The Edmund Trust

The Poplars

Inspection report

58 Station Road
Histon
Cambridge
Cambridgeshire
CB24 9LQ

Tel: 01223883130
Website: www.edmundtrust.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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen

The Poplars is registered to accommodate up to five people with learning disabilities who may also have an autistic spectrum disorder. A respite service is provided for people. The accommodation has five single bedrooms with en suite facilities. Four beds are purchased by the local authority for respite care and one bed is for private purchase or emergencies. There are 60 people who use the respite service. The local authority allocates each person with the number of days respite at the service. The registered manager and senior staff liaise with people and their relatives to ensure the individual allocation is provided. People do not stay at the service with the same people each respite stay. The staff are flexible in the way they provide the service as people can come in for respite for one night, a weekend, a week or more.

At our last inspection on 24 and 29 September 2015 we rated the service 'Good'. At this inspection we found the service was now rated overall as 'Requires Improvement'.

This inspection was completed on 22 May 2018 and there were four people receiving a respite service at the time of the inspection.

A registered manager was in post. 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 registered manager was not available as they were not on duty on the day of the inspection.

Staff had not followed the provider's policy on the administration and recording of medicines, which meant that people had not received their medicines as prescribed.

Staff were aware of how to reduce risks to people. However, although potential risks to people had been recognised, information on how to minimise risks had not always been recorded.

Staff understood their roles and responsibilities in relation to keeping people safe from harm. Staff recruitment was robust and there were enough staff employed to meet people's support needs.

People received an effective service because their needs were met by staff who were well trained and supported to do their job. People were supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice. People's nutritional needs were met by staff who knew each person's needs well. People's health and wellbeing was maintained and provided by a range of health and social care professionals.

People received good care because staff treated people with kindness, compassion, dignity and respect. People had choices in all aspects of their daily lives and were able to continue with interests and friendships outside the service. Staff ensured people remained as independent as possible.

People did not always receive a service that was responsive. Although people and their relatives (where appropriate) were involved in their personalised support plans and reviews the information about them in relation to their care and support was not always up to date.

People were encouraged to take part in a range of activities that they enjoyed, some were planned and others were the choice of the person at that time. This helped prevent social isolation. Systems were in place to support people with end of life care should this ever be needed.

People had not received a service that was well led. Quality assurance systems to check that the service provided quality care and made improvements where necessary had not identified concerns about the administration and recording of medicines.

There was a registered manager in post who was approachable and understood their responsibilities in relation to notifying CQC of certain events that happened at the service. People, relatives and staff were encouraged to share their views about the service being provided.

We identified one breach 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 not always safe.

People did not always receive their medicines as prescribed, and medicines were not always managed safely.

Risks to people had been assessed but not always fully recorded.

People were supported by staff who knew how to recognise and report concerns about people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

People had support plans but they were not always up to date.

People were supported by staff who had the necessary training.

Staff were acting in accordance with the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards codes of practice.

People were able to access healthcare professionals when they needed them. People were supported to eat and drink to maintain their health and well-being.

Is the service caring?

Good

The service was caring

People were treated in a caring and dignified way and with respect.

People were involved in their care planning and were encouraged to be as independent as they could be.

Is the service responsive?

Good

The service was responsive.

People's care and support was written in a person centred way and reflected people's needs.

People were encouraged to take part in a variety of activities and events in the service and out in the community.

People knew how to make a complaint and a system was in place to address any complaints made.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although audits were completed these did not identify the concerns that we found in relation to the management of medicines.

A registered manager was in post and they led their staff team in an open and supportive manner.

People and staff were involved so that they could make comments and suggestions about the quality of the care and the service provided.

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 and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection, which took place on 22 May 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because this was a small service that provides respite care for younger adults who are often out during the day. We needed to be sure that they would be in. The inspection was carried out by one inspector.

Before the inspection the registered manager completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We received the completed document prior to our visit and reviewed the contents to help focus on our planning.

We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

We requested information from the local authority commissioning team and safeguarding team. This information helped us with our planning of this inspection.
We spent time in the communal area and observed interactions between people and staff and observed the support offered to people.

During the inspection we spoke with two people who were staying at The Poplars. We spoke with a senior care staff who was managing the service during the inspection and three support staff. Additionally we spoke with one healthcare professional who visited the service during our inspection.

We looked at three people's support plans and looked at a range of relevant documents relating to how the service was run including management of medicines, complaints, training records, accidents and incidents and how the registered persons monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People were at risk of harm as they did not always have their prescribed medicines appropriately administered or recorded by staff. We looked at two people's medicine administration record (MAR) charts and noted that one person had one medicine prescribed to be administered as required. There were no protocols in place to provide staff with the information they needed before administering the medicine and at what point the medicine should be administered. Staff on duty were able to tell us when and why they administered this medicine. Nevertheless, the lack of written information put the person at risk of not receiving their medicine appropriately. We found that staff had not consistently recorded when medicine that was prescribed as required had or had not been administered. This meant we were not able to be sure people always received their medicines when they needed them.

As this was a respite service, people's families were responsible for providing sufficient medicines for the person's stay. Staff ordered medicines on the person's behalf only in an emergency. The provider's policy stated that staff had to record each person's medicines on a MAR chart when the person arrived for their stay or any changes in medicines were made during their respite stay . The policy stated that two staff should check the information on the MAR chart. This had been done but both staff members had missed that they had incorrectly recorded the dosage. We saw, and the senior in charge confirmed, that staff had not followed the provider's policy in recording medicines on the MAR charts for the two people we looked at. People were at risk because where new MAR charts had been written, incorrect information on the dosage had been recorded. The dose of one medicine (Risperidone) for one person had been increased by the GP from two milligrams twice a day to four milligrams twice a day. The previous MAR chart showed the changes in medicine. However, the most recent MAR chart stated that two milligrams twice a day should be administered. The person had received this reduced amount of medication since they started receiving a service three days before our visit. A health professional was in the service during the inspection and they reviewed this person's medicines and they provided advice to staff about the concerns detailed. The senior in charge acted on their advice and contacted the GP and psychiatrist. The senior also stated that they would complete a safeguarding referral as soon as possible.

As the result of a recent medicine administration error staff had been reminded to check when administering any medicines and record that administration was in line with the provider's policy. However, our findings showed that staff had not addressed the issue to improve the safety of medicine administration and recording.

This meant that people had not received their medicines safely or as they had been prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us, and records showed, that they had received training in relation to how medicines should be stored and administered. Staff had their competency checked regularly. We saw that medicines were stored and locked away safely by staff. All remaining medicines were returned to the person's family when the

person's respite stay ended.

Staff told us how they supported people to be as independent as possible by minimising the risks for each person. Systems were in place to assess and reduce the risks to people in theservice. People had support plans that included health care and mobility risk assessments. Most were individualised and provided staff with information about the risks, including how to minimise those risks in the way they supported people. A speech and language therapist (SALT) told us that for one person, "A risk assessment was completed and the guidelines were implemented as advised in the eating/swallowing care plan." We saw that the guidelines had been implemented and information to keep the person safe was provided, but a specific risk assessment had not been written. The senior in charge agreed that some risk assessments needed the information sent by other health and social care professionals, such as the SALT reports, to be included. Staff were aware of the issues and how to keep the person safe.

Up-to-date policies and procedures were in place in relation to safeguarding and whistleblowing that were in line with the local authority procedures. People were kept safe from harm because staff had completed the necessary training and were able to explain what they would do if they felt people were at risk. One staff member said, "[If someone had been harmed] I would whistle blow straight away. If it was the staff [who harmed a person] I would tell the [registered] manager or if it was them go to the [provider's] head of care, the local authority or CQC. All the details [of phone numbers] are available in the office." There was information in the hallway so that people in the service could see how they could raise any concerns.

People told us, and we could see that there were enough staff to support them and keep them safe. One person told us they could go out when they wanted and staff always accompanied them. Staff confirmed that any staff sickness or holidays were covered by other staff being asked to come in or the managers came in to provide care. Staffing levels were assessed in relation to the needs of the people coming into the service for respite. The senior in charge told us that if a person needed one to one support, then extra staff were rota'd on duty to provide that. Staff confirmed that was the case.

There was a robust recruitment process in place. A new member of staff told us that checks had been carried out by the provider before they started working at the service. These included references, identity checks and criminal checks through the Disclosure and Barring Service (DBS). This helped the provider ensure that unsuitable staff were not employed.

Staff were aware of the evacuation processes, where information on personal evacuation for people on respite was kept.

The provider had systems and processes in place to prevent the spread of infection. The service was clean and hygienic throughout. Staff used personal protective equipment such as plastic gloves and aprons appropriately. The service had received a food safety rating of 5 from the local authority.

Although we saw that incidents, such as errors in medicine administration, were used to remind staff of their responsibility to keep people safe, this had not always been effective in ensuring that lessons had been learned.

Requires Improvement

Is the service effective?

Our findings

Assessments of the care and support needed by each person were carried out before the person had their first respite stay at The Poplars unless they came in as an emergency. Where people came in as an emergency staff had minimal initial information available. However, there was evidence that they worked with the person to discuss and record anything that ensured the person's needs were met. The senior in charge told us that the registered manager was involved in ensuring that the service could provide the right level of support for each person before they were admitted. The registered manager and senior in charge liaised with the person's care manager and relatives to make sure that the person's needs had not significantly changed before each subsequent stay.

Technology was used in the service. There were call bells in each bedroom and bathroom. The service had a hoist, but people brought their own slings from home to use with the equipment. There were also alarms available so that staff could respond to a person who was incontinent in bed. One person brings their own epilepsy monitor when in respite so that staff can respond in line with the support plan. The equipment was used to enhance the care and support that was provided in the service.

Staff said they were supported through on-going training so that they were able to provide effective support for people staying at the service. Subjects staff covered in their induction and on going training included infection control, safeguarding, epilepsy awareness, autism, health and safety and food preparation. Staff had extra training to ensure they could provide the support people needed. For example one staff member told us they had completed training in the use of a system in which a tube (PEG tube) is used to provide a means of feeding when oral intake is not adequate. This meant that people were being looked after by staff who had received the necessary training to support and meet the needs of people at the service.

We saw that regular supervision was undertaken by senior staff, which supported staff in their roles. One staff member said, "I have supervision every month with [name of senior member of staff]. I do like it and we talk about the positives and negatives [of events that had occurred and general overview of their practice], reflect [on care practice], goals and the goals from the last supervision."

People told us that they were always given choices of food and drink. On the day of inspection one person told us they were going out to have a meal in a local café. They described the sort of foods they liked to eat when they went out. There was information on each person's support plan about their likes and dislikes and any special diets such as those for diabetics. Staff told us that people were encouraged to prepare their meals when possible and people confirmed that was the case. People who attended day centres were provided with a packed lunch of their choice to take with them. Details recorded in the diary ensured staff were aware of who required packed lunches each day. Staff told us that there was effective communication with the day services people attended, as well as other external professionals, local agencies and local shopkeepers and café staff.

We saw evidence that people had access to the necessary health and social care professionals. The senior in charge said that because the service provided respite most people had appointments made by their

relatives at the time when they were in their own home. Where people came into the service in an emergency then a GP and any other health or social care professional would be contacted when necessary. We spoke with one health professional who visited a person who was in respite care They said the staff had contacted them appropriately and in a timely way to ensure that person remained as well as possible. The speech and language therapist told us staff had "appropriately requested" their input because of a person with eating and swallowing issues. This meant that people could be assured that staff would support them to maintain their health and well-being.

The accommodation was on two floors, which could be accessed by stairs or lift. There were baths and showers available for people in their en suite bedrooms. On the day of inspection no-one required special equipment. However staff told us that some people had bed rails if necessary, which was agreed with them and/or their families.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People had their capacity to make decisions and consent to their care assessed appropriately under the MCA. DoLS applications had been made to the local authority. Staff understood the MCA and we saw that people were continually offered choices in all areas of their care and wellbeing. Information in people's care plans showed how the MCA impacted them and how staff provided care that was in their best interest and as least restrictive as possible.

Good

Is the service caring?

Our findings

Comments from The Poplars 2017 quality assurance survey questionnaire for people and their relatives included, "I am well looked after by the staff and I enjoy my stay," "I like the friendly staff and the way they talk to me and help me when I am upset about something" and "It's like a holiday for me when I come here." During the inspection one person told us, "I like it here because I can see my friends. They, [The Poplars has] a tablet [similar to a computer] and I can use it."

Staff were passionate about the care they provided for people. One staff member said, "I just love it here. I am now very confident because of this job. I meet lots of different families and people." We saw and heard how staff were kind and caring with people and the enthusiasm they brought to the service. We heard how staff interacted with people and there was a lot of laughter and positive responses from people. This showed us that people were looked after and cared for in a kind and considerate manner.

Staff communicated well with each person, in the way each person preferred and could understand. Staff demonstrated in their actions and conversation that they knew each person well, including their likes and dislikes. They made each person feel that they mattered.

There were enough staff on duty to enable staff to have time to spend with individuals. This ensured that people felt listened to and had time to ask questions or hold conversations with staff. People were able to be supported by a choice of male or female worker. One person told us they wanted female staff to support them when they needed help and that a female staff member was always available to meet their needs.

The senior on duty said that most people had a family member who advocated on their behalf. If people required an independent advocate then that would be requested where necessary. Independent advocates help support people or speak on their behalf to express individual's needs and wishes to get the care and support they need.

Staff were able to tell us about the person and knew how to provide the care they needed. Where applicable individual routines in relation to day centre attendance for people who came to the service for respite were detailed in their support plans. Information was also detailed in the staff diary so that they knew the people who were to attend day centres and whether they needed to take a packed lunch.

People told us they were supported for any personal care in the privacy of their bedrooms. Staff told us how they ensured people's privacy and dignity in a way that they did not take away their independence. We saw that personal care was offered discreetly and people were treated with respect. Confidential information was only discussed in private and people's personal records were stored securely.

As this was a respite service, people's families and friends did not visit The Poplars very often. Nevertheless, visitors to the service were made welcome.

Good

Is the service responsive?

Our findings

The registered provider stated in the information they sent prior to the inspection that they worked closely with the person, their relatives, the Learning Disability Partnership and any professionals involved with the person. Staff attended people's local authority reviews if requested as, "people want respite to be part of their review as we are seen as an integral part of their lives."

We sat with one person and went through their support plans. The records contained detailed information about the person, including their life story, likes, dislikes and preferences. We saw that some information was confusing and needed to be updated or changed to reflect what the person did whilst in respite. For example there was information in one person's support plan that detailed the day centres and work experience they attended each day. However, In discussion with the person they said that they did attend them whilst they were in respite because of the distance from those activities. This person did have alternative activities whilst they were on respite at the service. The senior on duty said the support plans would be updated as soon as possible. We saw that one person's support plan was gradually being created from information staff had gained, information from health professionals and relatives. One health professional told us that they gave advice when the person came in as an emergency, explained how the person presented and what staff should do in response.

We saw that most areas within the support plans contained comprehensive and individualised information so that staff could provide the support people needed. However, some areas of the support plan needed to provide more information . For example, one person was noted as being deaf. There was no information provided in how staff should communicate effectively. The senior in charge told us that new care plans were in the process of being completed. However, as a respite facility there were 60 support plans to be completed and this process had only recently begun. Communication was one of the areas that was not currently in the support plans. However, the staff we spoke with were aware of how to communicate with people even if the information was not recorded in the support plans.

People continued to be supported by staff to access the community and follow their interests. Staff said that people continued to attend day centres if they lived locally, and they went to the local cafes and shops where people knew them. We saw that one person had attended a music therapy session with a relative and people had individual time with staff on duty and were able to tell staff what they needed.

Information from the registered provider showed that there had been no complaints. People told us they would talk to staff if they wanted to raise any issues or complaints. There was a complaints policy and information detailed on the notice board in the hallway. Staff were able to tell us how to raise any concerns for people. There had been 13 compliments such as, "We thank God for The Poplars; you are our lifeline," "[Name of person] loves coming to The Poplars and now asks me to get them booked in [for respite]" and "[Name of person] was full of smiles returning from The Poplars, which reflects how they were looked after."

Information from the registered provider showed that "End of life care is not usually part of respite we will be involved in, but something we will be involved in through visits and conversations with those involved; being

a support network where we can." Staff told us that there was information in the provider's policies and procedures on End of Life care and that, where necessary, people had Do Not Resuscitate (DNACPR) for emergency care and treatment as well as guidance for staff. The senior in charge told us that information on end of life care was not currently detailed in people's support plans. However, the new plans being written would contain the necessary information for staff to support people and their families in the event the person wished to remain at the service at the end of their life. The senior in charge said that health and social care professionals would be requested to support people at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

The provider had a system in place to monitor and improve the quality of the service. There was an audit process to check the records in relation to areas within the service such as medicines, concerns and complaints, care and welfare and support plans. A medication audit had shown areas that needed to be improved and the registered manager had put actions in place. However, we found that some staff had not followed those actions. These were discussed with the senior in charge during the inspection and included the procedures and administration of medicines by staff. Audits to check risk assessments and support plans had found there were gaps in information. New support plans were being introduced and completed as quickly as possible. We saw that the new support plans included areas that would provide staff with the information they needed. This meant that the audits were not always robust and although issues had been actioned to improve the service they had not always been followed through by staff.

There was a registered manager in post but they were not at The Poplars at the time of the inspection. This was because they were not rota'd to work that day. 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 service had been developed and designed in line with the values that underpin the CQC guidance, Registering the Right Support, and other best practice guidance. These values included choice, promotion of independence and inclusion. People with learning disabilities and autism who used the service could live as ordinary a life as any citizen.

The registered manager promoted an open and transparent culture within the service. They sought feedback from people and their relatives (where appropriate) as well as staff. Information gathered from people had been used to help improve the service being provided. For example, the registered manager had recruited male staff so that there was a balance for male and female staff to be available on duty. This was to enable people to attend events or activities.

The registered manager was aware of their legal responsibilities and had submitted information to the CQC as requested. This included notifications of events that had taken place in the service, which they were required by law to notify us about.

The registered manager stated in the information they sent prior to the inspection that, 'the registered manager and senior management team have a good relationship with the staff, people they support and families. They are approachable, supportive and honest but not afraid to question or be assertive when required'. It was evident there was a good rapport between staff and people staying at the service. People felt able to raise issues. One issue was that staff had used their personal (staff) phones whilst working. As a result staff had been reminded that they must adhere to the provider's policies and procedures in relation to the use of private mobile phones whilst on duty.

Staff understood their roles and responsibilities and received support and training to do so. This was in line with the provider's values and expected standards of care.

Evidence showed that health and social care professionals were involved with people who used the service and that they worked in partnership with the registered manager. We spoke with one health professional who attended the service. They said that in their view the service was 'well led' and commented that staff monitored the moods of one person if requested and provided comprehensive reports.

We saw that people attended the day centres they used when staying at the service if possible. One person told us, and staff confirmed that where that was not possible because of distance, they were supported by staff to do other activities they wanted to do.

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm as people did not always have their prescribed medications appropriately administered or recorded by staff. There was not proper and safe management of medicines. Regulation 12 (2)(g)