Peninsula Care Homes Limited

Coppelia House

Inspection report

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Ratings

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

Overall summary

Coppelia House is registered to provide accommodation and personal care for up to 30 older people, some of whom are living with dementia. Nursing care is provided by the local community nursing team.

This inspection took place on 16 and 18 November 2015 and was unannounced. There were 30 people living in the home. The home was last inspected on 26 August 2014 when it was identified the regulation in relation to staff employment was not met. At this inspection we found improvements had been made in relation to this.

The home had a newly appointed manager who confirmed they would be applying to be registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Summary of findings

Although people, relatives and healthcare professionals felt the care and support was safe, we found a number of areas requiring improvement. Many of the people living at the home had health care needs or were of frail health. We found risks to people's health, safety and well-being were not fully assessed, recorded or reviewed. For example, one person who had fallen five times since their admission to the home had no risk assessment or care plan in place. Also, recording was not being properly completed for people who were assessed as being at risk of not eating or drinking enough to maintain their health.

People's care needs were not recorded in a personalised way that gave staff clear guidance about how to respond to their individual care needs. Some information about people's abilities was conflicting. People's preferences with regard to care delivery were not properly recorded or respected. At the previous inspection four people did not recall having a care plan or being involved in drawing it up. We found this continued to be the case. There was no evidence people were routinely consulted or involved in developing their care plans. People were not aware of their care plan document.

Staff told us about the people living in the home. They described people's care needs in a way that indicated they understood the risks to individuals and had taken steps to ensure safe care was provided. However, as the home used agency staff to fill shortfalls in staffing levels, failure to have accurate records of people's care needs placed them at risk of not having their needs recognised or met in a safe or consistent manner.

Staff had not followed the home's policy on the safe disposal of medicines.

Staff had not received recent training in, and had a limited understanding of, the Mental Capacity Act and the Deprivation of Liberty Safeguards. Capacity assessments in relation to people's decision about their care and treatment had either not been completed or were not decision-specific. Best interest decisions had not been recorded. An inappropriate application to restrict a person's liberty had been made to the local authority. There was no guidance for staff about how to meet people's psychological or mental health needs. Healthcare professionals told us they had been consulted about people's support needs and they said they had witnessed good practice in relation to how staff acted in a person's best interests. Senior managers from Peninsula Care Home Ltd were undertaking a training course in providing more responsive care and support to people who are living with dementia.

People had access to health services. The home met regularly with the GP and other healthcare professionals to discuss people's care needs. Health professionals told us the home was good at asking for advice and support.

We received a mixed response regarding the quality of the food and the choices provided. Some people said the food was very good, while others said it was not to their liking. People with memory loss were not supported to make choices about the food they wished to eat at the time of the meal, as meals were plated prior to being taken to the table. The business manager gave assurances people's views would be sought and menus changed in response.

The majority of people who were able to share their experiences with us spoke highly of the care they received. A small number of people said not all staff were as kind as others, and described some staff as being abrupt. During our inspection we did hear one staff member use language to describe people that was not respectful. We also saw evidence of good practice with staff taking time to sit with people, hold their hands and engage them in conversation or an activity. Staff were kind and patient. Health care professionals told us the home provided compassionate care.

The home employed an activity co-ordinator who arranged and undertook group and individual social activities. People told us they had enjoyed music sessions, quizzes and craft work. However, activities were focused on the activities room and the lounge area and there was little evidence of activities for people who found it difficult to engage or preferred to remain in their room through choice or health reasons.

At the previous inspection in August 2014, we found improvements were required in how staff were recruited. At this inspection we found recruitment practices were safe. There were sufficient staff on duty to meet people's care needs; however, at times staffing was insufficient to ensure people had the opportunity to engage in social and leisure activities.

Although the manager of the home was newly appointed, they had worked at the home for many years and knew

Summary of findings

people well. People and their relatives expressed a high level of confidence in the newly appointed manager. Health and social care professionals were confident in the manager's ability to lead the home and work in partnership. Communication between the home and relatives and healthcare professionals was described as very good.

The home used a wide range of quality assurance processes which had recognised some of the concerns identified through the inspection, but not all. Where complaints had been made, these had been addressed promptly and effectively in line with the home's policy. Senior managers were involved in community initiatives to share good practice and improve the services provided by the home.

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

Some aspects of the home were not safe.

Risks to people's health, safety and well-being were not fully assessed, recorded or reviewed. Staff had failed to follow the home's policy on the safe disposal of medicines.

People told us they felt safe living at the Coppelia House. Care was delivered in a way that indicated staff understood the risks to individuals and had taken steps to ensure safe care was provided.

Staff knew their responsibilities to safeguard vulnerable people and to report

abuse. Staff recruitment practices were safe.

There were sufficient staff on duty to meet people's care needs. However, there was not always enough time to sit down and have a chat with people or engage them in activities.

Is the service effective?

Requires improvement

Some aspects of the home were not effective.

Capacity assessments in relation to people's decision about their care and treatment had either not been completed or were not decision-specific. Best interest decisions had not been recorded.

Staff had not received training in, and had a limited understanding of the Mental Capacity Act and the Deprivation of Liberties Safeguards.

We received a mixed response regarding the quality of the food and the choice provided and manager was responding to this. People with memory loss were not supported to make choices about the food they wished to eat at the time of the meal.

Is the service caring?

Requires improvement

Some aspects of the home were not caring.

People were not routinely consulted or involved in developing their care plans.

The majority of people who were able to share their experiences with us spoke highly of the care they received. A small number of people said not all staff were as kind as others, and described some staff as being abrupt. We followed up these individual concerns with the business manager.

We saw staff to be kind and patient. The home provided compassionate care.

People and their relatives said the home was part of the local community.

Summary of findings

Is the service responsive?

Requires improvement

Some aspects of the home were not responsive.

People's care needs were not recorded in a personalised way. Some information about people's abilities was conflicting. There was no guidance for staff about how to meet people's psychological or mental health needs.

People at risk from social isolation did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing.

Health professionals told us the home was good at asking for advice and support. They had seen skilled care of people living with dementia.

Where complaints had been made, these had been addressed promptly and effectively in line with the home's policy.

Is the service well-led?

Requires improvement

Some aspects of the home were not well-led.

The home used a wide range of quality assurance processes which had recognised some of the concerns identified through the inspection, but not all.

People and relatives expressed a high level of confidence in the newly appointed manager.

Health and social care professionals were confident in the manager's ability to lead the home and work in partnership.

Communication between the home and relatives and healthcare professionals was good.

Senior managers were involved in community initiatives to share good practice and improve the services provided by the home.

Coppelia House

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 was 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 16 and 18 November 2015 and the first day was unannounced. Two social care inspectors undertook the inspection. Before the inspection we reviewed information we held about the service. This included previous contact about the home and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spoke with 13 people who lived at the home; five care staff, some of whom worked for an agency, as well as staff responsible for catering, laundry and maintenance. The manager was not present, but we spoke with the company's business manager, who was a senior manager involved in supporting all of the care homes in the Peninsular Care Homes group. We received an email from one relative and spoke with six other relatives over the two days of the inspection. We also spoke with three health care professionals who had regular contact with the home.

We looked around the premises, spent time with people in the communal areas and observed how staff interacted with people throughout the day, including during lunch. Some of these people, due to their complex care needs, were not able to tell us about their experiences of the home. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not comment directly on the care they experienced. We looked at six sets of records related to people's individual care needs; four staff recruitment files; staff training, supervision and appraisal records and those related to the management of the home, including quality audits. We also looked at the way the home managed people's medicines.

Requires improvement

Is the service safe?

Our findings

People said they felt safe. However, we found that improvements were needed to how risks to people's health and welfare were identified and managed, and how medicines were disposed of.

Staff understood there were risks associated with some people's care needs. They described how they managed these risks, and the actions they described were appropriate. Equipment was used as necessary when risks were identified in relation to people's moving and handling needs. However, records were incomplete. They did not contain the actions described by staff, and were not always reviewed as people's needs changed. For example, one person had fallen five times. A risk assessment had not been recorded and there was no written plan as to how this risk was to be managed.

We identified further risks to people's health and well-being when we looked at how people were supported to eat and drink. We found recording was not being properly completed for people who were assessed as being at nutritional risk. We saw from one person's care file their risk of not eating enough to maintain their health was "high". Records showed they had lost weight steadily since admission. Staff had been asked to weigh this person each week, however there were no weights recorded between 18 July and 29 October 2015. There were several days when the person's food intake had not been recorded. There was also no recorded evidence that medical advice had been sought or diet supplements considered. However, when we discussed this with the business manager and staff, they confirmed this person's nutritional needs were well known to staff and had been regularly discussed with the GP, but this had not been recorded. The failure to keep accurate records in relation to nutritional needs meant staff might not be alerted when people had not had adequate nutrition.

There were systems in place for recording individual incidents and accidents. These were individually recorded within a central file and specialists, such as GP's were contacted, which is good practice. The manager submitted a monthly record to their head office which showed the number and type of accidents within the home. We saw notifications had been made where necessary to the CQC during the last 12 months, for instance in relation to falls that had led to an injury. However, there was no evidence these records were used to review and update people's risk assessments or care plans to show how the risk was to be managed or mitigated.

Not all aspects of medicines management were safe. We found several pots full of mixed loose tablets in one of the medicine storage cabinets. We were told these were tablets that had been refused by people and were awaiting monthly return to the pharmacy. Refusals had been recorded on the individual medicine administration record (MAR) but there were no central records identifying what the tablets were, who had refused them and when they had been refused. This meant there was no record of the medicine for disposal of refused or unused medicine. The process for disposal of medicine was clear within the home's Medicine Policy but the process was not being followed by staff.

All medication apart from refrigerated medicines were stored safely and securely. The medicine fridge was accessible through an unlocked room which was also used as a hair salon. The fridge was unlocked, although it had the facility to be locked. This meant that the medicine stored within the fridge was accessible to anyone and could potentially be tampered with or taken.

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

The manager or senior carers on duty administered medicines and staff said they felt confident and competent to do this and received regular training through the pharmacy. Medicines were given as prescribed by the GP. The home completed regular audits to check that records had been accurately completed and that medicines received in to the home and administered could be accounted for. However, this had not picked up the issues identified during the inspection.

People told us they felt safe living at the home. One person said "yes, very safe" and another said "very much so" when asked if they felt safe living at Coppelia House. For people who were not able to tell us, we observed how staff interacted with them. We saw people smiling and taking hold of staff's hands when talking to them, indicating they felt safe in the staff's company. Relatives confirmed they were confident their relation received safe care and support. One relative said, "yes, very safe, I have no worries."

Requires improvement

Is the service safe?

At the time of our inspection, there were six care staff and additional housekeeping, laundry and catering staff as well as an administrator on duty. The majority of people we spoke with who were able to share their views told us there were sufficient staff to meet their needs. This view was shared by relatives. Comments included, "yes, the staff are very attentive", "I'm well cared for" and "I couldn't be better looked after." One person felt they had to wait a long time for staff to respond if they rang for assistance. Staff told us there were enough care staff on duty to meet people's care needs, as long as they did not have to undertake catering or laundry duties. They said on three days a week they had to undertake laundry duties and at other times support the cook if a second person was not working in the kitchen. This meant there were times when people's basic care needs were met, but there was not enough time to sit down and have a chat with people or engage them in activities. Also, there were times when staffing levels resulted in some people's movement around the home being restricted. For example, people who were at risk of falling remained in their rooms rather than being able to spend time in the lounge room as staff said they were not always able to remain sitting with them to reduce their risk of falling.

The registered provider told us they reviewed the staff requirements with the manager. Any shortfalls in staffing levels were covered by staff working extra shifts or the use of agency staff. We heard the provider tried to get agency staff who were familiar with the home and knew the people living there. We spoke with three agency staff who said they were well supported by the home's staff. They said they were working alongside the home's usual staff and felt people's care needs were being met very well. They said staff were unhurried when assisting people with their personal care. We observed this was the case; staff were busy but maintained a friendly and supportive approach and no one was made to rush.

At the last inspection we found there was the potential to place the welfare of vulnerable people at risk due to recruitment practices that were not robust. At this inspection we found improvements had been made to these practices. We looked at a sample of four recruitment records for staff and saw the risks of recruiting unsuitable staff were now reduced because there were effective recruitment and selection processes in place for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults and not allowing staff to start work until satisfactory checks and references had been obtained.

We looked at home's safeguarding of vulnerable adults policy and safeguarding records and talked with the company's business manager. We saw two safeguarding concerns had been raised in the past 12 months. Records showed appropriate action had been taken in response to each incident, including safeguarding alerts being made to the local authority. Outcomes had been recorded and CQC had been notified. This showed staff were competent and the registered provider knew when to make safeguarding alerts. They understood their responsibility to safeguard people and work alongside other professionals, such as the Local Authority Safeguarding Team. Staff confirmed they had received safeguarding training and were knowledgeable about how to recognise signs of abuse. They knew who they should contact to make a safeguarding alert, either within the company or via an external agency. Staff spoken with also demonstrated an awareness of how to whistle blow should the need arise. However, there had been no whistle-blowing concerns raised through the CQC in the past 12 months.

Equipment was maintained in safe working order and weekly checks had been carried out in relation to the safety of fire. A member of staff responsible for maintenance was on site during the inspection and they confirmed they undertook repairs and redecoration as needed. Records supported this. There was also a plumber and team of builders on call to the company to be able to respond to any environmental issues promptly.

Each person had a personal evacuation plan in case they needed to vacate the home in an emergency. The home also had a crisis plan for ensuring people continued to receive care and support if the home had to be vacated for a longer period.

People were kept safe by a clean environment. All areas we visited were clean and tidy. Protective clothing such as gloves and aprons were available to reduce the risk of cross infection and hand gel was available in the communal areas for people and staff to use. There was a plan in place for protecting people in the event of an infection control outbreak and we were told this had worked successfully in quickly bringing under control an outbreak of diarrhoea and vomiting approximately a year ago.

Requires improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005 as a number of people living at the home had conditions that affected their ability to make decisions about their care and treatment, such as dementia.

The MCA 2005 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 decisions 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 2005. This means there are safeguards in place to make sure there is a proper legal process and suitable protection when deprivation of liberty is unavoidable and is in a person's own best interests. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive somebody of their liberty to receive care and treatment.

We looked at the files of four people who we were told lacked mental capacity to make decisions about their care and treatment. In three of these there was no written evidence of capacity assessments being completed or of best interest decisions being made. Where a mental capacity assessment had been completed, this was not decision-specific as required by the MCA 2005, but had been written in a generalised way to cover all aspects of care. Healthcare professionals told us they had not been involved in any formal best interests meetings; however they had been part of other meetings where staff demonstrated good practice in relation to how they acted in a person's best interests to minimise their distress. This demonstrated that staff were acting in people's best interests, but were not following the correct legal process.

Staff did not demonstrate a good understanding of deprivation of liberty. For example, they had made applications to legally deprive some people of their liberty for their own safety. However, they had applied to deprive the liberty of one person who had capacity to make their own decisions. This demonstrated a lack of understanding of the fundamental principles of the MCA and DoLS as the safeguards only apply to people who have been assessed as lacking mental capacity.

Although staff were kind and helpful, they did not all have a good understanding of what mental capacity meant, and how they should legally support people with capacity issues. They could describe how they worked in a way which ensured people were given choices throughout their day. For instance, we also heard staff seeking consent from people by knocking and awaiting acknowledgement before entering people's rooms, or asking them if they would like more lunch or if they would like some help. However, they were less clear about people who may have been assessed as lacking capacity and whether best interests meetings had been held. We saw training in relation to the Mental Capacity Act was not up to date. The business manager told us there had been a decision by the company to move away from DVD training, to face-to-face training, which was believed to be more effective. However, there was no evidence of this having been recently provided for staff and Mental Capacity Act training was not on the training matrix. Staff did not make reference to having had it and there were no certificates in staff files.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed comments about the quality of the meals provided from people living at the service. Some of the positive comments included, "The food is lovely, plenty of it, too much sometimes", "The food is excellent" and "The food is remarkably good." However some people felt the quality of the food could be improved. Their comments included, "it's not very good" and "there's not a lot of choice." Relatives also held mixed views about the quality of the food, and one said the evening meal time was too early for their relation. One relative said their relation was eating better than they had at home and had put on weight since moving into the home. Another said the home did not take into account people's previous food likes and dislikes prior to them developing memory loss. This had resulted in people being offered food they previously had not enjoyed. Records showed that the manager was taking steps to resolve these issues by regularly discussing food preferences at resident meetings. The new cook also told us that they had started meeting individually with people to discuss their food preferences.

Requires improvement

Is the service effective?

We observed the lunchtime meal on both days of the inspection. People told us they enjoyed their meal. One person said, "That was absolutely lovely." Meals were plated prior to being given to people. This meant people could not see the food and were unable to choose what they would like to eat from the selection. Where staff weren't sure what someone would prefer, we heard them asking. Some people required assistance to eat. A staff member sat next to them, told them what they were eating with each mouthful and engaged them in conversation. Other people were provided with adapted plates to enable them to eat independently. People were asked if they wished to have more to eat and the meal trolley was taken to each table to allow people to choose what they would like. We saw people looking at the food and making choices. One person said, "I want that nice crispy roast potato."

Staff told us people chose their meal the day before. There was always a choice of two main meals, and people could request alternatives. We discussed with the business manager how meals were chosen and presented to people, particularly those who have memory loss and may not remember their choice from the day before. They agreed it would be better to allow people to see the meals available and to choose at the time of the meal. They said they would discuss with the manager about implementing this. We saw food and catering were regularly discussed at resident and staff meetings.

The cook showed us a list of people's food preferences and other information relating to their dietary needs, such as whether they had diabetes. Those people who required a softer meal due to swallowing difficulties were also identified. They said they were new to the role and had started to meet people individually to ask them their views and what meals they would like to see on the menu. They and the business manager said they would review each person's preferences in relation to the meals they liked to eat and the times they preferred to have their meals and make changes accordingly.

People told us they saw their GP promptly if they needed to do so and records showed that the GP visited people when staff had raised concerns over their health. People, when necessary, received support from the community nursing service, for example with monitoring their blood glucose levels and administering insulin injections. In addition, each month the business manager or the manager met with the GP's at a "community hub" meeting that discussed people's complex care needs. Other healthcare professionals including community nurses and occupational and physiotherapists were also present. This was an opportunity for the home to discuss people's care needs and to make referrals where necessary for specialist support. A healthcare professional noted this had improved communication with the home and this was a view was shared by staff at the home. They said staff knew people well. Relatives told us they were kept fully informed of any concerns over their relation's health and communication with the home had been excellent since the introduction of an administrator.

People and their relatives told us that staff were skilled and competent to meet people's needs and spoke positively about the care and support provided. One person told us "the staff are very friendly and helpful", another said, I couldn't do better than live here. The staff are very good." Relatives told us that they were confident their relation's care needs were being met. One relative said "Staff are always polite and kind and they have the skills to meet mum's needs, physically and in terms of dementia"

Staff told us they had received training in issues relating to the needs of people in the home. This included caring for people who are living with dementia, nutrition and hydration and the prevention of pressure ulcers. Training had been provided from a variety of sources, including external providers such as NHS Devon. The training records and certificates showed this training had been undertaken this year. Training in supporting people safely with moving and transferring and the use of the hoist had been arranged for 25 November 2015. A staff training matrix identified the training each member of staff had undertaken and when updates were due. We spoke to the business manager who told us the home had started providing care for people with dementia in 2013 and they were committed to increasing their expertise in dementia care. As well as staff receiving dementia care training, the company had joined external organisations who were dementia specialists in order to learn best practice from them.

Newly employed staff members were required to complete an induction programme and were not permitted to work unsupervised until they had completed this training and had been assessed as competent to work alone. They were

Requires improvement

Is the service effective?

also enrolled to undertake the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support.

Records showed staff had received supervision, although some staff had not received this since March 2015. Records indicated staff had been able to discuss issues of concern as well as their training and development needs. Staff told us they found these meeting useful and they felt listened to. Actions to be undertaken following these supervisions were recorded. We saw performance issues were also discussed at these times.

Adaptations had recently been made to the home to provide more suitable facilities for people with increasing mobility needs. A bathroom had been made into a wet room and a bath had been replaced with one fitted with a chair hoist. Some toilet seats had been replaced with dark blue seats to make the toilet more easily seen by people with poor sight.

Requires improvement

Is the service caring?

Our findings

The majority of people who were able to share their experiences with us spoke highly of the care they received. One person said, "I can't say enough kind words about them here", and another "the staff are very friendly and helpful." An email in the compliments book said "The staff are wonderful and better care could not be had anywhere. I wouldn't hesitate to recommend Coppelia House – never too busy to talk and keep me posted as to Mum's condition".

However, two people and one relative said not all staff were as kind as others, and described some staff as being abrupt. During our inspection we observed how staff spoke and interacted with people who were living with memory loss and dementia. We heard one staff member use language to describe people that was not respectful. For example, they referred to people who needed assistance with their meals as "feeders" and people were referred to by their room number, rather than their name. We discussed this with the business manager and they confirmed these concerns had already been raised with the manager and action was underway to address the issue through staff meetings and individual supervision. We saw supervision records reflected this and there was guidance on the wall in the staff office reminding staff of the importance of using appropriate language.

We also saw evidence of good practice with staff taking time to sit with people, hold their hands and engage them in conversation or an activity such as looking at books. They were patient and kind. A health professional told us that the home provided compassionate care. They said "You walk in the front door and get a sense of the contentment of the people that live there."

We asked people and relatives told us how they were involved in making decisions and planning their own care. They told us there were resident meetings where they could discuss any concerns and make suggestions about care at the home, for example, in relation to food. However, they said they were not routinely consulted or involved in developing their care plans. Some people did not know about their care plan document. We discussed this with the business manager who told us staff had now started sitting in communal areas while writing their notes to involve people in what they were doing. However, we saw no evidence in people's records of involvement in the writing and development of their plans. At the last inspection it was noted that four people did not recall having a care plan or being involved in drawing it up and no record of people's involvement was found. This meant people were not routinely consulted about their care needs and how they wished to be supported.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff to tell us about their caring role. They said they treated people as if "they are my own mum or dad" and "you can't help but form a bond with people. I get a lot of satisfaction out of helping people." The agency staff we spoke with said Coppelia House care staff had made them very welcome. They found staff to be kind and patient towards the people they were supporting. We spoke with the business manager about how the home recruited staff with the right attitudes for working in care. We were told adverts always stressed the need for a person's suitability for the role, rather than being focussed on tasks to be completed. They also said face to face interviews were always completed before any references were taken up.

The business manager said the home was part of the local community and people were welcome to call in whenever they wanted. People we spoke with supported this, saying their relatives were free to visit whenever they wanted. Relatives said when they visited they were always welcomed and offered a drink.

Requires improvement

Is the service responsive?

Our findings

We looked at the care records for six people and found people's strengths and areas of risk were not recorded in a personalised way that gave staff clear guidance about how to respond to their individual care needs. People had an assessment of their needs completed prior to moving into the home. This was a tick box assessment which briefly indicated their needs. We saw in one person's record there was no further description of their care needs other than this brief pre-admission assessment. Five of the six people had a further needs assessment in their file which had been completed after their admission. This was in a similar tick box format. For example, with reference to washing, bathing, dressing and using the toilet, one person's assessment had been ticked to indicate they required the assistance of two carers. Their mobility needs were referred to as "two carers and a handling belt" and "prone to falls". There was no further description of this person's needs or preferences. There was no guidance for staff about what the person could do for themselves, the person's preferred manner of support or how they should be assisted in a safe and consistent manner. This meant someone unfamiliar with providing care to the person may not have sufficient information to provide care safely.

One person told us they felt very uncomfortable having a male carer assisting with their intimate personal care and they had made this preference known to staff on several occasions. Despite this, a male agency carer had assisted them on the previous evening. They said the carer had respected their dignity and completed care as sensitively as possible. However they said "I didn't like it at all" and were clearly distressed when explaining what had happened. When we looked at records regarding the person's night time care needs, we saw a box had been ticked stating the person had "no preference" about whether they had male or female care staff. This indicated this person's preferences about an important area of care had not been noted or understood. We discussed this with the business manager who confirmed that this will not happen in the future.

Many of the people living at Coppelia House were living with dementia. We looked at three peoples records in relation to how their psychological or mental health needs were met. We found that staff may not have sufficient information or guidance to provide support people's psychological needs safely. Psychological needs were described very briefly and lacked specific guidance for staff about how the person should be supported when they were distressed. For example, one person's assessed mental health needs were described as "major anxiety" and another's as "feels lonely and miserable." Another said "can be frightened, tearful and lonely, behaviour can become agitated". There was no further information or guidance for staff about how to support the person, address their anxiety and distress or reduce their risk of social isolation. Although there was little written guidance about people's care needs, we were told by health professionals the home was good at asking for advice and support and they had seen skilled care of people living with dementia at the home. They said that staff were "gentle and respectful" and they "treat people with the highest level of positive regard". One person told us that "staff will come and sit and talk with me if I am upset – and I do get upset."

Established staff had the skills and knowledge to provide good care that responded to individual care needs. However, care records did not provide sufficient detail for staff who were unfamiliar with the home or the people living there to be able to support people safely and consistently. Staff told us one person could be reluctant to receive assistance with their personal care or become agitated. We looked at this person's records and saw there was no guidance available to staff about how to respond to this or the actions they must take to reduce risk and provide appropriate support. We spoke with an experienced member of staff who spoke knowledgeably about this person's care needs when offering personal care. For instance, by engaging eye contact, using sign language to complement verbal communication, interpreting body language, and leaving and returning at a time when the person was more receptive. We spoke with a health professional who knew this person and were told they had seen very skilled support provided by both the care staff and the manager. They said staff showed "a high level of compassion in how they reached and communicated" with this person.

As well as being very brief, some information was conflicting and lacked clarity. For example, one person's assessment in relation to how they were able to communicate described them as "speech impaired but able to communicate needs" as well as "unable to fully express / communicate needs." Another person had no care needs noted in relation to fragile skin, but their night time care plan was ticked to indicate that they should have

Requires improvement

Is the service responsive?

two hourly checks for "Pressure care needs." This meant staff did not have a correct or comprehensive picture of each person's support needs, which could lead to incorrect care being provided.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The business manager told us the home was introducing a new style care plan in which staff would describe people's abilities and how they should be supported in a lot more detail than the current format.

There was no signage around the home to assist people with dementia to find their way around. We spoke with the business manager about this and they acknowledged there was further work to be done to make the home a more dementia friendly environment to live in. The business manager told us, they and other senior managers from Peninsula Care Home Ltd were undertaking a training course in providing more responsive care and support to people who are living with dementia. As a result of this course, they and the manager would provide training for staff and review the home's practices in relation to providing a more "dementia friendly" environment.

During our inspection we looked at how people were supported to follow their interests and take part in social activities. We saw people participate in a communion service and very much enjoy an interactive music and dance session. Several people were also enjoying having their hair cut and styled in the home's hair salon. The home has two budgies and a guinea pig and people told us how much they enjoyed these. One person said it was their "job to feed the guinea pig." The home employed an activity co-ordinator who arranged and undertook group and individual social activities. There was a weekly timetable of activities with something happening every day during the week. We were told there were rummage boxes for people living with dementia, which helped prompt discussion and interest. There were laminated cards showing pictures of different famous people on the dining room, which were intended to promote conversation at mealtimes, although we did not see people using these. People told us they had enjoyed music sessions, quizzes and craft work. The activities coordinator was involved in resident meetings where forthcoming events were discussed and new suggestions were shared.

Activities were focused on the activities room and the lounge area and there was evidence of craft work having taken place. However, there was little evidence of activities available for people who found it difficult to engage or preferred to remain in their room through choice or health reasons. It was difficult to ascertain how these people were supported to socialise and maintain their individual interests. For example, one person we spoke with told us they got very bored, but they did not like joining in with group activities. A pre-admission assessment had been completed, but information about this person's life, their interests or abilities had not been transferred into an individual activity plan about how to stimulate or occupy them. We looked in the activities book and found that there were no records of any activities undertaken at all, either communally or individually. We looked in the daily records book and found that there was no description of how this person spent their day meaningfully. We raised our concerns about this person's apparent social isolation and were told the activities coordinator had been working hard to engage this person in activities, but there was no record of this.

We saw, where meaningful leisure and social activities were undertaken, they were provided by the activity co-ordinator, who did not work full time and was not available at weekends. Staff said they felt too busy with their caring duties to be able to provide activities as well, although they did try to spend time talking with people when they could. The records for one person, who spent the majority of the time in their room, indicated the activity coordinator had spent time with them on four occasions over the past three months. From the evidence available to us it was apparent the activity coordinator was providing as much as possible, but this was not sufficient to meet the needs of individuals who cannot or will not join in with group activities. There was a risk of social isolation and loneliness for these people.

People were encouraged and supported to maintain relationships that mattered to them. Family and visitors felt welcome and were encouraged to visit and be involved in the home. Relatives and friends could join people for celebrations such as birthdays and the Christmas party. People's rooms were personalised with things that were meaningful, for example they were encouraged to bring family photographs, pictures and ornaments that were precious to them.

Requires improvement

Is the service responsive?

The service had a complaints policy and process which was posted in areas of the home and available to people and their relatives. There had been one complaint in the past twelve months and we saw this had been dealt with effectively and in line with the home's complaints policy. Records were kept of all communication and the actions taken to resolve this. People said they could discuss their concerns with the manager or bring them up at the quarterly residents' meeting. Relatives confirmed this. People and their relatives were confident that the manager would listen to any concerns and get things done.

We recommend the service seek advice and guidance from a reputable source, about supporting people at risk of social isolation with engagement in meaningful activity and stimulation.

Requires improvement

Is the service well-led?

Our findings

The home was managed by a person who had been appointed to the position in October 2015. They had long experience of working at the home, having started in 2007. Prior to their appointment as manager they had been working in the role of deputy manager. They were intending to become registered with the Care Quality Commission. It is a condition of the home's registration that there is a registered manager in place. At the time of our inspection the home had been without a registered manager for approximately two months. Unfortunately the acting manager could not be available on the days of our inspection.

As part of the Peninsular Care Homes group the home had a wide range of set systems in place for quality assurance. These included resident and staff meetings, questionnaires and surveys as well as internal audits. However, in this home the systems did not always operate effectively. For instance, the system in relation to the safe disposal of medication was not being followed. The system for ensuring care plans were accurate, up to date and used by care staff was not operated effectively. The home had not identified the issues we highlighted as requiring improvement to ensure people received safe care and treatment. These related to risk assessment and care planning; management of people's nutritional risks; not involving people in decisions about their care and treatment; not adhering to the principles of the MCA 2005; the safe disposal of medicines, and the activities programme not addressing the needs of people at risk of social isolation.

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

People and relatives expressed a high level of confidence in the new manager. They were pleased a senior member of staff known to them over a number of years, had been appointed to the role. Comments included, "I could dance around the table", "He's very good, I'm pleased" and "I have absolute confidence in him."

Health and social care professionals were also confident in the manager's ability to lead the home and work in partnership. They said communication was good and the manager always contacted them appropriately, and they were open and honest about what they could and could not do. They were impressed by the manager's level of knowledge and skill in supporting people who are living with dementia. One said "he leads by example and mentors staff by role modelling good care." Also, that he was "extremely thoughtful and knowledgeable about skilled interventions."

Staff said communication within the home was good and their views were listened to. They valued the daily handover meetings which were led by the manager. They said these meetings were always helpful and they all shared information well as a team. They said they were well supported by the manager who they found very approachable. The business manager and managing director both said the culture of the company, Peninsular Care Homes Ltd was open and supportive. They valued hearing the views of people and staff, and wanted to learn from feedback. There was evidence of this through records of quality assurance reviews held with people, relatives and staff. The business manager told us the ethos and aim of the home was for it to be as much like people's own home as possible and to be a central part of the local, closely-knit community. We saw pictures of the annual carnival and saw that people played an active part in this. Relatives confirmed the home was very much part of the local community and valued and supported this.

The manager attended monthly meetings held by the Peninsula Care Homes group where managers met, shared ideas and gained support from their colleagues.. We were told managers in the group were also going to become involved in reviewing each other's homes. We heard learning was shared across the group of homes. For instance, in recent months all of the window restrictors had been replaced with tamper-proof locks, following an incident in another home. Quality assurance methods had been developed in relation to seeking staff opinions. Staff completed a feedback questionnaire, but also had the opportunity to meet with the business manager to give feedback and discuss actions being taken in response to any concerns. The registered provider was committed to investing in their staff and had been a member of Investors in People since 2006. The managing director had been nominated as a finalist for Devon in the Venus employer of the year award for women in business. The registered provider was trying new and more creative ways of advertising to overcome the recruitment challenges caused by the location of Coppelia House. This included using

Requires improvement

Is the service well-led?

social media, such as Facebook as well as local shops and county wide channels. There was also consideration of providing staff with transport and adapting part of the building to provide accommodation for staff.

As well as internal audit systems, there were external processes in place to support development and drive improvement. For example, the home was awaiting a 'critical friend' review of the home. This was part of a scheme called the Devon Care Provider Kitemark, which aimed to share best practice about dementia care amongst providers. External audits were completed by Nat West Mentor, who supported the registered provider with employment and HR issues, environmental audits. There were also robust internal systems for maintenance of the home.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014. Person –centred care. People who use the service were at risk of not having their needs met as the registered provider had not ensured people received person-centred care that is appropriate, meets their needs and reflects their personal preferences. The registered provider had failed to involve people in the assessment of their needs and preferences for care. The provider had failed to make available a clear care and treatment plan to staff in relation to people's needs and preferences. Regulation 9 (1) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014. Need for Consent. The registered person must act in accordance with the Mental Capacity Act 2005. They must ensure staff are familiar with the principles and codes of conduct associated with Act. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Good governance. The registered provider failed to have effective processes to ensure the service was compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider failed to maintain an accurate, complete and contemporaneous record in respect of each person receiving a service. Regulation 17 (1) (2) (a) (b) (c)
	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed asses the risks to people's health, safety and welfare and to ensure care and treatment was provided in a safe way to mitigate these risks. Regulation 12 (1) (2) (a) (b) (g)