Essex County Care Limited

Poplars

Inspection report

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Date of inspection visit:
20 June 2017

Date of publication:
04 September 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 20 June 2017 and was unannounced.

Poplars provides care and accommodation for up to 34 people who may need assistance with personal care and may have care needs associated with living with dementia. The service does not provide nursing care. At the time of our visit there were 21people living in the service. There were three people living on the first floor, known as "Tree Tops."

A registered manager was not in post at the service. 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 met with the interim manager who going to apply to become the registered manager.

Staff supported people in a caring and compassionate manner. They spent time talking to them and developing positive relationships. Whilst activities were in place, we found these were not always person centred. Where people had more complex needs, such as dementia, they did not have always have access to pastimes tailored around their needs and interests. We have therefore made a recommendation about developing person centred activities.

Care plans had been developed which outlined people's care needs. Improvements were underway to ensure these were more person centred and easier for staff to read. Reviews of care were not carried out and recorded effectively, however staff responded well to people's changing needs. People knew how to complain and the manager responded well to concerns.

Risk was well managed and people were supported to remain safe. People were protected from the risk of abuse. Staff used a new electronic system for administering medicines and people received their medicines as prescribed. There were sufficient staff to keep people safe.

Staff were well supported and worked well as a team for the benefit of the people they cared for. Staff knew how to meet people's needs effectively. The manager knew where there were gaps in knowledge and skills and were supporting staff to access improved training.

The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. Personalised decisions were made in people's best interest, involving family and outside professionals as appropriate. Staff were skilled at supporting people to be involved in decisions about their care.

People had enough to eat and drink in line with their preferences. Staff monitored where people were at risk

from losing weight or not drinking enough and any concerns were addressed promptly. Staff worked alongside health and social care professionals to support people to maintain good health and wellbeing.

The manager was committed to driving improvement and had responded well to concerns raised by outside professionals. There was an open and calm atmosphere where people and staff were encouraged to give feedback about the care at the service. There were a number of checks in place to monitor the quality of the service. These had been revised to provide a more robust oversight of the care people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk was well managed and people were protected from the risk of abuse.

People were supported by sufficient, suitably recruited staff who knew how to keep people safe.

There were safe systems in place to support people with their medicines.

Is the service effective?

Good

The service was effective.

Staff were supported to develop skills to meet people's needs. Access to training had improved.

Staff had the skills to support people to make their own choices about their care. Decisions made on people's behalf were done in their best interest, and in consultation with the appropriate people and professionals.

People were supported to maintain good nutrition and hydration.

Staff worked well with other professionals to promote people's good health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff developed meaningful relationships with people and treated them with kindness and compassion.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to engage in person centred activities which had been developed in line with their needs and preferences.

Care plans were being improved to ensure they were more personalised. Staff responded well to people's changing needs, however there was not an effective system in place to review people's needs.

People knew how to complain and their feedback was taken seriously.

Is the service well-led?

Good

The service was well led.

The manager had focused on making improvements when concerns were raised.

There was a calm open culture where people and staff felt able to give feedback and speak out about any concerns.

There were improved systems in place to check the quality of the care provided and address poor practice.

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.

The inspection took place on 20 June 2017 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. This included safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We met with the interim manager. We spoke with 7 members of care and domestic staff and 6 people who used the service. We had contact with two family members. We also spoke with two health and social care professional to find out their views on the service.

We reviewed a range of documents and records including the care records for people who used the service. We also looked at three staff files and documents relating to the employment of staff, complaints, accidents and incidents and the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the service and our observations confirmed they were supported by staff to stay safe. A person told us, "Of course I am safe here." A family member told us, "Any concerns I may have are taken very seriously and dealt with accordingly."

People were protected from the risks of harm and abuse. Staff had received training in how to keep people safe and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice. Staff were aware of whistleblowing procedures, and felt able to speak out if they were concerned about something at the service. They said, "I would follow the whistleblowing policy, talk to the manager or head office" and "I would go straight to the manager, if I was not happy I would go to the police or CQC."

Risk was well managed at the service. People had a full assessment of their needs, which included specific risk assessments, such as pressure areas, mobility and falls. When a risk was identified, there was a care plan, which provided guidance to staff about how to support the person in such a way as to reduce the risk. We saw one person that had a high risk related to their mobility and equipment was in place to help staff minimise the risks. There was also a risk assessment and care plan for a person at high risk of developing a UTI which described signs and symptoms staff needed to look out for.

A member of staff told us, "We discuss all risks in handover, and the seniors advise us what to do." When we observed the handover we noted staff spoke about risk in great detail so that the whole team could support people effectively. We then observed staff giving people the support which had been discussed, such as prompting a person who was losing weight to eat.

Each person had a personal evacuation plan. These had been recently improved to provide more personalised information on the support needed. For example, one person's plan said they needed two members of staff to assist them into their wheelchair, and which equipment was needed for this transfer.

People and families told us there was sufficient staff to meet people's needs. A person told us, "Yes, as I can always call them and they are here quickly." Our observations confirmed this. At one point during our visit two staff were supporting seven people in one of the lounges. We noted that when both staff were needed to support a person outside of the lounge another member of staff came to cover for them. The lounge was not left unattended at any time and people's needs were responded to quickly. A member of staff said, "We have some occasions where there is someone sick, but [registered manager] will always cover the floor."

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. Appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

We discussed with the manager that there was a gap in the staff file around a person's employment history

and in another file the manager had not recorded fully the decision around a specific recruitment decision. From our discussions we were assured that safe decisions had been made when the staff were recruited. The manager advised that they would address these issues when new staff joined the service, which would help in the on-going auditing and checking of employment decisions.

People were supported to take their medicines safely. The manager had recently introduced a new electronic system and we observed the senior administering medicines to a high standard. They used a hand held devise that scanned each individual medicine box, the scanner then identified the individual medicine administration record (MAR). The MAR included all relevant information staff required to administer the medicine as prescribed. The system prevented medicines from being administered too early and included protocols for medicines that were prescribed as required (PRN). The senior told us that they were able to see at a glance when stock was required as reminders flagged any stock that required ordering. When we noticed that for one medicine the stock listed was different to what we found in the box, the senior was immediately able to show the reason for the discrepancy.

Medicines were only handled by members of staff who had received appropriate training. Staff had recently received training on the new electronic system. We found that the storage and disposal of medicines was undertaken safely, and in line with current professional guidelines. The manager received reports outlining what medicines had been administered. They followed up any issues identified in the report and recorded what action they had taken.

Staff had considered in a person centred way how best to support people with their medicines. For example, one person's care plan stated that they had discussed with the person and together decided that although the person understood the importance of the medication it would be "safer timing wise for a member of staff to administer her medication."

Good

Is the service effective?

Our findings

People received care and support from staff who had the appropriate skills and training. A family member told us, "My relative has been in Poplars for several years now and I am very happy with their treatment to her." Another family member had written to the manager saying, "Any home is only as good as the staff that work in it and the staff at Poplars are second to none."

Staff received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff were also required to complete a workbook, following the principles of the care certificate, which needed to be signed off by a senior member of staff. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. Staff were provided with training as part of their induction and attended classroom based training for most subjects.

Staff told us, "The training here is getting better, I have had 3 training sessions this week" and "Training is good, but I also learnt a lot shadowing more experienced staff." The internal trainer for safe manual handling was carrying out a training session on the day of our visit. The manager used a training plan to identify whether staff were up to date with their training. They provided us with a plan of booked training to address any shortfalls identified on the training plan. Specific need training was also organised, for example, staff had attended training on how to support people when they found their behaviour challenging.

Staff received regular supervision and appraisal of their work. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. The manager told us that they had supervision meetings with staff and observed their practice bi-monthly. Staff felt supported and engaged in decisions made in relation to the care people received. They told us, "We can speak to the manager whenever we want as she is very supportive" and "I have sit down meetings with the manager and if I have a problem I go to them."

The staff team worked well and calmly together. Staff told us, "It's a supportive staff team, everyone helps each other" and "We all get on really well together." We observed the staff handover meeting and found this to be an effective way to share information. Staff discussed each person individually and knew them well, for example, reminding staff to help a person keep their legs raised.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 make particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. Care files contained completed capacity assessments, which

highlighted the person's ability to make particular decisions. Staff considered people's individual circumstances when an application was made to deprive them of their liberty. Assessments were personalised, for example, for a person who was not safe to leave the building independently, staff had written, "[Person] will often ask staff to let them out." Where people had some understanding it was clear they had been consulted, even if the final decision to restrict them was made in their best interests.

Decisions taken had been appropriately documented, including information as to why they were in the person's best interests. However, some of the mental capacity assessments we looked at did not always record who was part of the best interest decision process, for example which family member had been consulted. There were consent forms in peoples' files, though these needed checking to ensure they were completed consistently, in line with people's ability to make decisions.

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. The application procedures for this in care homes are 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 were being met. We found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority for people using the service.

We did note that the manager did not keep an overview of applications sent, authorised DoLS or expiry dates. They explained that as they audited care plans monthly they checked these details, and could describe to us what stage each application was at. They acknowledged an overview would help to have an at glance view of the applications and authorisations.

Staff had received training in MCA and DoLS; and understood the importance of considering people's capacity to make decisions. A member of staff told us, "We check capacity and would involve family where required." And another person said, "If I thought someone was struggling to make a decision, I would go straight to the manager." We observed that staff obtained consent from people about everyday tasks and activities, for example, "Would you like a clothes protector on," and "Is it okay to use the hoist". One person told us, "I don't do anything I don't want to do."

People told us they had enough to eat and drink and enjoyed the food on offer. We observed lunch in the two main lounges. The atmosphere was calm and relaxed and staff chatted to people during the meal. People in one lounge had their meals sitting in their armchair with height adjustable tables, rather than at the dining table. Staff told us people preferred this, although we did not see anyone being asked on the day.

We noted staff were skilled at encouraging people to eat, ensuring they were as independent as possible. Staff demonstrated an awareness of people's likes and dislikes. For example, there were two choices available for lunch both which contained gravy or a sauce. The staff member knew that one person did not like sauce or gravy with their food and went through other choices with the person.

Staff offered people a choice of drinks and snacks between meals and went round some time later to prompt people who were not drinking. This was done in a gentle and kind manner. Prior to lunch, a member of staff went round and help people make their meal choices. This was done gently but where people did not understand or remember what meals were due to their dementia, staff did not use any specialist communication methods. The manager told us they were busy taking photos of all the meals produced at the service and they had ordered white boards where the photos would be presented each day so that people would be able to see what food was on offer.

The chef had been at the service for many years and we received a number of compliments about her home cooking. A family member told us, "The food is extremely good and dietary requirements are catered for. They told us, "I don't buy anything in, I even make the pies from scratch." They knew people well and their nutritional needs such as who was diabetic or needed pureed food. They could tell us exactly who at the service was at risk of weight loss.

Risks to people's nutritional health were assessed, recorded and monitored using best practice guidance so that they maintained a healthy lifestyle and wellbeing. When risks were identified, people were referred to relevant health care professionals such as the dietetic services or the speech and language service if they were at risk of choking. We observed staff discussed at handover the best way to support someone who was losing weight and shared information, deciding that "yogurt and mashed cake" was working best.

People were supported to maintain good health and had access to appropriate healthcare services. Their care records showed they had regular appointments with health professionals, such as chiropodists, opticians, and GPs. The district nurse visited daily and gave us positive feedback about the care at the service. They told us, "Care staff listen to my advice and want to know about the care we have given people."

Good

Is the service caring?

Our findings

People told us that kind, caring and committed staff cared for them. Comments included, "I have never had an issue here; the staff are positive and caring. They are always willing to help" and "I am happy these days I have someone to talk to." When they were asked their views by staff another person said, "You girls put everything right for me."

A family member told us, "The home is not too large & has a calm atmosphere." During our observations we saw the interactions between people and staff were calm and not rushed. Staff laughed and chatted with people and helped create a positive atmosphere in the service. Staff greeted people with a smile, made eye contact when talking to people and used positive touch to connect with, or reassure people throughout the day. One member of staff told us, "The best thing about the job is talking and singing with people."

We heard staff speaking warmly about the people they supported. One member of staff told their colleague that a person was unhappy with where they had to sit as their usual chair was being cleaned. They said, "I know what to do, I'll go in to the lounge again and make them smile." Staff introduced us to a person who was over 100 with great pride and affection, as if they were speaking about a family member.

Communication between families and staff was warm and personalised. We saw in an email that a family member had said, "She looks really happy and content, thank you for taking such good care of her." Another family had written, "You were so kind and caring, they could not have had a better home, excellent food, friendly helpful staff. [Person] loved you all."

Much of the feedback we received centred on the familiarity between people and the staff which had built up over years. Staff were proud of the stability this gave people and their families. One member of staff said, "I've always enjoyed working here. It's nice for people to have the same carers, they get used to you." A person told us, "The staff are very good." "I have been here a long time, the girls are nice."

Staff knew people and their preferences so well that they did not always have to ask them what they wanted, such as whether they wanted sugar with their hot drinks. We did observe staff checking with people and seeking their consent before providing care. The close relationships between people and staff meant people had developed patterns and routines over times. This meant that although staff treated people with kindness they were not always given the opportunity to make new choices or break away from established routines.

Staff treated people with dignity and their privacy was respected at all times. One person told us "They do respect my privacy and knock on my door." We observed a hoist manoeuvre, which was carried out respectfully, during the manoeuvre staff chatted to the person about the name and breed of their dog and this helped to reassure the person. We also noted that when a professional visited the service the person was supported to go to a private place during the visit.

Requires Improvement

Is the service responsive?

Our findings

Whilst people told us staff were very kind and spent time talking to them, we received feedback and observed that some people did not have many opportunities to engage in stimulating pastimes, based on their personal preferences.

There was a part-time activity coordinator who was on duty three times a week. They were at the service during our visit and we observed they were drawn into providing personal care, including covering for staff and supporting people to have snacks and drinks between meals. This affected their ability to focus on developing good quality activities.
There was a programme of group activities and one-to one activities including painting, remembering, sing along, manicures, and quizzes. Whilst we observed activities taking place, we noted they did not involve many people. For example, we saw a member of staff doing some colouring in with one person, who appeared to be enjoying the activity. Staff then invited the same person out for an ice cream and walk later.

Staff engaged in activities with compassion and enthusiasm, for example, staff had done a sponsored walk to pay for a fish and chip supper for people and their families. In one lounge, there was a throwing game taking place and a game of scrabble. However, some of the activities we observed lacked structure and purpose. In particularly, in one lounge where people were living with dementia, music was playing and staff sang with people but for the majority of time there was nothing for people to do.

A family member told us, "The outside spaces and gardens are not used by residents and there are not enough activities." We visited on a warm day and we did not observe people being given the option of spending time in the garden. In addition, the gardens did not seem to be readily accessible, should a person wish to independently and safely go for a walk. The manager told us they had started to address this and had recently encouraged a member of staff to involve a person in gardening, which had been successful.

The building supported people to move freely; people could walk safely throughout the property, with limited restriction. There was a music room, with a selection of vinyl records, overlooking a small garden. We did not see this room in use and staff told us people tended to sit in the same lounge, usually in the same chairs. Leading off of the lounges there were enclosed spaces with beautiful views overlooking the sea but we did not see many people being supported to sit there.

We asked the activity coordinator if the activities on offer had been developed based on people's previous interests and hobbies. They gave us the example of a person who had taken part recently in a gardening activity. The organiser explained that this was a new role within the service and they had not received training in this area. They told us however that the current manager was supportive in developing the role. Another member of staff confirmed, "There is not much for people to do but it is better than it used to be."

We recommend that the service seeks improved training and guidance for staffing in relation developing person centred activities and pastimes, in particular to meet the specialist needs of people living with dementia, in line with current best practice.

Staff treated people as individuals. One member of staff told us, "We get to know people, talk to them to understand what they want." However, we observed that some routines had become entrenched. For example, we saw a member of staff putting music on and we noted they did not ask people what they wanted to listen to. A person asked when the television was going to be turned on and a member of staff reminded them gently that, "Its music in the morning and TV in the afternoon."

People's needs were assessed prior to their admission to the home, and these assessments were used to develop their care plans. The care plans we checked covered all aspects of people's health care needs and how they preferred to have those needs met. Staff were able to tell us about people's individual preferences as well as what support staff were to provide. Care plans did contain some information about people's background history although not in great detail.

The manager had introduced a one page profile which was completed with people and which was aimed at providing a more person centred service. They had researched the best profile to use and had found an accessible and attractive form. This information was personalised and could be used by staff when chatting with people, for example one person's form said, "I like dogs and I used to sell nail scissors."

Staff recorded the support people received daily; however this was a fairly repetitive, task based process. For example, when recording a person's daily routine, under "activity" a member of staff had written "Feeding and talking to them." Each individual element of people's care plan was reviewed monthly. The process around recording reviews of people's care was time consuming and did not provide easily accessible information for anyone monitoring people's changing needs. Staff wrote repeatedly in each section the phrase "no change," unless there had been a major incident, such as a fall or a hospital admission.

We discussed this with the manager, so they could consider a more effective way to record and review people's care needs. We were told that the service was planning to introduce electronic care plans which would improve on-going recording and enable staff time to be used more effectively.

Staff responded well to people's changing needs. "We observe people and if their needs change, we ask the senior to assess. For example, if we notice a person cannot stand while using a stand aid we would ask a senior to reassess."

The provider had complaints policies and procedures in place and people told us they felt able to speak out if necessary. One person told us, "If I had a complaint, I would go to the seniors" and a family member said, "Any concerns I may have are taken very seriously and dealt with accordingly." There were few formal complaints as concerns were largely dealt with through informal discussion with families. Where complaints were received these were investigated and people received a positive response.

The manager had checked with family members that they knew how to complain. Compliments were also collected and we saw these were received frequently.

Good

Is the service well-led?

Our findings

A family member spoke of, "The kindness and friendship (of staff) over the years." A member of staff described the service to us, "This is a happy home." We found this to be a very apt description of the culture and atmosphere at the service.

Whilst there had been some disruption due to changes in manager, the current interim manager had previously been a senior member of staff in the service which provided continuity to staff and people. We received positive feedback about the manager. Staff told us, "They are very supportive, I have never had a problem" and "The manager is lovely and never talks down to us."

The manager had started to make changes at the service, for example they had fixed a "thank you" board to the staff room where they put up cards and letters from family members. They told us they had done this so that staff would feel more appreciated. They responded with enthusiasm to our discussions and to input they had received from outside professionals and showed a real commitment to improving the service. A health and social care professional told us, "I've shared some tools and resources with the manager which have been implemented or tweaked to fit the service…Some of the things that they are planning on implementing, I think will be really beneficial. The manager seems to be quite innovative with their ideas."

The manager promoted an open culture at the service. People, staff and families had a number of opportunities to give feedback about the service and shape. Staff completed "listening forms" to find out how people felt about the service. These were completed monthly, which meant a member of staff spent time with each person chatting about the service. The manager told us the forms had been in place for years and we discussed ways of refreshing them to ensure they were more interactive; nevertheless we found this was an excellent opportunity for people to spend individual time with staff and provide feedback about the service. The manager reviewed the forms monthly and addressed any issues raised.

We looked at the minutes of a recent staff meeting and saw that discussions were honest and challenging and aimed at improving the service. For example, staff were reminded to spread their breaks out to make sure there was enough cover.

The manager arranged residents meetings where there was open communication about the service. We noted in a recent meeting there was a discussion about the lack of activities at the service and saw that the manager was already started addressing the concerns we found in this area, though there was still room for improvement. The manager also arranged a relatives meeting which was not well attended. In response, they arranged to meet individually with all the families to gain their views on the service. We saw from the notes from the meeting that families had found this useful and had raised specific issues regarding the individual care of their relatives, which the manager had responded to positively. This demonstrated a persistence and creativity by the manager to try things in a different way.

Despite only being in the post for a short time, the manager had a good understanding of the service. They carried out a number of audits, such as a "walk around" of the property and review of care records. As a

result they had implemented the "one-page profile" to ensure people's care plans were more person centred. They had picked up that there was no end of life plan for a person whose health was deteriorating, and arranged for one to be put in place so that care could be provided in line with their wishes.

The manager told us they received a monthly visit from a senior manager in the organisation. They also spoke regularly with them on the phone, as needed. We looked at the monthly audits carried out by the area manager and found these to be quite repetitive and largely on focused health and safety checks and records. They did however support the monitoring of risk, for example they checked whether adequate fire checks were in place. There was some reference to people's experience and feedback, though this was limited. The manager told us this new style of audits had been introduced within the last 6 months.

Prior to our inspection we were aware of concerns raised by the CQC and other stakeholders about the lack of oversight by the provider into the care people received in individual services across the organisation. Whilst there was scope for improvement in the audit we looked at, we were assured that the provider had taken on board comments and was implementing the necessary changes.

Throughout the inspection there were other signs of improvement, such as better training for staff. The manager also showed us emails outlining the resources they had requested recently, which focused on the on-going improvements. For example, they had ordered new slings so that people had individualised slings and additional equipment which they had found out about at a training course in infection control. The manager demonstrated an enthusiasm to drive improvements which we were assured would improve the quality of life for people at the service.