Aspire Healthcare Limited

Poplar Lodge

Inspection report

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Date of inspection visit:
13 February 2018
23 February 2018

Date of publication:
09 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This focused inspection of Poplar Lodge took place on 13 and 23 February 2018. It was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

We last inspected the service on 3 April 2017 and rated the service as 'Good.'

We completed this focused inspection, as we were aware the placing authority had recently raised concerns about the operation of the service. In January 2018, the local authority commissioners discussed their concerns around the way potential risks for people were managed.

Poplar Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Poplar Lodge provides care and accommodation for up to nine people who are living with a learning disability and who may have an offending history so may present a risk of harm to others. On the day of our inspection there were eight people using the service.

The service has a registered manager 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 2008 and associated regulations about how the service is run.

We found staff needed to receive training around meeting the specialism the service was designed to deliver, for instance completing risk management with people who have an offending history and understanding the use of the Mental Health Act 2983 (amended 2007) in the community.

Also staff needed to be supported to understand the actions they were able to take to ensure people were safe when going out independently. They needed to be more proactive and find out if people were subject to any court restrictions, Ministry of Justice conditions or Community Treatment Order conditions. Although some links had been formed with the local Protection of the Public Unit at present no information was available to assure staff that the courts had not imposed additional restrictions when sentencing people. Also no information had been gathered in respect how the police dealt with any incidents.

Staff knew the people they were supporting but the care records did not reflect this knowledge. Also the records did not provide evidence that could be used to support staff to fully understand people's histories, the impact of their learning disability or mental health needs on their behaviour, be able to contextualise and formulate risk profiles for people or determine what restrictions were in place. For instance one person had an electronic tag fitted but we could not determine why, what conviction had led to this and what requirements the Court expected the person had to adhere to. The person told us they were subject to a curfew but staff also thought the tag might offer them safeguards if the person became violent again but were unclear as to how this worked.

The care records contained no information about people's capacity and no MCA assessments had been completed. We found people were required to only go out when accompanied by staff but neither a 'best interests' decision or formal agreement from the individual for this arrangement was on file. Staff we spoke with did not know if people had DoLS authorisations in place or when they were subject to restrictions via legal processes such as conditional discharges and court orders what were the conditions of these orders.

Although the registered manager had been completing audits these had not picked up issues we highlighted, for instance the lack of 'as required' protocols for medicines, the uninformative care records, the lack of robust risk management plans and that staff had not received specific training to enable them to work in this specialism.

People were very complimentary about the staff at the service and their attitude. They told us the service was very supportive and met their needs. People told us that staff were kind and caring.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment; the need for consent; staffing; and having good governance systems in place.

You can see what action we told the registered provider to take at the back of the full version of the report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk"

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments around the potential for people to re-offend, working as volunteers and when going out independently were not in place.

Staff were trained to recognise signs of potential abuse. No concerns had been raised since February 2017.

The medicines were safely and appropriately managed.

Procedures were in place to ensure all staff were subject to proper employment checks before commencing employment.

The service was clean and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Assessments did not contain sufficient information to ensure staff understood people's needs, their history and potential triggers for offending behaviour or the measures that could be used to reduce any risks.

People's consent was not always sought. The documentation linked to the application of the Mental Capacity Act 2005 was not in place.

Staff needed to gain the knowledge and skills to fully support people who used the service.

People were provided with a choice of nutritious food and their on-going healthcare needs were managed.

The environment met people's needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not ensured the systems for assessing and monitoring the performance of the service were effective which placed people at risk.

Statutory notifications had not been submitted since September 2017 but we were aware that incidents had occurred that should have been reported to us.

The registered manager was taking action to improve the operation of the service but further work was needed.

Poplar Lodge

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 registered 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 unannounced inspection took place on 13 and 23 February 2018. The inspection team consisted of two adult social care inspectors.

Before the inspection, we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also reviewed reports from recent local authority contract monitoring visits and spoke with the contract monitoring team members.

During our inspection we spoke with five people who used the service. We also spoke with the regional manager, the registered manager, a senior carer and five care staff.

We looked at five people's care records, as well as records relating to the management of the service. We looked around the service and, with permission, went into some people's bedrooms, all of the bathrooms and all of the communal areas.

Requires Improvement

Is the service safe?

Our findings

Staff knew the people they were supporting and could discuss at length how they supported people on a day to day basis and what would indicate there was a change in people's behaviour. However, staff we spoke with were very unclear about their role in relation to ensuring people were not a risk to the public. Staff had not been provided information around what to do if people behaved in risky ways when in the community or what information they could share with other care providers and voluntary organisations. The provider had not considered contacting individual's care manager's to discuss the approach that they could take and how to provide some boundaries for the people who used the service.

Risk assessments were not in place around managing risks of reoffending or violence. The assessment information and the care plans did not provide any information about people's offending behaviour, last incidents, any indicators that might suggest an increased potential for individual's to offend and how to reduce the potential for this to occur. The risk assessments that were in place for behaviours that may challenge combined multiple behaviours and did not provide specific information around how to work with the person to reduce each one.

When people were subject to conditional discharges from a section 37/41 of the Mental Health Act 1983 (2007), staff did not appreciate that they did not adhere to the conditions of their discharge they could be recalled to hospital.

We found that for all bar two people, staff accompanied people whenever they left the home. Staff did not understand that one of the purposes of the being accompanied in the community was so staff could assess any changes in the level of risk this person may pose to the community. Thus no system of monitoring how they acted in the community had not been set up and without this information the clinicians and any tribunal panel would not be able to reach a determination around whether their behaviour had changed to such an extent that they no longer posed a risk to the public so could start to go out more independently or not.

The two people who go out independently had recently come into contact with the police following allegations that they were exploiting members of the public. No charges were pressed but the police had spoken with the two people and they no longer go out together and this had not reoccurred. However, there was no risk assessment in place detailing how staff could work with the individuals to ensure this behaviour was not repeated. Another person was prone to violent outbursts but the risk assessments did not provide detail around how staff were to work with this person and what techniques would de-escalate a situation.

Some of the people who had offending histories volunteered at a local charity. None of the care records contained any risk assessments in relation to taking on the role or clearly set out what people were to do. A member of staff had set this activity up but it was unclear what information had been shared with the voluntary organisation or discussions held with the individuals' care managers. We found from our discussions with staff that the people were always accompanied when volunteering but this was not documented in the care records. We found that the potential risks had, been mitigated by the fact that staff

accompanied the individuals and stayed with them at all times but staff had not recognised this fact.

When exploring risk management strategies with staff there was clearly a knowledge gap as staff did not know what to look for when assessing whether changes in people's potential to re-offend, working with other organisations or how to check if people were not posing a risk to others when out.

Also the records did not provide evidence that staff used people's histories, the impact of their learning disability or mental health need on their behaviour to contextualise and formulate risk profiles for people or determine what restrictions were in place. For instance one person had an electronic tag fitted but we could not determine why, what conviction had led to this and what the person had to adhere to. The person told us they were subject to a curfew but staff also thought the tag might offer them safeguards if the person became violent again but were unclear as to how this worked and what would happen if they did attempt to assault staff. Staff did not appreciate that they had the right to call the police to press charges if they were assaulted.

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

People we spoke with told us they felt safe at Poplar Lodge and liked living at the service. One person told us, "The staff are good and have helped me to improve my behaviour." Another person commented, "Poplar Lodge is very good and the staff make sure we are alright."

We found there were sufficient numbers of staff on duty to keep people safe and to ensure they had safe access to the community. There was a core team of a senior and carer who remained in the home at all times and then during the day support staff came in and accompanied people out and about or to provide one-to-one support in the service. There could be an additional eight staff in the service during the waking hours. People who used the service, staff, and external professionals confirmed the staffing levels met the needs of people.

Accidents and incidents, involving both people who used the service and staff, had been appropriately recorded and no accidents had occurred since the registered manager came into post late last year. In discussions with them we found they understood how to analyse information to determine if there were trends and patterns that could be altered by the adoption of remedial action.

We found the registered manager and all staff we spoke with understood their responsibilities with regard to safeguarding and staff had been trained in how to protect vulnerable people. Information such as local safeguarding contact numbers and procedures were readily available for staff. Since February 2017 staff had not raised any safeguarding alerts.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. People who used the service and care staff were responsible for ensuring the service was kept clean. We found all areas of the home, including people's rooms, kitchen, laundry and communal areas were clean. Whilst some areas would benefit from refurbishment we found the premises to be clean and in good working order.

We found that there were appropriate arrangements in place for obtaining medicines, checking these on receipt into the service and storing them. We looked through the medication administration records (MARs) and found medicines had been administered and recorded correctly. Adequate stocks of medicines were securely maintained to allow continuity of treatment. However protocols for people's 'as required' medicine

needed to be developed and include for the staff team clear understanding of when and why these would be given. All staff who administered medicines had been trained and had completed competency checks to ensure they could safely handle medicines.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and reduce the risk of unsuitable people from working with vulnerable children and adults.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 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 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

Records showed that staff had received training around the use of the MCA and DoLS but it was clear further training was needed. None of the care records we reviewed contained any MCA information or records, yet it was clear from what staff told us that people lacked capacity to make decisions about some aspects of their life, for example people had appointees managing their monies and needed staff to accompany them when they went out in the community.

Staff needed to understand the process for referring individuals to the Court of Protection when they objected to being subject to a DoLS authorisation. We also found that staff did not have a good understanding of the requirements of the Mental Health Act 1983 (Amended 2007) and the associated Code of Practice. Thus they had not supported people who were on sections of the Mental Health Act 1983 (amended 2007) understand the conditions that were in place and their right to appeal this section.

With no mental capacity assessments being completed we found staff did not consider whether people were being deprived of their liberty and although some people clearly were, we found no evidence to show DoLS authorisations had been sought. We had been notified of one DoLS authorisation being obtained in February 2017 but this would have lapsed and staff could not tell us if anyone at the service was currently subject to a DoLS authorisation. We found people were required to only go out when accompanied by staff but neither a 'best interests' decision or formal agreement from the individual consenting to this requirement was on file.

We found that staff needed to be more proactive when finding out if people were subject to any court, Ministry of Justice or Community Treatment Order conditions and restrictions. Although some links had been formed with the local Protection of the Public Unit at present no information was available to assure staff that the courts had not imposed additional restrictions when sentencing people. Also no information had been gathered in respect of the route the police took to deal with the potential that people who used the service had been exploiting vulnerable members of the public. Thus, staff could not be confident that they were fully supporting people to meet any conditions and restrictions imposed upon them by external parties.

Also the provider's record templates did not prompt staff to establish who had enacted lasting power of attorney for care, welfare and finance and if the Court of Protection had appointed anyone to act as an individual's deputy.

This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Records showed staff had received training in subjects that the service deemed to be mandatory, such as moving and handling, health and safety, safeguarding and first aid and this had been kept up to date. Mandatory training and updates were deemed by the provider as necessary to support people safely. We found that staff training had been kept up to date.

However, we found, despite the provider referring to the service as a specialist unit for people with a forensic history, staff had not received training around this specialism. For instance, staff had not received any specialist or comprehensive training around completing risk management assessments with people who have a forensic history, they had received no training around understanding the use of the Mental Health Act 2983 (amended 2007) in the community, or working with people who had offended in the past. This had led to staff not understanding the actions they were able to take to ensure people were safe when going out independently or when to make need to know disclosures in relation to people completing voluntary work.

We found that staff could not clearly outline what their role was in relation to supporting people manage their potential to reoffend. Staff had taken no action to find out from the placing authorities what treatment programmes, such as violent offenders treatment programmes, people had completed or what was involved in these courses and whether there were aspects of the courses they could support people to reflect upon. Without this knowledge staff would struggle to appreciate if risks were reduced and indicators of a re-emergence of problems.

We found that staff had no understanding of the legal frameworks that people might be subject to so could not clearly articulate restrictions and conditions imposed. For instance they did not grasp that when someone who was subject to a section 37/41 the Courts would have found the offence was committed when the person was suffering from a mental disorder, so would not have been sentenced. Thus these individuals would not be monitored by the probation service. This lack of knowledge had led staff to put general information about compliance with requirements of the criminal legislation in people care records when it was not relevant.

This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We found that the assessment information the staff compiled did not give full details around people's life histories, issues they have had in the past, current issues or what treatment programmes they has completed and what had worked to reduce any challenging behaviours or risks. We found the level of detail in the care records was minimal so it was difficult to understand the needs of people. The registered manager and regional manager confirmed that following a recent local authority contract monitoring visit they had been made aware of the problems with the care documentation and were taking action to improve the assessment records.

Since the registered manager had come into post staff had been supported with regular supervisions and appraisals Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff.

People told us that they felt the staff were very supportive. One person said, "The staff do know what I need and will talk to me about my behaviour." Another person said, "The staff are good and like living here." Another person told us, "This is the best place I moved to as they keep me off the drink. They take me out to where I want to go and they have a car."

Staff supported people to make their own meals and monitored whether people's weight is within healthy ranges. People told us that staff encouraged them to eat healthy meals. People were seen by GPs and dietitians when concerns arose and attended regular appointments with these healthcare professionals. Each person had a Hospital Passport, an easy read document all about them using photographs and symbols and which told other services how people needed to be communicated with and any allergies or sensory needs. This meant that people who used the service were supported to obtain the appropriate health and social care that they needed. However, we noted that some needed to be completed and the registered manager confirmed that they were in the process of ensuring all were complete.

The environment was designed to support people's privacy and dignity. People's bedrooms had personal items within them, such as photographs.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post for several months and became the registered manager on 2 November 2017. Since coming into post they had been reviewing the service to identify areas for improvement.

Currently the statement of purpose and registered service user bands for this service only stated that people with a learning disability can be admitted to this service. However, the service also offers accommodation to people who have a learning disability and a mental health disorder. The provider needs to ensure that this is reflect in their registration.

Although the regional manager completed bi-monthly audits they told us that this did not normally involve visiting the service to visually check information, as they usually looked at what was recorded on the system. The regional manager told that they oversaw another 14 services and had found this was the only way to manage their workload. But since the council visited they have been visiting the service on a weekly basis. We found that this method of oversight had not picked up the issues we identified throughout the inspection. Also we found that even with visual checks gaps were still not being identified. For instance, on the first day of the inspection the regional manager told us that in their view the deficits in the care records had been addressed but we found this was not the case.

Although the registered manager had been completing audits these had not picked up issues, for instance the lack of 'as required' protocols, the uninformative care records, the lack of robust risk management plans and that staff had not received specific training to enable them to work in this specialism. The manager had never received training in completing audits, writing care records or risk assessment and acknowledged this gap in understanding impacted their ability to be effective when overseeing the service.

We found the quality assurance procedures in place lacked 'rigour.'

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager and registered manager assured us that the provider was committed to ensuring the service operated in line with regulatory requirements. The regional manager discussed that staff from a sister service were being asked to support staff to improve their knowledge of working with people who have a forensic history and to develop the care records. Also the registered manager outlined how they were going to contact local healthcare professionals working with people who have learning disabilities and a forensic history and ask if they could provide training or resources to assist staff develop their skills and knowledge in this field.

The registered manager told us that since coming into post they had made a conscious effort to be available for people to approach on an adhoc basis and always kept their office door open. They felt this was starting to encourage people who used the service and staff share their thoughts about the service. They also told us that since coming to post they had introduced regular staff and resident meetings and we saw these were

well attended.

Staff told us "I find that the manager is very keen to run a good service." Staff told us that the registered manager was really supportive and always at hand to help.

The people who used the service were complimentary about the registered manager. One person said. "[Registered manager's name] is a good one and always listens to what I have to say."

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured staff understood the requirements of the MCA, MHA and court orders regarding areas where restrictions could be imposed on people. Neither had they ensured that staff obtained people's consent to their care and treatment and if people lacked capacity the MCA code of practice was followed. Regulation 11 (1), (2), (3) and (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the potential risks were managed effectively. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems and processes that were in place to assess and monitor the quality of the service were effective. Regulation 17 (1)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff had not received the support, training, professional development, supervision and appraisal needed to enable them to carry out the duties they are employed to perform.

Regulation 18 (2)