Solent Healthcare Limited

Poplars Care Home

Inspection report

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Date of inspection visit:
11 July 2019
16 July 2019

Date of publication:
16 April 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Poplars Care Home is a care home which can accommodate up to 14 people in one adapted building. At the time of inspection, there were 14 older people at the home, all of whom were living with dementia.

People's experience of using this service and what we found
People living at the home were not always safe. There was not enough staff deployed to ensure people's needs were meet in a person-centred way, this meant staff were task focused and spoke with people in an instructional way which did not promote their choice and independence. One person said, "They tell me what to do and I do it."

Although staff were aware of the risks related to people's care, the records did not always provide adequate guidance to staff on how to manage those risks. People's medicines were not always managed safely; the home was not always clean and the systems in place to manage infection control were not always effective.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Staff had access to training to enable them to meet people's needs. However, there was not a structured induction process for staff new to the home. We have made a recommendation about developing an induction process in line with best practice.

People's privacy and dignity was not always respected and people did not always receive support that met their religious and cultural needs. People's wellbeing was not always enhanced though meaningful activities. One person told us, "You wake up here and go to bed here. There's not much to look forward to."

The provider had failed to ensure records related to people's care were accurate and up to date; and their quality assurance processes were not robust and did not identify the concerns found during the inspection.

People's families told us they felt involved in their relatives' care and support decisions. The registered manager dealt with complaints in an effective way. Staff had received safeguarding training and knew what action to take if they had any concerns regarding people being abused.

Staff were aware of people who needed extra help with communication and sensory loss and supported them in a positive way. People had enough to eat and drink.

The registered manager was aware of their responsibility under their registration. The rating from the previous inspection was published on their website and they notified the appropriate authority when

appropriate.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Enforcement
We have identified breaches in relation to staffing levels, the management of risk, the safe management of medicines, delivering person centred care, respecting people's dignity and privacy, maintaining up to date and accurate records and a lack of an effective quality assurance process at this inspection.

Please see the action we have told the provider to take at the end of this report.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Poplars Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had two managers registered with the Care Quality Commission, a husband and wife who were also the providers. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided. Although, both registered managers were present during the inspection, it was the husband who mostly engaged with us. During this report the husband will be referred to as the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed information we held about the service including statutory notifications, which providers are required to inform the CQC of, such as accident or incidents that have happened at the service.

We used all of this information to plan our inspection.

During the inspection
We spoke with seven people and two people's relatives about their experience of the care provided. We spoke with eight members of staff including the two registered managers, a husband and wife team who are also the providers. We also spoke with three members of care staff and the activities coordinator. We spoke with three visiting professionals and used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medicine records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, quality assurance audits and accidents and incidents were reviewed.

After the inspection
We continued to seek clarification from the registered managers to validate the evidence found. We looked at further policies and a variety of records relating to people's care. We also spoke with or received feedback from a further four members of staff and another professional who regularly visited the home.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● People were at risk because there was not enough staff deployed to meet their needs in a person centred way. The registered manager told us there were three care staff during the morning shift from 8am to 2pm; two care staff from 2pm until 8pm; and one wakeful night and one sleeping night from 8pm to 8am. In addition to the care staff there was a house keeper who worked three and a half hours a Day during the week and an activities coordinator who worked three hours a day during the week. In addition to their care duties care staff were also required to cook, serve the meals and do the laundry; as well as do cleaning and managing activities when the house keeper and activities coordinator were not working.

● We observed staff were task focussed and did not have time to sit and engage with people other than in an instructional way. For example, we observed staff tell one person to "go upstairs to your room, you know where it is. Go up and have a lie down." When we asked one person if staff had time to sit and chat to them, they replied, "Chat? What do you mean. They tell me what to do and I do it." A member of staff told us, "You can't have that one to one chat [with people], get to know them. You start to do something and then you have to leave them midway through to do something else, which upsets them."

● People in the home all lived with dementia or a cognitive impairment and had complex support needs, including behaviour that some people and staff may find challenging. . During the inspection we saw many occasions where there was no staff available to support people in the communal areas of the home for long period of time. For example, during their evening meal people were left unsupported to eat their meals, including those people identified as being at risk of choking. The care plan for one person at risk of choking stated they "eat rapidly" and advise that staff should "slow down her eating". We observed this person was left to eat their meal on their own without any staff being present or nearby to provide support or manage the risk.

● At one point during the evening meal a person became agitated and distressed. This prompted a second person to become verbally aggressive to them. A loud aggressive verbal exchange took place between both people, which then dissipated as they were distracted by their meal; this loud exchange lasted approximately five minutes. There were no staff present or nearby to provide support, reassurance or intervene had that been necessary.

● During the shift handovers staff all congregated around a table in the dining area. These handovers could take up to 25 minutes during which staff did not respond to people's support needs. For example, at one handover a person who was sat near to staff became very anxious and distressed. This was ignored by staff. A short while later another person approached staff and was told, "We are doing handover please can you leave us alone."

● Most staff told us the staffing levels at night were not sufficient to keep people safe. Staff told us in addition to supporting people they had a list of tasks to do, such as laundry, ironing, prepping food for the morning and cleaning. One member of staff said, "We do have people who wander at night so that can be

difficult. [Person] wanders, you never know where he is and he is at risk of falling so you have to try and keep an eye on him." They gave an example of where a different person had fallen while they were working in the kitchen and they did not find them until they did their hourly checks.

● Staff told us and records confirmed that people were woken early, given personal care and dressed by the night staff. When asked whether night staff woke people early to assist the day staff a member of staff replied, "I think it is a mixture of their needs and ours. For example, if they are wet, then staff will get them up anyway as it makes it easier for us." Another member of staff informed us that they had been told by other staff that the registered manager likes a certain amount of clients up before 8am to make it easier for the day staff.

● The registered manager told us they used a dependency tool to help them assess people's needs and staffing levels. However, we saw the dependency tool used did not always correctly reflect people's actual dependency needs.

● A family member told us, "I've always had concerns [about staffing levels] particularly at tea time. There are too many residents that need two staff [to support them]." They added "More staff would be great but if something goes wrong there is always someone around that notices."

● All of the professionals we spoke with raised concerns over the level of staffing at the home. One professional said, "I feel the staff do care but because there is not enough staff they are pushed and pulled so are not able to care."

We found no evidence that people had been harmed. However, due to the failure to ensure sufficient staff were deployed to meet people needs people were placed at risk of harm. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes protected people from being cared for by staff that were unsuitable to work in their home. A range of recruitment checks took place before staff started working at the home. These included the requirement for staff to complete a Disclosure and Barring Service (DBS) check prior to commencing their role. This enabled the provider to check the applicants' suitability for their role.

● The provider kept the necessary records to show robust recruitment processes were followed.

Assessing risk, safety monitoring and management

● People were support by staff who knew them well and were aware of the risks associated with their care. However, people's records did not always provide sufficient information to support staff to manage individual risks to people's safety and welfare. For example, one person was identified as being at risk of falls however there was no plan in place to manage or mitigate that risk and provide guidance to staff on how to support them to mobilise safely. Another, person was identified as being at risk of choking but there was no plan in place to manage or mitigate that risk.

● Where risks had been identified these were not always managed safely. For example, one person who was in a shared room had been identified as being at risk of falling out of bed. A crash mat had been put in place on one side of the bed but not the other side. This was because it would be a trip hazard to the other person sharing the room. The registered manager was not able to provide any evidence that other options, such as bedrails had been considered. When we visited this person, who was at risk of falls, in their bedroom they were sat in their room unable to reach the alarm call bell for assistance or in an emergency.

● People's personal emergency evacuation plans (PEEP) did not always reflect their needs, they were not accurate and up to date. For example, one person had moved rooms and their PEEP had not been updated to show their new room.

● The provider did not have effective systems and processes in place to effectively monitor and manage the safety of the environment. During the inspection we found the door to the shed in the garden was wide open and could not be locked. This meant people had access to sharp tools, paint thinners and other hazardous

substances. Outside of the shed there was a clutter of rubbish and discarded ladders, which placed people at risk of falls. There were a number of other trip hazards within the garden, such as a large hidden indentation on the lawn by the patio, where we observed someone trip and nearly fall.

We found no evidence that people had been harmed. However, due to the failure to ensure there were effective systems and processes in place to monitor, manage and mitigate risks to people's health, welfare and the environment placed people at risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to some of these concerns during the inspection and by the second day of the inspection they had taken action to ensure the shed was secure and mitigated the other risks from the environment.

Using medicines safely

● People's medicines were not always managed safely. Records related to the administration of medicines were not always accurate. On the second day of the inspection, two people received their medicines at 10.30am and at 10.40, due to being asleep when the morning medicines round was completed. However, the medicine administration record (MAR) was incorrectly completed and showed the medicine as being given at 8am. This placed the people at risk of receiving an overdose of repeat medicine when receiving another dosage before the required time interval had lapsed, such as pain relief, which was due on the MAR chart at 1pm.

● Where people refused their medicine, the provider and staff did not contact any health professionals to assess the impact on the person of not receiving their medicines. For example, one person who was diabetic and on antipsychotic medicines had refused to take their medicines. No action was taken by staff to understand how this may affect that person.

● Medicines were not always kept securely. During the inspection we saw a stack of tablets in blister packs left on top of the medicines trolley. There were no staff present or nearby, which meant the medicines were easily accessible to people in the lounge and dining area.

● The provider did not have effective systems and processes in place to ensure people received their medicines as prescribed. For example, one person was given their medicine covertly by staff who told the person they were "sweeties". Based on the person's mental health and presentation it appeared they did not have capacity to understand that they were receiving their medicine and there was no best interest decision about administering the medicine in a covert way so they would not know what they were taking.

● Another person's MAR chart stated staff should administer one or two sachets of medicine daily. On 28 June 2019 staff administered three sachets. We raised this with the member of staff who was administering medicines and they told us the change was on the instructions of the GP. The provider's medicine policy under the section 'Verbal Change of Dose by the Prescriber' stated when receiving any verbal changes of dose staff must "Record on the MAR sheet the date on which the treatment is to be changed and sign this amendment." A note in the communication book dated 27 June 2019 "doctor has said to increase [medicine]". However, it did not state how much the medicine was to be increased by or for how long. The MAR chart showed that the medicine had only been increased on one day.

● Where paraffin based creams had been prescribed to some people, known additional risks, in respect to their use and storage away from sources of ignition had not been identified and action had not been taken to mitigate those risks.

● The provider and staff did not always follow the guidance of the National Institute of Clinical Excellence (NICE). Medicines were not always disposed of safely. For example, tablets that had been spat out by a person were wrapped in tissue and disposed of in general waste, rather than being placed in a sealed envelope and returned to the pharmacy in line with NICE guidance. Although, MAR charts contained a list of

people's allergies they did not record the type of reaction experienced.

We found no evidence that people had been harmed. However, due to the failure to ensure medicines were managed safely people were placed at risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were at risk because the provider did not have effective systems and processes in place to manage the risk of infection. The provider did not comply with the Department of Health codes of practice on the prevention and control of infections and related guidance. There was no effective infection control risk assessment, audit and no annual statement regarding compliance with infection control practice.

● People lived in an environment that was not always clean and free of the risk of infection. Areas of the home were dirty and had black cobwebs hanging from the ceiling; the toilet brush in the upstairs communal bathroom was dirty and covered in bits of old toilet tissue; the floor of the communal bathroom and an en-suite bathroom around the toilet pan was dirty and stained with dried urine.

● People using the downstairs toilet were unable dry their hands after washing them as the paper towel dispenser and paper towels had been removed. There were no other facilities for people to dry their hands. We pointed this out to the registered manager who said it was because a person would block the toilet with the tissues. By the second day of the inspection a new paper towel holder and paper towels were available in the toilet.

● We checked the mattress in one bedroom, which was covered with a mattress cover. When we removed the mattress cover we found it had a large number of brown urine stains which smelt strongly of urine. The registered manager told us that the person using that room had been there for three weeks and was not incontinent. The registered manager said he would replace the mattress immediately.

● There was a large damp patch stained with mould on the ceiling of the lounge area, near to where people frequently sat. This placed people at risk of health related problems.

● Although staff wore personal protect equipment when supporting people, such as disposable gloves and aprons, these were not always disposed appropriately. For example, we found used gloves disposed of on top of a clinical waste bin in the downstairs toilet.

We found no evidence that people had been harmed. However, due to the failure to have effective systems and processes in place to manage the risk of infection and ensure the home was clean people were placed at risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong

● The people and family members we spoke with told us they felt safe in the home.

● The provider had appropriate systems and processes in to record safeguarding incidents. Staff had received safeguarding training and could recognise safeguarding concerns and the action to take if they had any concerns. One member of staff told us "I have done lots of training including safeguarding. If I had a concern I would report to the manager and then go from there. If nothing happened I could go to social services."

● Accidents, incidents and safeguarding concerns were reviewed by the registered manager; however, it was not always clear as to what lessons had been learnt or action taken to prevent a reoccurrence. For example, the provider notified us that in November 2018 a person was scalded when they spilt a hot drink. Records showed in January 2019 a person split a hot drink on themselves, requiring a cold compress to be applied, and during the inspection we saw a member of staff give a different person a drink, which the person tried to drink but said it was hot. The member of staff them said, "I told you it was hot" and then left it with them

without offering further support.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider did not ensure that staff worked within the principles of the MCA. All of the people living at Poplars Care Home were living with dementia or a cognitive impairment and based on people's mental health and presentation it appeared they did not have capacity to make complex decisions.
- Although the registered manager told us he had received training in respect of MCA and DoLS he had not completed a capacity assessment for people when he applied for a DoLS to restrict their liberty. Capacity assessments and best interest decisions were not always documented for people who based on their dementia and presentation appeared to lack capacity, and were required for decisions, such as sharing a bedroom with another person, transporting someone to hospital for an invasive procedure, administering people's medicines, both openly or covertly, or to provide personal care.
- Where people's records showed a family member had a power of attorney to make decisions on the person's behalf, the registered manager was unable to confirm what the power of attorney was for; whether this related to financial decisions or decisions for health and wellbeing. He told us he had not seen any documentation but had taken the word of the family member that the paperwork existed.
- Where people were deprived of their liberty, an application had been made or applied for from the relevant authority. However, these were not always managed effectively. When a DoLS authorisation required renewing, the registered manager waited until it had expired before applying for a renewal, which meant there were times when people did not have an appropriate authorisation or application to deprive them of their liberty in place.

The failure to have effective systems and processes in place to ensure you complied with the requirement of the MCA and DoLS meant that people's legal rights were not protected. This is a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager told us they had enrolled in further MCA and DoLS training for themselves and their staff.

Staff support: induction, training, skills and experience
• Staff who joined the home did not always receive a comprehensive induction process. A new member of staff told us, "My induction wasn't very good. I did two shifts during the day [observing more experienced staff] but they were too busy so couldn't really show me anything. I was shown how to do medicines twice and then left on my own." The registered manager told us, "Any staff who is new to the care will have to take care certificate training." The Care Certificate is awarded to staff new to care work who complete a learning programme designed to enable them to provide safe and compassionate care.

We recommend that the provider seek current guidance in respect of inducting new staff into the home to ensure they are supported to perform their role safely and effectively.

• Staff told us they had access to ongoing training that was relevant to their roles, such as safeguarding training, moving and handling, fire safety, first aid and medicines management. One member of staff told us, "We had outside trainers for fire safety and first aid who were excellent."
• Staff had additional training around people's specific conditions, for example, dementia training, challenging behaviour and falls education. Another member of staff who provided feedback listed the training they had received, including food hygiene and end of life care and added, "The training does help me understand resident's needs but you need to know individual residents to care for them."
• Staff told us that with the exception of staffing levels they felt supported in their roles and had regular supervision and one to one meetings with their manager to discuss their care practices and development opportunities. One member of staff said, "We have supervisions and appraisals. They are useful and you get some good feedback."

Supporting people to eat and drink enough to maintain a balanced diet
● People's records documented their food and drink preferences and the staff support they required. One person told us the food "was okay, quite acceptable". Where people were identified as being at risk of malnutrition or poor hydration they were on food and fluid charts, which were completed appropriately by staff.
● Staff who prepared people's food were aware of their dietary needs and preferences. However, they did not always look to identify foods that reflected people's cultural background.
● People were offered a choice of meals. However, due to the lack of staff, mealtimes were not a social and relaxed experience. Staff identified where they wanted people to sit for their meals and directed them there. One member of staff directed other staff to "go an encourage [person] to come down [for lunch] so it is easier for us".
● Where people were supported to eat their meals, staff were not able to spend time focused on the person they were supporting. For example, one member of staff was supporting a person with their meal and then left them whilst they went to deal with a visiting professional. This left the person with no one to support them to finish their meal and drink.
● A professional told us, "There is a good diet. Home cooked food, three courses." They added, "At meal times there are not enough staff to support the residents if they require it, so the [staff] end up moving around various residents, the meals then go cold while they are waiting for the [staff member] to return."

● Staff ensured people were adequately hydrated, however, this was not managed in a person-centred way with set drinks rounds. Although there were jugs of cold drinks available in the communal areas of the home staff did not prompt people to have a drink throughout the day.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● When appropriate the provider used nationally recognised tools to help them assess people's needs, such as risk of malnutrition or pressure related injuries. However, they did not always follow best practice guidance for care homes, such as in respect of medicines management.
● People's needs were assessed prior to them moving into the home. This provided staff with the information necessary to understand the people they were supporting.
● The information gathered included people's health care needs, preferences, backgrounds and personal histories.
● A professional told us, "Staff seem to know people well. They know where people are when we arrive and what we are here for."

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
● Staff and the registered managers worked closely with other agencies to maximise the support and care people received.
● The registered manager told us they worked in partnership with district nurses, pharmacies, GPs, social workers and other health and care professionals to meet people's needs, we saw evidence of this in people's care files.
● Professionals told us they felt the home contacted them when appropriate and followed their instructions to ensure people's health care needs were meet.

Adapting service, design, decoration to meet people's needs
● The home was an adapted house located in a residential area. The décor of the home was tired and shabby. For example, some chairs were worn and faded and the wall paper in some areas was peeling or torn.
● There were some examples of dementia friendly signs, such as pictorial signs showing where the toilets were, however dementia friendly guidance was not fully applied in the home décor. For example, the home could be improved by painting doors and the hand rails a different colour to the walls to make them more easily visible to people.
● The registered manager had obtained a series of memory boxes to hang outside people's rooms with items that reflected aspects of their life or interests.
● The rear garden area had a pathway around a lawned area to allow people with limited mobility to enjoy going outside in a secure environment.
● People's bedrooms were personalised with items they had brought with them and pictures they had chosen.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● People's privacy, dignity and confidentiality was not always respected. People on the ground floor were frequently asked by staff in a loud voice comments such as, "Come on let's have a wee," "Do you want to go to the toilet?" and "[Name of person] do you want to go to the toilet?" This was so loud that it was heard upstairs.
● At the end of each shift, staff sat together to have a handover. This was done in a communal area of the home with people nearby who could hear what was being discussed, including personal, sensitive or confidential information. For example, during one handover a member of staff said, "[Name of person] wet the bed overnight; bedding changed." This information was discussed in the presence of people who could have overheard the comment.
● Staff discussed people's healthcare needs in front of other people. For example, we heard the registered manager and a member of staff discussing a care needs and their food and fluid chart. This was in the communal area of the home with other people nearby. A family member said, "I think they treat the residents with dignity but sometimes they are too open talking about people's personal things."
● The records relating to people's healthcare were not always kept securely. People's care records were kept in a cabinet in the lounge area. On a number of occasions, we found this cabinet was unlocked, with no staff being in the area which could be accessed by visitors to the service.

The failure to ensure people's privacy and dignity were respected is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although staff did not always speak with people in an age appropriate way, for example one person who appeared anxious and tried to engage with staff was directed by staff to do some colouring. They were sat on their own at a dining table colouring in a picture. A member of staff walked past and said, "You are keeping it in between the lines well done. It looks nice you are really clever." The person did not appear to react to the comment. The registered manager told us this was people's preferred communication style. However, they accepted the person's care plan did not reflect this. A professional told us, "On the whole, most of the staff appear to be caring and offer support. They appear to be able to be kind, compassionate and age appropriate in their communications."
● People were supported to be independent. People's care records documented things they were able to do for themselves and the decisions they could make, such as choosing their own clothes.

Ensuring people are well treated and supported; respecting equality and diversity

● People and family members spoke positively about staff and the care provided. One person said, "It is a good place where I can sit and enjoy talking to all the ladies and eating food. You can't complain." A family member told us, "On the whole it is very nice. I think the [staff] are caring."
● Although we saw occasions when staff interacted with people in a positive and caring way, on other occasions staff engaged with people in a way that lacked sensitivity and in an authoritarian way. People were told to "take a seat and wait for me there"; "if you don't eat, you're going to lose weight and go into hospital, which you really don't want"; "you've got to eat or you'll be skinny" and "drink it, finish up your coffee".
● People were not always supported in a way that embraced their diversity, religious and cultural needs. Some people's care records identified a specific need related to their faith. We checked with the registered manager what action they had taken to support these people to fulfil their individual religious needs but he was unable to provide any evidence to show any action had been taken. One person's authorisation to deprive them of their liberty stated the provider should support them to have access to people who spoke their first language and to their cultural community, however this had not been met by the provider.
● One professional we spoke with visited the home to support a person who had specific cultural needs and based on their mental health and presentation it appeared they did not have capacity. The professional requested a chaperone due to the nature of their intervention. This role was carried out by the male registered manager, which was contrary to the cultural beliefs of the person.
● People were not always supported to eat meals that were culturally relevant to them. A professional told us they did not feel the home was responsive to people's cultural needs.

The failure to support people in a way that meets their cultural and religious needs is a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
● People's families told us they were involved in the care and support decisions regarding their relatives. One family member said if their relative's needs changed, "they communicate straight away."
● People's care records showed that, where they were able to, people were involved in decisions regarding their care.
● The registered manager ensured people and their families could feedback about the home and the support they received both on an informal and formal basis.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care plans were detailed; however they did not always fully reflect people's care needs. For example, one person's care records stated they had epilepsy but they did not have an epilepsy care plan in place to assist staff in understanding how to support them should they have a seizure. We raised this with the registered manager and by the end of our inspection they had completed an epilepsy care plan for that person.

● People's personal emergency evacuation plans (PEEP) did not reflect people's current health needs. For example, one person's PEEP did not reflect that their mobility needs had changed or that they now displayed behaviours that some people and staff may find challenging. This meant they would not be able to be evacuated in the manner described in the PEEP to ensure their safety.

● People's care plans were not always person-centred and did not always reflect people's individual needs. For example, the care plan for one person, who was diabetic, guided staff to contact the GP if their blood glucose was high for 'several days'. There was no information to aid staff in how long several days was or what glucose levels constituted high for that person.

● Where people had been identified as having an allergy, there was no information to assist staff with how the allergy would affect the person or the action to take it they had a reaction.

We found no evidence that people had been harmed. However, the failure to ensure records were up to date and reflected people's current needs put people at risk of harm and is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's daily care records were up to date and reflected the care and support that had been delivered. Staff took part in a handover at the start of each shift to ensure they were aware of any changes to people's care needs.

● People were supported by staff who had a good understanding of their care and support needs. A family member told us told us staff knew their relative well and said, "They know all of their little habits and quirks." Another family member said, "Everybody here knows mum. They know she doesn't like to shower or bath but they will spend time encouraging her."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People living at Poplars care home did not always have access to meaningful activities to keep them stimulated and enhance their wellbeing. The National Institute for Excellence (NICE) and the Alzheimer's society recognise the importance of meaningful activities for older people living in care homes, particularly

those living with dementia.
● The provider employed an activities coordinator for three hours a day during the week. When they were present, they arranged a number of group activities in the communal areas of the home, such as painting, cooking and chair exercises. They also arranged for visited from a Pets as Therapy (PAT) dog and a local church which held a regular church service. They supported people to access the garden and where people were unable to do so they had created a portable garden that could be brought into the home. They also arranged for trips outside the home.
● However, the activities coordinator was not allowed to support people who did not come into the communal areas of the lounge. They told us, "I don't do one-to-one activities as [the registered manager] does not see it as a good use of my time. [I am] disappointed as I have done [specific person-centred] training which is focused on one-to-one."
● When the activities coordinator was not present people did not receive any meaningful activities or support. The activities coordinator told us, "I feel unsupported by the management team and care staff. There just isn't enough staff to allow them to do activities when I am not here."
● People appeared to have their own dedicated chairs in the lounge, which were situated around the outside of the room. This made it difficult for people to socialise with different people throughout the day. When the activities coordinator was not present most people were left to sit and sleep in their chair in the lounge area. Where people became anxious or started to walk around the home, staff distracted them by giving them a picture to colour on their own.
● People and their families told us there were not enough activities and those provided did not always reflect their wishes or needs. One person told us, "You wake up here and go to bed here. There's not much to look forward to." Another person said they were unhappy at the home, "I do nothing all day, just sit here. I wake up and come down. Then I go to bed." They added they wanted to work, cook knit or do something with their time. A family member told us, "There's probably not enough activity here for [my relative]."
● A professional who provided feedback told us, "Although there is an activities coordinator who provides activities for the home daily, the plan for these are not responsive to the individual care plans and expressed wishes and preferences of the residents and person-centred." Another professional said, "There is no structure to the day, Residents are sat around with little stimulation, there were no activities during the time I was in the home."

The failure to have meaningful activities to meet people's needs and enhance their wellbeing is a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The provider complied with the Accessible Information Standard and the communication support they needed. Where people did not communicate verbally, staff understood people's non-verbal communication, such as body language.
● Staff were aware of people who had a sensory loss and supported them in a positive way. For example, we saw one member of staff supporting a person who was slightly visually impaired with their meal. They explained to the person what was eating and then guided them to their cutlery so they could eat independently.
● Staff used a pictorial menu to support people in choosing what they wanted to eat.

Improving care quality in response to complaints or concerns

● The provider had policies and procedures in place to deal with complaints about the home and the quality of the care provided. People's families told us they were aware of how to complain and people had access to advocates to support them to raise any concerns.

● The registered manager told us they had received one complaint during the last year, which was dealt with in line with their policy and to the satisfaction of the family concerned.

End of life care and support

● At the time of the inspection no-one was receiving end of life care from the service. However, people's care plans identified people's end of life wishes.

● There were detailed advanced care plans in place to help staff to understand how to support the person at the end of their life.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● People were placed at risk of harm because the provider did not have effective systems in place to monitor and improve the quality of the service provided.

● The registered manager had a quality assurance system in place and carried out a series of reviews and audits, including care file reviews, medication audits, infection control audits, maintenance and grounds audits and Health and Safety audits. However, the quality assurance system was not robust and did not always identify areas for improvement, such as those as described throughout the report. This meant people were placed at risk of harm because the quality assurance process did not identify when there was not sufficient staff to meet people's needs; when medicines were not managed safely; when systems and processes to monitor, manage and mitigate the risks to people's health and the environment were ineffective; when people's legal rights were not protected; when the risks of infections and the cleanliness of the home were not managed safely; and when records were not accurate and did not reflect people's needs.

● Although the registered manager had developed a process for identifying areas of improvement across the home these were unstructured and did not ensure the people received high quality care, in line with accepted best practice.

We found no evidence that people had been harmed. However, the failure to operate systems or processes to assess, monitor and improve the quality and safety of the services provided meant that people were placed at risk of harm. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Although people and family members told us the where happy with the way the home was led, the evidence detailed in the previous domains demonstrates that the home was not person-centred, open and empowering. For example, people's cultural needs were not always met; they were not always treated with dignity and respect; and there were not always meaningful activities available to them to enhance their wellbeing. One person said, "I have nothing to complain about; there could be worse places I suppose." A family member told us, "It may not be the smartest place but it is small and it is more like being at home."

● People were not always supported in a positive, inclusive and empowering environment. There was a tension between some staff and the registered managers. We received mixed feedback from staff regarding

the support they received from the managers. One member of staff feedback to us that they, "The management team is very supportive and helpful. They are always available when I need them or ask for help or clarification." While another member of staff told us, "I don't think it is well-led. You don't get listened to. The focus is on finances rather than delivering care." Other comments from staff regarding a lack of support included comments in respect of staffing levels, staff induction into the home and support with activities. One professional said, "I think the home muddles along. I think there is some bad feeling between some staff and the manager."

● The registered manager told us their vision was to provide a good quality of care for residents; to be one of the best homes in the area. They accepted and acknowledged that they had "taken their eye off the ball" in not identifying the areas of concern.

● During and after the inspection the registered manager provided evidence of the action he had taken to ensure the home improved and met the required standards. For example, reviewing care records to ensure they reflected people's current needs and facilitating additional training such as awareness of the Mental Capacity Act (MCA).

● The registered manager was fully involved in the daily running of the home. They were visible and accessible to people and staff within the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff had the opportunity to feedback on the service through a questionnaire and regular staff meetings. However, their concerns were not always acted upon. For example, the feedback from the February 2019 staff questionnaire identified a concern regarding a lack of staff. The lack of staff in the afternoons was also discussed at the February 2019 staff meeting. One member of staff said, "We have staff meetings now and again but I don't feel listened too."

● The provider used a range of ways to seek feedback from people, such as a relative and residents' feedback surveys. The registered manager analysed the feedback from the questionnaires and took action when concerns were identified. We saw the analysis from the latest residents' survey and 25% of residents were not happy with the lack of entertainment. The registered manager told us this had prompted the employment of the activities coordinator.

● The new activities coordinator also chaired the residents meetings where people had the opportunity to put forward their suggestions, regarding what they would like to eat and activities they wanted to do.

Working in partnership with others

● The registered manager was responsive to opportunities to work in partnership with other people. Health professionals told us they had spoken with the registered manager regarding a training opportunity and said, "After I explained the training and the reasons, he did sign up to the course. I thought this showed a willingness to improve."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There was a duty of candour policy in place to help ensure staff acted in an open way if people came to harm. The registered manager showed us an example where they had contacted the family of a person who went missing from the home.

● The registered manager notified CQC of all significant events and had displayed the previous CQC rating on their website and prominently in the entrance hall.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to always support people in a person centred way and in a way that met their cultural needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people's privacy and dignity were respected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to have effective systems and processes in place to ensure the requirement of the MCA and DoLS were complied with, which meant that people's legal rights were not protected

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to; ensure risks to people's health and the environment were managed safely; ensure medicines were managed safely; and ensure there were systems and processes in place to ensure people were not placed at risk of infection.

The enforcement action we took:

We took enforcement action against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure records were always accurate and their quality assurance was effective.

The enforcement action we took:

We took enforcement action against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough staff to support people in a person centred way and keep them safe.

The enforcement action we took:

We took enforcement action against the provider.