressed by people living at the service the provider held a meeting in April 2017 to update them about the changes taking place and to advise a new scheme manager, team leaders and care staff were being recruited. In addition representatives from the provider's customer experience department were planning to spend the day at the service to speak with people and gather their views. The operations manager told us, "I am confident we will get there and address all the issues identified, I want open dialogue with people living here and the staff."

Some staff we spoke with told us morale had been affected by the recent changes in the management team and some of the long standing permanent staff leaving Poppy Court. Several told us they had found recent months unsettling; comments made were, "There has been a complete turnaround. We are in the middle of it, it can only be positive going forward but it has been very difficult." And, "The atmosphere has been poor; we have done our best to reassure people living here though."

However some staff felt the service was stabilising and starting to improve, comments made were, "Overall things are pretty good considering, we have all pulled together and stepped up to help each other. I think the managers are approachable." Another commented, "The new managers have been amazing, we just need a core team now. I love Poppy Court, it's wonderful and the provider is trying really hard."

The provider had met with staff to update them regarding the changes at Poppy Court and the Director of Retirement Living and Care Services told us they had discussed with staff the importance of providing high quality 'customer' care. They went on to tell us, "It's not a quick fix solution, but I am positive our committed team can turn things around and one day achieve an outstanding rating with the CQC."

They went on to say obtaining peoples, relatives and staff feedback was key to the success of the scheme, they told us, "I want people and staff to tell us what they want to see improved."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(g) The proper and safe management of medicines.