# Autism East Midlands

# The Poplars

## Inspection report

1 The Poplars, Whitwell, Derbyshire
S80 4TD
Tel: 01909722244
Website: www.norsaca.org.uk

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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 |

## Overall summary

The Poplars is owned by Autism East Midlands. The service is situated in Whitwell, Derbyshire, and provides care and support for up to five people over the age of 18 years with learning disabilities and autism. At the time of this inspection there were five people accommodated.

This inspection took place on 20 and 21May 2015. The first day was unannounced.

At our last inspection in May 2014 the service was not meeting the regulations we inspected with regard to record keeping, so we followed up this issue and found this had been attended to.

A registered manager was not in place. 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 and associated Regulations about how the service is run. The current manager had made an application to be the registered manager and was awaiting an interview to become the registered manager.

Since our previous inspection in February 2014, we had received information from the local authority safeguarding team which had substantiated issues of

# Summary of findings

abuse concerning people living in the service. This had included inappropriate staff behaviour and medication errors. We looked at these issues on this inspection and found people were treated in a friendly and respectful way and their prescribed medication had been supplied to them.

People and their relatives said they felt safe in the service.

Testing of fire systems was largely in place though there was no confirmation that requirements of the fire service had been met.

Detailed risk assessments had not always been undertaken to inform staff of how to manage and minimise risks to people's health from happening.

Staff had received training on how to protect people who used the service from abuse or harm. They demonstrated they were aware of their role and responsibilities in keeping people as safe as possible.

The Commission had not been informed of situations of abuse to people which meant that monitoring action to prevent these situations could not be considered.

Staffing levels needed to be reviewed to ensure they always met people's needs.

We found people received their prescribed medication in a safe way by staff trained in medication administration.

The provider supported staff by an induction and some ongoing support, training and development. However, comprehensive training had not been provided to all staff, although we saw evidence this had been planned for the near future.

The Mental Capacity Act (MCA) is legislation that protects people who may lack capacity to consent to their care and treatment. People's capacity to consent to specific decisions had been assessed.

People received a choice of what to eat and drink and they liked the food provided.

People who used the service and relatives told us they found staff to be caring and friendly. Our observations found staff to be friendly and attentive to people's individual needs.

Staff had read people's care plans so they were aware of how to provide care to people that met their needs.

People were encouraged to be as independent as possible. People had their rights respected in terms of privacy and dignity.

Activities were provided though provision was limited and needed to be expanded to include people's preferences.

Complaints had been followed up though the complaints procedure did not provide full information as to how to make a complaint.

The provider had internal quality and monitoring procedures in place, though there was not always evidence that identified actions had been implemented.

The manager enabled staff to share their views about how the service was provided by way of staff meetings and supervision. Staff said management provided good support to them.

# Summary of findings

## 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 not always safe.

People and their relatives spoken with, except one relative, said that they felt safe living in the service. Staffing levels did not always meet people's needs.

The safeguarding authority and CQC had not been informed of situations of abuse to people, which meant that monitoring action to prevent these incidents had not been comprehensive.

Support plans were in place to manage people's behaviour risk assessments to manage aggressive behaviour were not in place.

Recruitment procedures designed to keep people safe were in place.

Medication had been supplied to people as prescribed. People's finances were kept securely.

Staff had been aware of how to report concerns to all relevant agencies if the service had not acted properly to protect people.

**Is the service effective?**

Requires improvement

The service was not fully effective.

Incidents of restraint that has occurred to prevent injury to people had not been recorded in detail, so evidence was not in place to see whether these situations had been managed properly.

The provision of training to staff was in place to ensure staff had the necessary skills and knowledge. Staff had been aware of the process of assessing people's mental capacity to ensure people, as much as possible, were able to choose how they wanted to live their lives. Staff were aware of people's needs. Staff received supervision to support them to provide care that met people's needs.

People reported that they enjoyed the food provided to them and staff had offered choices of food and try to ensure people were eating.

**Is the service caring?**

Good

The service was caring.

People and their relatives said that staff were friendly and caring.

Staff showed consideration for peoples' individual needs and provided care and support in a way that respected their individual wishes and preferences.

**Is the service responsive?**

Requires improvement

The service was not consistently responsive.

# Summary of findings

Care plans were in place though not fully individualised or regularly reviewed. Staff had relevant information on people's needs as they had read people's care plans.

Activities had been provided but they had been limited and not always in line with people's expressed preferences.

Complaints had not always been recorded and investigated. The complaints procedure did not give detailed information as to how to make a complaint.

**Is the service well-led?**

**Requires improvement**

The service was not consistently well led.

A registered manager was not in place.

Incidents involving people had not always been reported to us so that we could consider whether we needed to inspect the service to ensure it was meeting its legal obligations to keep people safe.

Systems had been audited to try to ensure the provision of a quality service, though issues identified had not all been followed up.

Staff told us they felt well supported and that management listened and acted on their comments and concerns.

# The Poplars

**Detailed findings**

## Background to this inspection

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

The inspection took place on 20 and 21 May 2015 and was unannounced. The inspection team consisted of one inspector and an expert by experience on the first day and one inspector on the second day. 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 also reviewed information we received since the last inspection including information we received from the local authority safeguarding team, notifications that had been sent to us by the service and a provider information return, which is a document completed by the provider that sets out how they provide the service to people.

During our inspection we spoke with the manager, the deputy manager, the area manager, three people that lived in the service, three relatives, and four care staff. We also spoke with a psychiatrist and GP.

We observed how staff spoke with and supported people living at the service and we reviewed three people's care records. We reviewed other records relating to the care people received. This included the fire records, audits on the quality and safety of people's care, staff training and recruitment records and medicine administration records.

Requires improvement

# Is the service safe?

## Our findings

Two people told us they felt safe living in the home. Two relatives agreed their relatives were safe. One relative said; “yes, she is definitely safe there.” However, one relative said her relative daughter did not feel safe because of the actions of another person living in the service. This caused her to be isolated in her room and not to socialise with other people. She also had a concern that another person went into a daughter's bedroom and pulled her around against her will. The manager said she was aware of the issue of one person being a potential threat to this person and the person was constantly monitored. She did not know of the actions of the other person and would follow this up.

One of the people using the service presented with behaviour that challenged the service. The manager and staff told us they had sought advice from the person’s consultant and psychologist. These recommendations were incorporated into the person’s care plans. Staff were able to tell us how they acted to manage these behaviours in line with the professional advice and training supplied.

Incidents were recorded on an incident/accident form. This did not give an explanation as to what happened during the incident or identified any contributory factors and action needed to prevent a similar incident occurring in the future. The manager said this would be followed up.

The local authority safeguarding team and the Commission had not been informed of all incidents of possible abuse, for example, when people had unexplained bruises. By not reporting this information at the time, so that proper action could be considered, this did not provide protection for people living in the home. The manager said this would be acted on in the future.

We found that the floors in a bathroom and bedroom had water on the floor which made these surfaces slippery. This meant people had not been completely protected from the risks of slipping and falling. The manager said staff would be reminded to make sure all excess water was mopped up to prevent risks to people.

We found stained carpets in some bedrooms. There were daily and weekly cleaning schedules in place. However, they were not always completed. There was no cleaning schedule for deep cleans of the bedrooms or the shampooing of carpets and soft furnishings. The manager told us there was a plan to replace the carpets in several areas of the home and then she would remind staff to clean carpets when needed.

There was no evidence that risk assessments regarding premises safety issues had been in place. For example, there were no risk assessments about relevant issues such as hot water temperatures, uncovered radiators, legionnaires disease and locking away potentially unsafe objects. This did not keep people safe.

These issues were a breach of Regulation 12 of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

We saw risk assessments in place in people's records of care we looked at. For example, there was a risk assessment relating to behaviour that included how to manage risks to the person and other people. This gave staff detailed information as to how to manage these situations.

A person said she thought there was not enough staff on duty. A relative said “I do not think there is enough staff, although the ones that are there are good”. Two members of staff we spoke with said there were staff shortages especially when a manager counted as one of the three staff members on duty. With two people assessed as needing one to one staffing or two to one staffing when they went out for activities, this meant staffing was stretched. Staff told us other people's activities were curtailed if incidents occurred. The manager said she would review staffing levels and send us a staffing needs assessment to see whether staffing was sufficient to meet people's needs. She stated that the company was actively recruiting for more staff.

We found that medication administration was in place. People told us staff managed their medicines for them. They said their medicines were always available and they were given to them.

We checked medication systems and found them to be secure with stocks of medication and records in place which indicated people had received their medication.

We saw that staff looked after people's money, as they did not have the assessed capacity to do this. We checked the

Requires improvement

# Is the service safe?

financial records of some people. We found they were securely kept, systems were in place to regularly count monies, and records were kept of all incomings and outgoings. Monies we checked tallied with the records.

We looked at fire records to see whether people had been protected from fire risks. We found that testing fire equipment had been carried out regularly. A recent fire drill had been conducted to ensure staff knew what to do in the event of an incident. There was a personal emergency evacuation plan in each person's care records. This gave details of the support someone would need in an emergency. We found the fire officer had inspected in February 2014 and stated some issues had not been complied with. There was no evidence in place to indicate these issues had been dealt with. The manager stated she would follow this up.

The provider had safeguarding policies and procedures in place. These were designed to protect people from harm. Staff we spoke with had an understanding of their responsibilities and told us they would immediately raise any concerns with their line management. If management did not act properly, staff knew of relevant agencies to report their concerns to.

Staff told us they had followed various recruitment procedures such as completion of an application form, interview, and proper criminal checks had been taken up. We looked at four staff files and found recruitment processes, designed to keep people safe, had largely been followed. One staff member's criminal records check was over 10 years old which did not indicate any current relevant issues. The manager said this would be followed up and a policy put in place for regularly checking systems.

Requires improvement

# Is the service effective?

## Our findings

We saw that staff had an induction day at head office with a comprehensive training programme, including training on physical intervention. This means that staff can manage people with behaviour that challenges the service.

Staff who had gone through induction training told us they were up to date with their mandatory training. They administered medicines and said they had competency checks to ensure they could administer medication properly. We saw evidence of this.

A training matrix was available so it was possible to see at a glance the training that had been completed and outstanding training. Some staff said they had completed their vocational NVQ training. The staff we talked with said they were encouraged to identify training they felt they needed or would like to complete. We saw evidence of this in supervision records.

We asked staff about people's needs. They were able to tell us in detail what people's assessed needs were and how they met them. We saw staff encouraging people to do activities and to do various tasks around the home.

We saw that staff had been provided with training in line with the provider's training programme. For example, training in relevant issues had taken place such as behaviour support, food hygiene, health and safety, epilepsy, safeguarding people, medication, autism awareness, and the Mental Capacity Act. We saw that some staff training had not been supplied. was outstanding. The manager stated that more training had been organised and we were supplied with evidence of this.

The staff we talked with said they had regular supervision and we saw evidence of supervision in staff records. They said they had the opportunity to raise issues and problems themselves and they also discussed people's care needs, and risk assessments.

We found that the provider was ensuring that the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted, in their best interests, to keep them safe.

Staff understood the issues of assessing people's mental capacity and making decisions based on people's best interests. They knew if people living in the home had a DoLS in place.

Staff gave us examples of where people's choices had been restricted in their best interests. They also gave examples of where people were giving the choice in their daily lives. For example, a person did not want to go out that day and was able to stay in the home, as she wanted. We heard staff giving peoples choices as to what food they wanted that day. This meant people's ability to choose how they lived their lives had been promoted as much as possible.

We saw in records that some people had been restrained due to outbursts. Staff explained to us that the approach they took in terms of using this approach as a last resort and trying other methods to calm the situation. However, there were no detailed descriptions in place as to what happened during the incidents of restraint. The manager said she would ensure that such incidents were fully recorded in the future to be able to ensure that the situations were handled appropriately.

People told us the food was good and they could have the portion size they wanted. There was a choice of meals at different mealtimes and we observed staff giving people this choice. We heard conversation between staff members that a person had refused breakfast that they had insured the person had eaten something as nuts were offered and the person had eaten them. This showed us that staff were creative in supplying food alternatives so that people would not at nutritional risk.

A person told us there was something different each day and there was always something they liked. We saw that good portion sizes were offered to people at the mealtimes we observed.

Good

# Is the service caring?

## Our findings

Relatives were concerned about changes in staff but said they thought staff were caring and respectful. We saw that people were encouraged and supported to be as independent as possible. One person told us; “I go to the Tea Trolley (local community café) on my own and help there”. Relatives were concerned about changes in staff but said they thought staff were caring and respectful. (repeated from above)

We saw there were meaningful relationships between people and staff. We saw that people were treated with respect and approached in a friendly and caring way. Staff explained what care they were providing to people and what they were doing. Staff were able to give us examples of how they protected people’s privacy, choice and dignity when supporting them with personal care, for example, making sure toilet doors were kept shut when in use, people choosing to do activities or not, and people choosing what clothes to wear.

Relatives told us they could visit whenever they want to and they phoned regularly for updates on their loved ones and were supplied with relevant information.

We saw that staff supervised a person who was assessed as needing this, and we observed staff managing episodes with patience and respect.

We saw there were no residents or relatives meetings. The manager said she was looking to organise these, or to have a system of one-to-one meetings with people to gain their views on the running of the service on relevant issues such as food and activities, as some people did not like being in a group.

People we talked with did not know they had a care plan and were not interested in this. However, we saw evidence of discussions about persons care with relatives. This showed some involvement of representatives planning for people's care needs.

We saw a person using the kitchen, helping to make their meal. This showed that people’s independence was being promoted.

Requires improvement

# Is the service responsive?

## Our findings

One relative said she had frequently complained about staff not opening a window in her relative's bedroom despite the air being stale in the room. She said staff told them that it was for safety reasons. We brought this to the attention of the manager and she said she would review window restrictors so that they could open more and freshen the air in the room. The provider stated that staff do open the windows but for health and safety reasons, window restrictors needed to be in place.

At our last inspection in February 2014 we had concerns about proper record-keeping, so we followed this issue up. We found proper records were in place.

We saw that people had care plans. The plans described the support people required and their preferences. Each person had a care plan containing a description of the individual needs of the person. They included relevant information such as things a person liked and did not like to do, things important to the person, things the person could do for themselves and what makes a person feels sad and upset.

We found that people had reviews of care and relatives were invited to attend, though they had not always been reviewed on a regular basis, which meant there was a risk that people would not receive the care they needed due to their changing needs. Information about people's past history was scarce. The manager said she was in the process of making plans more person centred – ensuring information was individual to the person – and would be addressing these issues.

We saw risk assessments in place in people's records of care we looked at. For example, there was a risk assessment relating to behaviour that included how to manage risks to the person and other people. This staff detailed information as to how to manage these situations.

Staff told us they would make appointments for people if they became unwell. There was evidence of this in people's plans. However, we saw that there had been problems in the past with people not visiting a dentist regularly. One relative told us staff had not taken their daughter to the dentist so they arranged this themselves. Another relative said; "they had not supervised her cleaning her teeth and they were in a state. They are much better now though". The provider stated that this issue had been investigated to try to ensure proper dental care was arranged.

There was an accident and emergency sheet in each person's care record providing details of the person in case of an emergency attendance at hospital.

We saw that people had activities including shopping, bowling, swimming and horse riding, although the expert by experience commented there did seem to be a lack of things to do in the home, apart from watching TV and board games.

Staff told us they worked with a limited budget for people's activities which was low and people would benefit from more outside activities such as more frequent trips out such as more swimming sessions, pub trips and cinema. The manager she said she was reviewing activities and would look towards arranging more trips out in the future.

We saw evidence of planned activities in people's care records. However, we were told that these were not a true reflection of activities that were provided. The manager said she was in the process of reviewing people's activities to make them more meaningful for them. We saw evidence that a person liked to go swimming and went weekly. The person became calmer as a result. We asked why the person could not go on a more regular basis if this benefited person. The manager said she would review this with a view to making swimming trips more regular.

We looked at details of complaints records. No complaints had been recorded. However, we were told that relatives had made complaints in the past as described above in relation to people not being taken to the dentist. The manager said she would ensure that complaints were appropriately recorded in the future.

The complaints procedure showed that people could complain to management but this information did not include information about how to raise concerns with the local authority that has the responsibility for investigating complaints. The manager said the procedure would be amended to include this.

Requires improvement

# Is the service well-led?

## Our findings

The home did not have a registered manager in place. It is a legal requirement that services have registered managers in post. This is to ensure the efficient organisation of the home to enable appropriate care to be provided to meet people's needs. The current manager stated that she would shortly be applying to be the registered manager. We will monitor this issue and take action if needed.

We saw evidence of incidents where people living in the home had unexplained bruising, and therefore could have been subject to abuse. There was no evidence that these incidents had been reported to us. The provider has a legal duty to report such incidents to both CQC and the local authority. The manager said she would follow this procedure in the future.

Staff told us there were regular staff meetings. They told us the agenda was available and they could ask for items to be added to the agenda. This meant the service was aiming to build teamwork to ensure it was running efficiently. We saw evidence of these meetings. They included relevant issues such as discussing people's care.

We did not see that people and their relatives had been provided with a satisfaction questionnaire to give their views of the service. The manager said that this would be drawn up and supplied to all relevant parties.

There was no evidence that 'residents meetings' had been held. Meetings provide an opportunity for people to feedback comments or concerns to the management team. The manager said she was considering what method message would be best for gaining people's views and this would be implemented in the near future. She said it may be that residents meetings were not the most effective forum to do this as a number of people living in the home did not like being in a group.

There were quality assurance and audit processes in place, such as medication, premises and plans of care audits. These helped management identify problems. However, there were no action plans in place for these audits to show that effective action had been taken to ensure a quality service was provided. The manager said this would be followed up. The provider stated that all issues had been identified and were in the process of being acted upon.

These issues are a breach of Regulation 17 (1) (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

Relatives we spoke with were hopeful that the change of management would bring about improvements within the home. One relative said; "we hope this (manager) one is good and makes changes for the better."

All the staff we spoke with said that management supported them if there were problems. One staff member said; "my manager is approachable and I feel well supported".

The manager and deputy manager, both new in post, seem committed to improving the ethos and day to day running of the home, working together as a team with a common vision of a well run, effective service.

Staff told us that the management had emphasised that people's rights should be protected and promoted. This gave a strong message to staff as to the importance of preserving and enhancing people's rights.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**People had not been protected from risks to their safety.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**There was not an effective system in place to assess and monitor the service to improve quality and safety.** |