The Poplars (Thornaby) Limited

The Poplars Care Home

Inspection report

375 Thornaby Road
Thornaby
Stockton-On-Tees
Cleveland
TS17 8QN
Tel: 01642 675376
Website: www.astonbrookcare.co.uk

Date of inspection visit: 04 & 14 August 2015
Date of publication: 22/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

We carried out our unannounced inspection on 04 & 14 August 2015. The Poplars is registered to provide personal and nursing care, and accommodation for up to 43 people. The service was registered with CQC under the current registered provider on 13 April 2015, but was an existing service before this. The service is located in Thornaby and is a purpose built care home. Accommodation is provided over two floors and includes communal lounge and dining areas. There are garden areas surrounding the building which are secure and accessible to people who use the service. A car park is located at the front of the home. At the time of our inspection visit the service had 37 people living there, including 1 person receiving respite care.

The service had a registered manager, who has been registered with us in respect of the service's new registration since 16 April 2015. Before this they were registered as manager for the service's previous registration. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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.

People who used the service told us they were safe and could raise concerns if they needed to. Staff were aware of safeguarding and whistle blowing [telling someone] procedures. People using the service, relatives and staff told us that management were approachable and listened to them.

Improvements were needed to staff recruitment processes and records, to ensure that the required information was received and checked before staff started work. Overall there were sufficient numbers of staff on duty to meet the basic care needs of people using the service, but we also received feedback from people that sometimes staff struggled to have time to provide more individual care and attention. There was also some confusion about the systems used to determine what safe and appropriate staffing levels were at the service.

The service had health and safety related procedures, including systems for reporting accidents and incidents, and maintaining equipment. The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering the person's care.

Overall the systems in place for the storage and management of medicines were generally safe. However, we have required some improvements to the records related to medicines and storage arrangements, to ensure that medication is always stored within safe temperature ranges.

People who used the service told us that their staff were competent and looked after them well. Staff were appropriately supported through management supervision, appraisals and meetings. However, we found that staff hadn't always received the training that was appropriate to their role and training records were difficult to access and interpret.

The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff were also able to describe the principles of the MCA and how people's legal rights should be protected. At the time of our visit 5 people living at the home were subject to the DoLS.

People told us that they received enough food and drink, with a choice of regular meals and snacks provided. Records showed that people's nutritional wellbeing was assessed and monitored. We saw that staff were aware of people's individual dietary preferences and needs. Where people were at risk of dehydration or poor nutrition systems were in place to monitor this and involve other professionals.

People told us that they were supported to access healthcare professionals when needed and the records we saw supported this. Two healthcare professionals who visited people at The Poplars told us that they had no concerns about the care people received and that staff involved them when needed and acted on their advice.

People who used the service told us that staff were caring, treated them well, respected their privacy and encouraged their independence. Staff were able to describe how they worked to maintain people's independence, privacy and dignity.

People's care records showed that their needs had been assessed and planned, with details about people's individual wishes and preferences recorded. People told us that they received the care they needed and staff were able to tell us about people's individual needs and how they met these. However, we found that although staff worked hard to meet people's basic care needs, people did not always receive the support they wanted to maintain their individual interests or links with the local community.

Information about raising complaints was on display and issues and concerns people had raised had been listened to and acted on. A record of complaints and the actions taken in response was available and showed that complaints have been investigated and responded to by the registered manager.

People told us that the new registered provider had responded well to requests for resources or equipment and were investing in the service. Staff felt that there was a strong staff team and that the registered manager was approachable, supportive and listened to them.

Summary of findings

A system of audits and checks was in place to help ensure that people received a good quality service. Regular meetings with people who used the service, relatives and staff took place and included asking people for feedback on their experiences.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing, Fit and proper persons employed and safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People who used the service were protected from abuse, by staff who understood how to recognise and report any concerns.

Staff were not recruited safely. There were enough staff to meet people's basic needs, but there was some confusion over how safe and appropriate staffing levels were determined.

Health and safety, maintenance and emergency procedures were in place to help ensure people's safety.

Medicines were usually administered safely, but we have required some improvements regarding the storage of medicines and record keeping.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not received the training they needed to do their jobs and training records were difficult to access and interpret.

Staff felt supported by management and the staff team, and had received formal support through appraisals, supervision and meetings.

The registered manager and staff demonstrated a good understanding of the Mental Capacity Act 2005 and DoLS, although some of the assessment tools in use would benefit from review.

People were supported to maintain an adequate diet, with additional support provided if people were at nutritional risk. People's assessed minimum fluid intake was not always provided in practice, although staff did monitor fluid intake to ensure people's safety.

People had access to healthcare professionals and medical care when needed.

Is the service caring?

Good

The service was caring.

Staff were caring and respected people's privacy and dignity.

People who used the service said that staff were caring and kind, and we saw staff treating people well during our visit.

People we spoke with told us that staff listened to them and respected their wishes.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

We saw that people's personal care was provided on an individual basis, based on people's individual needs and preferences. However, we also found examples where the additional support people needed to regain independence, maintain their individual interests or access the local community had not been provided.

Activities and opportunities for social stimulation were provided, but tended to be group based, rather than individual and person centred.

People felt able to raise any issues or concerns and had confidence in the registered manager dealing with any issues brought to their attention. People also had access to information on how to make formal complaints if they needed too.

Is the service well-led?

Good

The service was well led.

The registered manager was well thought of by people using the service, relatives and staff. The service appeared to have a friendly and open culture.

The new registered provider was in the process of implementing new management and paperwork systems and was investing in the service.

Quality monitoring systems were in place and included asking for feedback from people who used the service, their relatives and staff.

The service worked with outside agencies, such as the Local Authority and Clinical Commissioning Groups, to monitor and improve the quality of the service.

The Poplars Care Home

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 checked 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.

We carried our inspection on 04 & 14 August 2015 and it was unannounced. This meant that the registered manager and staff did not know that we would be visiting on the first day of the inspection. They did know that we were returning on the second day of the inspection, so that we could be sure that the registered manager and specific information we needed would be available. The inspection team consisted of two adult social care 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.

Before the inspection we reviewed all of the information we held about the service. This included looking at the information we held relating to the service's recent registration process. We asked the local authority (LA) commissioning team and clinical commissioning group (CCG) for feedback about the service. We also looked for any notifications we had received from the service. Notifications are information about changes, events or incidents that the provider is legally obliged to send us within the required timescale.

The registered provider completed a provider information return (PIR) and returned it to us within the expected timescales. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR had been completed well and provided lots of information about the service.

At the time of our inspection visit the service was occupied by 37 people who received residential and nursing care and support. The inspection team spent time talking to 11 of the people who used the service and 5 relatives. We spoke with two members of the local church who visited regularly to give people holy communion and the foot health practitioner who visited regularly to carry out foot care. During the visit, we also spoke with 9 staff members, including kitchen staff, maintenance staff, care staff, a senior carer, staff nurse and the registered manager.

We did a Short Observational Framework for Inspection (SOFI) during this inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also used general observations of people's care and support throughout our visit, including observing the lunch time meal. The inspection team spent time in the communal areas of the home throughout our visit, and with the permission of individuals we looked in a sample of bedrooms.

During the inspection we reviewed a range of records. This included 5 people's care records, including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

Requires improvement

Is the service safe?

Our findings

We looked at the arrangements that were in place to ensure that staff were recruited safely and people were protected from unsuitable staff. We also checked the recruitment records for four newly employed staff. These showed that staff had been through a recruitment process which included completing an application form, attending an interview, and obtaining written references and a Disclosure and Barring Service check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. However, we found that the service was not obtaining all of the required information before staff commenced employment. For example, one staff member did not have a photograph on their records. Three staff did not have a full employment history or explanation of employment gaps on their records. Three staff had commenced employment before the service had received their references, which provided information about their past employment and conduct. For two members of nursing staff a check of their professional registration with the Nursing and Midwifery Council (NMC) had not been carried out before they commenced employment. This is important because the NMC are the professional regulatory body for nurses and maintain a register of nurses and midwives allowed to practise in the UK, including any restrictions that have been placed on an individual's practice. **These findings evidenced a breach of Regulation 19 (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

We looked at the arrangements that were in place to ensure the safe management, storage and administration of medicines. The service used a blister pack system, supplied by a local pharmacy company. We spoke with the nurse and senior carer who were administering people's medicines on the day of our inspection. Both staff told us that staff who administered medicines at the service had received training and had their competency checked on an annual basis. They were also able to describe how they administered medicines safely and answer queries about people's individual medication needs when asked. For example, how they knew if one person needed pain relief and how they ensured that another person received their medicine in line with its very specific administration instructions.

We looked at the storage arrangements for medicines. Secure storage for medicines was available, including arrangements for the secure storage of controlled drugs. The medicines storage fridge and room temperatures were monitored and recorded daily. However, we saw that the room temperature where medicines were stored was regularly recorded as between 25 and 27 degrees Celsius. This meant there was a risk that medicines could be stored at temperatures outside of the manufacturers safe recommended ranges.

We looked at a sample of three people's medicine administration records (MARs). Each person's medicine MAR included a photograph and important information, such as the person's name, allergies and doctor. The records were up to date and overall showed that medicines had been administered in accordance with people's prescriptions. Some people at the home were prescribed medicines on an 'as required' (PRN) basis. Information was available in the medicine records we looked at to guide staff on what the PRN medicines were for and how decisions about their use should be made. However, we found that some aspects of recording related to medicines and the MARS could be improved. For example, the quantities of medicines received or carried over from one monthly cycle to the next were not being recorded on the MAR, meaning that a full audit of stock against the MARs was not possible. However, the registered manager did let us know that a separate check of stock was undertaken weekly and recorded in a separate book, although this was not shown to the inspectors during their visit. Body maps were being used to record the application and removal of pain relief patches, but staff were not recording information on the forms correctly. This mean that the recorded information was inaccurate and confusing. We also found that one person was prescribed a medicine to be taken on a 12 hourly basis. The administration records did not include the times the medication had been given. When we asked staff how they ensured that the medicine was given every 12 hours we were told that the medicine was given each morning and at bedtime [which would be "about right"], but that there was no formal monitoring to ensure

Is the service safe?

that the prescribed frequency was adhered to. **These findings evidenced a breach of Regulation 12 (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

We looked at the arrangements that were in place to ensure safe staffing levels. Feedback from people who used the service and relatives was that staff were good, worked hard and did their best to meet people's needs, but that sometimes people didn't feel there were enough staff available. For example, comments made to us included "The staff have to work really hard," and "The staff are always rushed off their feet, there are never enough of them on duty." In addition two people who used the service said that very occasionally in the past they had known only one carer to be available to use the hoist when assisting them with manual handling tasks. This is not safe practice and puts both staff and people who use the service at risk of harm. During our inspection visits we saw that staff provided good levels of basic care to people, but we also received feedback from people about a lack of staff time to enable more individual care and attention. For example, to enable people to go out when they wanted or access meaningful individual activities. We also saw during our visits that people sometimes spent long periods of time in communal areas without a staff presence.

During our inspection we spoke with the manager at length about staffing levels and the dependency tool the service used to assess what staffing levels were necessary. The manager and staff we spoke with told us that staffing levels had recently been increased, to allow one extra member of staff on duty, who "floated" between floors and provided assistance where most needed. This was reported to have been very beneficial and to have made a big difference to staffing within the service. However, when we looked at the staffing hours indicated as needed by the dependency tool and the staffing provided according to the rota and manager's descriptions we found that there was some confusion and lack of clarity. For example, some people using the service were duplicated on the dependency tool meaning that its calculations were not a true reflection of the staffing needs of the service. We also found that the staffing hours provided did not equate to those indicated as needed by the dependency tool [although if the dependency tool calculations had been corrected they would have been closer to the staffing hours actually provided]. Overall, we could not establish if the tools being used to determine staffing levels or the staffing levels provided adequately reflected the needs of the people using the service. **We recommend that the registered person reviews and monitors this to ensure that robust systems for determining and providing appropriate staffing levels are in place.**

The people who used the service told us that they felt happy and safe at the service. The relatives and visitors we spoke with also felt that people were safe and received good care. For example, one visitor told us "I am happy to visit and work here. There are no issues and no concerns." We looked at the arrangements that were in place for safeguarding vulnerable adults. This included the arrangements for managing allegations or suspicions of abuse and managing concerns raised by staff. During our visit we saw that whistleblowing information [encouraging staff to tell someone if they had concerns] was displayed in the reception area, including a confidential telephone number for staff to call if they needed to raise concerns outside of the service. Staff told us that they had been trained to identify and respond to suspicions or allegations of abuse and the training records we saw confirmed this. The staff we spoke with were able to describe the different types of abuse and how they would report any concerns. Staff said they would feel comfortable raising safeguarding or whistle blowing concerns with the manager. Staff also felt confident that any concerns would be handled appropriately. We had received a recent notification from the service regarding an incident that had been referred to the local safeguarding team. This showed that staff had recognised signs of possible abuse and had taken appropriate action to ensure that the concerns were reported to the local safeguarding authority and investigated appropriately.

We looked at the arrangements that were in place for risk assessment and safety. We saw records of a health and safety audit that was completed every six months. These audits included an action plan with dates for any identified improvements. On 27 February 2014 the home had received a visit from an environmental health officer and was awarded a 5 star rating (the best rating available) for food hygiene. A fire risk assessment had been completed by an appropriately experienced and qualified consultant in May 2015 and three fire drills had taken place during May and June 2015, to help ensure that staff knew what to do in the event of a fire.

Requires improvement

Is the service safe?

The service had considered emergency events and had made plans to ensure the safety of people who used the service if an emergency arose. For example, we were shown the 'Emergency Contingency Plan' and saw that relevant information and contact details were available to help staff deal with emergency events. We also saw that personal emergency evacuation information was in place for the people who used the service.

The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering each individual person's care. For example, risk assessment were in place to help identify individual risk factors, such as safe manual handling, falls, nutrition, maintaining skin integrity, medicines and mental wellbeing. These had been reviewed regularly to identify any changes or new risks. This helped to provide staff with information on how to manage risks and provide people's care safely.

We looked at the arrangements that were in place to ensure the safety of the premises. This included looking at the home's maintenance records and observing the premises during our visit. The home's fire equipment, electrical and gas installations, and manual handling equipment had all been serviced and inspected appropriately. Regular tests of the emergency lighting and fire equipment, water temperatures, window restrictors, the flushing of water outlets and checks of other equipment [such as bedrails and the nurse call system] were recorded by the services maintenance personnel. This showed that routine servicing and inspection of the home's premises and equipment was taking place to help maintain people's safety.

We looked at the arrangements that were in place for managing accidents and incidents and preventing the unnecessary risk of reoccurrence. Records were available to show that the manager was monitoring accidents and incidents. This included a monthly review and audit looking at the causes, volumes, severity and any remedial actions taken or still needed.

Requires improvement

Is the service effective?

Our findings

We looked at the arrangements that were in place to ensure that staff had the training and skills they needed to do their jobs and care for people effectively. We looked at staff training records and discussed staff training with the registered manager. We had some difficulties accessing up to date staff training records, due to the recent change over of IT systems at the service which had corrupted the training spreadsheet. The information available showed that there were gaps in staff training and that staff had not completed all of the training and updates that were relevant to their jobs. For example, according to the training spreadsheet only 50% of kitchen staff had completed food hygiene training, 61.4% of staff had infection control training, 84.1%were up to date with moving and handling and 50% up to date with safeguarding training. We also found that the information contained in the training spreadsheet was not always accurate. For example, when we tracked individual staff safeguarding training records for current staff we found that only 26% of staff had completed this training within the last 12 months, but the staff training spreadsheet suggested that 50% of staff were appropriately trained. Overall the training record did not provide the manager with a clear and up to date picture of the training their staff team had completed or what was needed. **These findings evidenced a breach of Regulation 18 (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

People who used the service told us that the staff had sufficient general skills to look after them properly. One person said "The way the girls look after you is absolutely marvellous". Another person told us said, "The staff here are all good and some are brilliant."

We looked at the arrangements that were in place to ensure that staff were adequately supported, through effective support, supervision and appraisal systems. Staff we spoke with told us that they felt well supported by the manager and wider staff team. Staff also told us that they received formal support through appraisals, one-to-one meetings and staff meetings. We looked at the supervision and appraisal records for four staff. We saw that staff had received appraisals and supervisions. A wall chart was also available in the office to show when staff had received formal supervision and to help the manager plan and organise supervisions. Records were also available of regular staff meetings and the discussions that had taken place.

We looked to see if appropriate arrangements were in place to ensure that people's legal rights were protected by implementation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA sets out what must be done to make sure the rights of people who need support to make decisions are protected. The DoLS is part of the MCA and aims to ensure people in care homes are looked after in a way that does not inappropriately restrict their freedom, unless it is in their best interests. The Care Quality Commission is also required by law to monitor and use the Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. At the time of our visit 5 people living at the home were subject to a DoLS authorisation.

We saw that information about the MCA and DoLS was available at The Poplars. This included an easy read guide to DoLS on display in reception. Training records showed that MCA training had been provided to 35 staff during 2015. The staff we spoke with demonstrated a good understanding of the principles of the MCA and DoLS and were able to tell us how this related to their work with people living at The Poplars. For example, staff had recently identified that one person living at the home had fluctuating capacity and that they may need to be deprived of their liberty to keep them safe. A DoLS authorisation had been sought and health and social care professionals were visiting the home on the day of our inspection, to complete the necessary DoLS assessments. This showed that staff understood their responsibilities and were implementing the MCA and DoLS appropriately. The care records we looked at included information relevant to MCA and DoLS. For example, a DoLS and best interest's checklist were included in people's care records, as well as information about any DoLS authorisations that were in place. However, we saw that the DoLS checklist format that was in use was dated 2011and had not been updated to reflect current best practice or legal judgements. **We recommend that the registered person takes action to ensure that the assessment and checklist tools in use for the MCA and DoLS are up to date and reflect current best practice and legal judgements.**

Requires improvement

Is the service effective?

We looked at the arrangements that were in place to ensure that people received a balanced diet and received the help they needed with eating and drinking. People we spoke with told us that they were provided with regular meals and drinks and did not go hungry or thirsty. Most of the people we spoke with felt that the food provided was good. For example, one person commented "Good food here." Although one person commented "The quality of the ingredients has deteriorated over the last few months." Another person said, "The catering manager is lovely, he is one of the ones that will always find time to have a word with you." Two people told us how they had been taken out to lunch by carer staff, but indicated that this was done by staff volunteers rather than as a routine and formal activity.

We saw that people living at The Poplars were provided with three cooked meals each day, plus regular hot drinks and snacks. The menus showed a choice of main course at lunchtime and a light hot meal [such as scrambled eggs on toast] and/or sandwiches at tea-time. During our visits we observed a lunchtime meal and the Expert by Experience ate with people who used the service, sampling the food. The atmosphere during lunchtime was relaxed and unhurried, with nicely set tables and gentle background music playing. The meal served in the dining room on the day of the visit was simply presented and hot. The vegetables were fine but the expert by experience found that the main course of chicken casserole was mainly thickened gravy with a few very thin strands of chicken floating in it. There was a filling lemon sponge and custard for desert, although we observed that no alternative was offered. Drink refills were offered throughout the meal. We saw staff providing people with assistance with their meals if needed, both in people's rooms and the main dining area.

People's care plans contained assessments of nutritional needs and information about people's dietary preferences. The records showed that people's risk of poor nutrition, dehydration and weight was being monitored. Staff were aware of people's different nutritional needs and how these were catered for. For example, the catering manager told us, "All our desserts are suitable for diabetics; we always use sweeteners rather than sugar. We provide soft or pureed food and some residents get fortified drinks if we think there is a weight problem. All the residents are weighed monthly and the ones we are concerned about get weighed weekly." Where there was concern about people's nutritional or fluid intake staff were monitoring and recording people's intake and where appropriate other professionals, such as the dietician, had been involved in people's care. People's records included a dehydration risk assessment and a calculation of what their minimum daily fluid intake should be. However, we found that the fluid intake monitoring records did not always evidence that people's assessed minimum daily fluid intake were being met, although they did show that people were receiving regular fluid intake. Staff showed us how fluid intake totals were discussed at staff handovers to help ensure people received an adequate, safe fluid intake, but there was no cross-reference between people's actual intake and their individual daily intake assessment to ensure that this had been provided. **We recommend that the registered provider reviews how people's fluid intake is monitored, to ensure that their assessed minimum intake is actually being provided.**

We looked at the arrangements that were in place to ensure that people were able to maintain their health, including access to specialist health and social care practitioners when needed. People we spoke with told us that home did ensure medical help was summoned when required. For example, community nurses supported some residents and a chiropodist visited the home regularly [including on the day of our inspection]. The local doctor visited the home every Wednesday, but could also be called when needed. Staff told us that they knew how to contact other professionals when needed, for example, the district nurses and doctor, and felt that they had good working relationships with other professionals. As part of the inspection we contacted the community nursing team for feedback about their experiences of working with The Poplars. The feedback given was positive, stating that the service worked well with the community nursing team, involving them appropriately and following their advice.

We looked at the arrangements that were in place to ensure that the design and adaptation of the service's premises met the needs of the people receiving care. During our visit we saw that some refurbishment and decoration work had been completed recently. For example, new carpet, chairs and curtains were evident in the lounge, which had been redecorated recently. Some rooms were in the process of having flooring changed from carpet to laminate flooring to provide an easy clean and non-slip surface. We saw that the environment was clean and clear of clutter and that shower and bathing facilities were easily accessible. However, we also saw that some

Requires improvement

Is the service effective?

areas of the home would benefit from renewal and redecoration. For example, we noticed that the carpet and paintwork in the dining room corridors were marked and in need of attention. We also saw that while the majority of people's rooms were personalised and homely, this was not the case for one person who had no family support.

Their room looked bare and stark in comparison with others. We discussed this with the manager, so that they could ensure that people without family support were still enabled to make their rooms homely and personalised spaces.

Good

Is the service caring?

Our findings

We looked at the arrangements in place to ensure that the approach of staff was caring and appropriate to the needs of the people using the service. People who lived at the service told us that they felt cared about, as well as cared for. For example, one person told us "I can get washed and dressed independently, but they still come and stand near to make sure I don't fall." Other comments made to us by people using the service included "No-one orders me around, but they come in regularly to ask if I am all right" and "The staff are all very helpful." One person who used oxygen told us how staff took special care of them, by carrying out regular checks during the night, "The staff come in regularly throughout the night, perhaps every 15 minutes, to make sure my oxygen is running properly."

The relatives we spoke with were also complimentary about the care people received and how people were treated. For example, one relative told us "My mother is receiving wonderful care. Everyone checks on her regularly and the young lad will always find time for a little chat with her." Another regular visitor to the home told us "The staff are good; really seem to know the people and care."

Our observations showed that staff cared for the people living at the service and worked to uphold people's privacy and dignity. For example, we saw that staff spoke with people in a caring and friendly way as they went about their duties and used "Care in Progress" signs on doors to help protect people's privacy and dignity. Staff we spoke with were able to describe how they protected people's privacy and dignity. For example, by knocking on doors before entering and ensuring that personal care was carried out in private and done in a way that made people feel comfortable.

The service had named staff who were designated 'champions' for particular areas of care. For example, a dementia champion, dignity champion and end of life care coordinator. These staff had a particular responsibility for raising staff awareness and promoting good practice in these areas.

We looked at the arrangements in place to support people in maintaining relationships. Visitors told us that they were made welcome to the home and that staff were helpful and friendly. There was a notice in reception letting people know that there were tea and coffee making facilities available for friends and family upstairs. The only restrictions on visiting were around 'protected meal times.' Protected meal times are a scheme which allows people to eat their meals without disruption and enables staff to focus on providing assistance to those people unable to eat independently.

We looked at the arrangements in place to ensure that people were involved in decisions about their day to day lives. We also looked at how the service provided people with appropriate information, explanations and advocacy to enable their involvement and to maintain independence. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them, such as their personal care choices. Staff we spoke with were able to describe how they involved people in decisions about their day to day lives. For example, by asking people what they would like, giving people choices and helping people to pick their own clothes. One staff member commented that they always tried to, "Treat people as I would like to be treated."

During our visits we looked at the care provided to one person who was living with a dementia. In their care plans it stated that the person had a dementia, but also that they had capacity to make their own decisions and choices. The person had agreed and consented to all their care plans, which clearly stated that staff were to provide full choice and information to enable the person to make their own decisions. The care plans also stated how to support them when they got lost within the home and forgot their way back to their room. We saw that it was a very empowering plan of care which helped to promote the person's independence and choice.

One person whose records we looked at lacked capacity to make their own decisions about their care and welfare. When we looked at their care records we saw that the person's care plans had all been signed by the service's nurses and managers. This included best interest decisions that had been made. The records contained no evidence of the involvement of family, external professionals or advocacy in the person's care planning or decision making. When we asked staff about this they confirmed that the person had no family or advocacy support. We discussed with the manager the need to ensure that people received appropriate independent support and advocacy where they had no one to represent their own individual interests.

Requires improvement

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure that people received person-centred care that had been appropriately assessed, planned and reviewed. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the individual person. During our visits we looked at the care plans and assessment records for five people. The care plans and assessments we looked at contained details about people's individual needs and preferences, including person centred information that was individual and detailed. Care plans and assessments had been reviewed regularly and provided good information about people's needs. However, one of the records we looked at was for a person who had only been living at the service for a few weeks. Their pre-admission assessment contained really good and detailed information about the person, their needs and preferences, but some of this information had not always been transferred into their care plans. In addition some of this person's care plans had not yet been completed, including plans for health and medication. We pointed this out to the manager during our visit, so that action could be taken.

The relatives of one person who lived at the service told us that they had attended a care review meeting for their relative, but most of the people we spoke with were unaware of how their care was planned or if reviews took place.

We looked at the arrangements in place to help people take part in activities, maintain their interests, encourage participation in the local community and prevent social isolation. The staff were working hard to provide a safe and friendly home and to provide adequate care for people. However, we received feedback suggesting that staff sometimes struggled to respond to the more specific and individual health and social needs of people living at the service. One person said, "What I miss most is the walking. If I use my frame there is no-one available to carry the oxygen so I stay in my room all day." Another person told us, "I can do my leg stretching exercises alone, but no-one here can help me do my standing exercises so I'm making very little progress" and "I have to stay in this wheelchair all day as I do not have a suitable easy chair to sit in." Another person who used to be a keen walker told us "The door is locked and I just have to walk up and down these corridors every day."

At the time of our visit the Activity Co-ordinator was on holiday so activities were not taking place as usual. The registered manager told us that the activities coordinator usually worked during the afternoons, Monday to Thursdays. Information about activities was displayed in the reception area, but apart from this there did not seem to be any notices or information available for people living in the home about activities. One person told us about various activities they participated in, saying "There are up to seven of us who join in activities." Another person told us that before moving into the service they played Bingo four times a week. When asked if they enjoyed bingo in the home they said, "I did not know they played it here." Another person said, "I like puzzle books and reading," but we saw that the lounges were very tidy with no evidence of papers, magazines, jigsaw puzzles or games that might stimulate or engage people.

We looked at the activities records that were kept to show what activities people had taken part in. This showed that some people regularly took part in group activities, but that others were recorded as regularly watching TV in their room, resting/sleeping in their room. Overall the service provided regular activities for those who were able or wished to joint in with group activities during the afternoon on Monday to Thursdays. However, there was a lack of evidence that individual, person centred activities were provided for people who either did not wish or were unable to join in group activities or for those who were more difficult to engage.

During our visit to people were visiting from the local church to enable people to take part in holy Communion. They told us that they visited weekly. Some people who used the service were taken out by family or friends, and some people told us how staff had volunteered to take some people out to the pub, which had been really enjoyed by those who went. However, most of the people we spoke with told us that they were confined to the home and there was no regular organisation in place to take the people out either locally or on trips. One resident said, "I would love someone to take me out occasionally, even just for a walk up the road." Another said, "I have one friend whose car is big enough to get my wheelchair in and for me to get in or

Requires improvement

Is the service responsive?

out of, otherwise I am confined to this room." Another person said "I don't go out of my room much, only when my son visits and can take me out." The home is situated in a busy community with shops, pubs and a park within wheelchair pushing distance but local facilities were not being utilised or local community groups accessed. **We recommend that the service considers how activities and opportunities for maintaining interests and community participation can be developed and provided in a more individual, person centred way.**

We looked at the arrangements in place to manage complaints and concerns that were brought to the service's attention. Information about the service's complaints procedure was displayed clearly in the service's reception area. This included information about how people could raise complaints and how they would be dealt with. It also included contact details and information about the role of the local authority, local government ombudsman and CQC, in case people needed to escalate their complaint outside of the service. The service kept a record of complaints and the actions taken. A complaint had recently been received and when asked about this the registered manager was able to explain how they were meeting with the complainant to discuss the complaint and resolve the issues. There were also 'ideas' and 'concerns' books in reception, so that people could make suggestions and raise minor concerns. The manager had written responses in the books, letting people know what had been done about the issues they had raised. Overall we found that complaints and concerns were taken seriously and responded to by the service.

Good

Is the service well-led?

Our findings

We looked at the arrangements in place for the management and leadership of the service. Since our last inspection the registered provider of The Poplars has changed. The registered provider for the service is now The Poplars (Thornaby) Limited, part of the Astonbrook Care Limited brand. At the time of our inspection visit, the home had a registered manager in place who had worked at the home for a long time. A registered manager is a person who has registered with CQC to manage the service. During the inspection we received feedback from people who used the service, visitors and staff that the registered manager was approachable and that people felt able to go to them to discuss issues or concerns.

Discussions with staff and observations made during our visits showed that the staff team worked well together and there were many very long standing members of staff. Several of the service's bank staff had started as volunteers while at college and continued to do part time and relief work while at university. One said, "I started here to gain experience for my CV, but as I enjoy working here so much I have continued and become a regular member of staff. The staff and the residents are great." Another staff member we spoke with referred to the staff team being like a "family." A visiting health professional who visited the home regularly told us that the service was a "friendly place" and that from their perspective everything was well organised. Staff let them know if there were any issues they needed to deal with and that the manager and all staff were "really approachable." Overall, the service appeared to have a friendly and open culture with people feeling safe and comfortable with the staff and management.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The manager confirmed that the new owner was investing in the service and that any requests for equipment or works needed were responded to promptly.

We saw records of regular audits and checks that were taking place. For example, care plan documentation and daily chart audits were completed monthly. Other regular audits included infection control, dignity, medicines, meals and nutrition, maintenance and health and safety. The records we saw included action plans and dates, to help ensure that any necessary improvements were made. The manager also completed a monthly quality report, which included a review of quality indicators and an explanation of what was being done about any identified concerns and risk areas. For example, reviews of people's weight and BMI, and the occurrence of infections and pressure sores.

Feedback from people who used the service had been obtained during a survey completed in October 2014. We saw that the individual survey results had been reviewed by the manager and that any issues raised by the surveys had been followed up by the manager and recorded. In the reception areas there was a notice advertising the next resident's meeting and a notice advising people of the actions that had been taken in response to the issues raised during the last meeting. Records showed that monthly 'we matter' meetings were held with people who used the service and included the discussion of things like safeguarding, complaints, food, activities and following up matters that had been raised at previous meetings.

During our inspection we viewed a number of the registered provider's policies and procedures. These were generally up to date and had been reviewed and updated. However, we did find some examples where further review and updates would be beneficial. For example, the service provided us with a copy of their adult safeguarding policy, which had been reviewed in April 2015. The policy appropriately set out the service's approach to preventing, identifying and reporting abuse. However, the policy still referred to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and associated outcomes and had not been updated to reflect the new 2014 Regulations and associated guidance which came into force in April 2015.

We looked at the standard of records kept by the service. Overall the majority of records we viewed at the service were up to date, accurate and fit for purpose. However, in some areas improvements have been required, recommended or suggested. For example, in relation to staff recruitment and training records, records relating to medicines and the incomplete care plans for one person who had recently come to live at the service. The new registered provider was in the process of implementing their own paperwork systems at the service.

Good

Is the service well-led?

We looked at how the service worked with other agencies, such as the local authority, commissioning groups and other stakeholders. The service had recently had a quality monitoring visit by the local Clinical Commissioning Group (CCG). The CCG shared their report with us and the manager gave us a copy of the action plan that had been drawn up to address the areas for improvement that had been identified. Feedback was also received from the Local Authority. The local authority told us that they had no particular concerns about The Poplars, who had recently taken part in the Local authority's voluntary Quality Services Framework assessment. Feedback to us included, "Their policies were robust and that staff had a good knowledge of their roles and procedures."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The information specified in Schedule 3 of the Health and Social Care Act (Regulated Activities) Regulations 2014 was not available in relation to each person employed for the purposes of carrying on a regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person must ensure the safe and proper management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Persons employed by the service provider in the provision of a regulated activity had not received appropriate training to enable them to carry out the duties they were employed to perform.**