Larchwood Court Limited

Copperfields Residential Home

Inspection report

42 Villa Road
Higham
Kent
ME3 7BX

Tel: 01474824122

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection was carried out on 17 May 2018. The inspection was unannounced.

Copperfield's residential home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide care and support for up to 20 people. There were 15 people using the service at the time of our inspection, who were living with a range of health and support needs. These included diabetes and dementia. Some people had mobility difficulties, sensory impairments and one person received their care in bed. The accommodation was provided over three floors. A lift was available to take people between floors.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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. The provider and the registered manager assisted us during the inspection.

At the last comprehensive inspection on 21 March 2018, the service was rated requires improvement overall. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Copperfield's residential home on our website at www.cqc.org.uk.

We undertook this focused inspection because we received allegations of concern about the service made by former staff. The allegations of concern related to the safe management of medicines, the management of people's finances, moving and handling practice, safeguarding checks on new staff and the management of incidents and accidents. We checked to see if the service was Safe and Well led. This report only covers our findings in relation to those requirements.

At the time of this inspection, to safeguard people we were working in liaison with other agencies. The local authority had visited the service to check on people's safety and care. The police had been investigating some of the allegations about the management of people's finances. The police had also carried out an investigation into possible links between a fall a person had in the service and their subsequent death. We also used our powers under Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to look at this during this inspection.

At this inspection we found people were not at serious risk of harm. The registered manager and provider were still in the process of reviewing and acting upon the findings from our comprehensive inspection on 21 March 2018. At this focused inspection we could not corroborate all of the allegations we had received. However, we found medicines were not managed to minimise the risks of harm. Medicines were not audited by the registered manager or provider to check if people had received their medicines as prescribed. When people's medicines had been changed, the changes were not appropriately recorded on medicine

administration records (MAR's). Medicine counts could not be audited back to the prescription amounts.

There was a lack of organisational oversight into auditing medicines.

Risks assessments had been updated and were in place for the environment, and for each individual person who received care. Assessments identified people's specific needs, and showed how risks could be minimised. However, the information recorded for staff to follow in people's risks assessments did not always match other information in peoples care plans. We could not be sure that people were not at risk of potential harm from staff using incorrect methods of care. Also, not all risks were mitigated by actions to reduce risks.

The premises and equipment in the service was clean, odour free and maintained to protect people from infection. Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and carried personal protective equipment like disposable gloves and apron's.

However, at the time of the inspection seven small dogs were on site. We observed that the dogs had access to the patio areas of the garden used by people living in the service, which may present an infection risks if the patio was not regularly cleaned and washed down.

Safety systems in the service, like fire alarms were serviced by an engineer and tested to maintain people's safety. General risks within the service had been assessed and maintenance issues were reported and dealt with in a planned and timely manner.

Recruitment policies were in place. Safe recruitment practices had been followed. The management employed enough staff to meet people's assessed needs. Staffing levels were kept under review as people's needs changed.

Staff were deployed in sufficient numbers to meet the needs of the 15 people currently living at Copperfield's. People's care was delivered safely and staff understood their responsibilities to protect people who were frail from potential abuse. Staff had received training about protecting people from abuse. The management team had access to, understood the safeguarding policies of the local authority, and when needed followed the safeguarding processes.

Incidents and accidents were recorded and checked by the management team to see what steps could be taken to prevent incidents happening again.

The provider had planned for foreseeable emergencies, so that should they happen people's care needs would continue to be met. There was an up to date procedure covering the actions to be taken in emergency situations.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Risks to people's safety and welfare were assessed but staff did not have access to consistent and accurate records to make sure they protected people from harm.

People were exposed to the risk of harm from the poor management of medicines and infection control.

The management team and staff were aware of their roles and responsibilities in relation to safeguarding people.

Suitable numbers of staff were available to provide the assessed care needs of people.

Safe recruitment processes were in place to make sure new staff were suitable to work with people who may require safeguarding.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Quality assurance processes consistently failed to identify risks and deficiencies within the service.

Communication systems were in place for people who lived at the home, their relatives and staff.

Meetings were facilitated to gain feedback about the service.

Copperfields Residential 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This focused inspection took place on 17 May 2018 and was unannounced. The inspection was carried out by three inspectors, one of whom was a specialist medicines inspector. The medicines inspector carried out a detailed inspection of the management of medicines in the service.

Before the inspection, we reviewed previous inspection reports and provider notifications. A notification is information about important events which the service is required to send us by law. We also reviewed information of concern/allegation's supplied to us by former staff whistle blowing, information from the police and the local authority. These professionals included local authority commissioners. We used this information to help us plan our inspection.

We spoke with five staff during the inspection, which included the provider, the registered manager, a senior carer and two care staff.

We looked at seven people's personal records, care plans and medicines charts, risk assessments, staff rotas, staff schedules, one staff recruitment records, meeting minutes, policies and procedures. We also looked at one set of care plan records for a person who had recently died in hospital after being admitted from the service after falling.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 21 March 2018 we rated this question as requires improvement. Following this inspection, this question has been rated Inadequate.

People were not always protected from the risks associated with the management of medicines. Medicine Administration Records (MAR's) contained a photograph for each person to identify them. However, there was no detailed information regarding allergies or how a person would like to take their medicines recorded to help staff administer people their medicines. For example, should tablets be placed in their hand or on a spoon. MAR's were signed by staff following administration of medicines. Although there were no gaps on MAR's, for two people we found there was more stock of their medicines than there should have been if they had received their medicines according to the MAR. This meant people may be exposed to the risk of harm from not receiving their medicines as prescribed.

Some people were prescribed medicines to be taken on an 'as and when required basis' (PRN), for example paracetamol. There was not always written information available to show staff how and when to give PRN medicines to people to ensure they were given consistently and appropriately. For example, one person had been prescribed liquid paracetamol PRN. The MAR stated, 'Take two to four 5 ml spoonful's every four to six hours as required. There was no PRN protocol saying when and how staff should record whether the person had been administered 10 ml or 20 ml or why the person needed the medicine frequently as the PRN was shown as administered nearly every day. This meant that medicines administration was not always accurately recorded to protect people's health and wellbeing.

We found staff members had made changes to people's medicines and recorded these on MAR's during the current and previous medicines cycles. For example, a person's Zopiclone medicine had been recorded as being stopped by the persons GP. A member of staff had crossed through the MAR. Up to that point the person had been taking the medicine every night. However, there was no written confirmation record found from the prescribers of the changes made to people's medicines. This did not meet the guidance issued by National Institute for Health & Care Excellence which states 'care home staff should ensure that any change to a prescription or prescription of a new medicine by telephone is supported in writing (by fax or email) before the next or first dose is given.' This meant that there were no records of why the medicine and been stopped.

Some people were prescribed high-risk medicines such as anti-coagulants. Anticoagulants are medicines that help prevent blood clots. There was no guidance in place for staff to identify likely side effects for the high-risk medicines. This meant staff might be unable to identify when side effects from medicines may be affecting people's health and wellbeing.

A medicine audit had been carried by an external auditor in February 2018. However, actions derived from the audit had not been completed. There was a medicine policy in place. Records showed not all current members of staff handing medicines had read and signed the policy. This meant that medicines audits were not protecting people from harm and that some members of staff may not be following correct processes on

how to handle medicines at the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. Safe care and treatment. The provider had failed to manage medicines in a safe way.

We observed staff give people their medicines in the afternoon. Staff were polite, gained permission/consent and signed each medicine they had given on the MAR. There was a process in place for the storage, recording and administration of medicines including controlled drugs (CDs - medicines which are more liable to misuse and therefore need close monitoring). Staff members checked and recorded room and refrigerator temperatures daily. Temperatures were found to be within the required range. Staff recorded and returned unwanted medicines to the designated pharmacy for disposal.

We observed the service to be clean and odour free. Staff were provided with infection control training and we observed staff accessing gloves and aprons. Cleaning staff confirmed that they followed a system of cleaning that included deep cleans. Staff said, "We clean to a schedule and get access to cleaning equipment and gloves." However, when we accessed the patio area to the rear of the property we found small amounts of dog faeces were present. We noted that the dogs living in the service had access to a grassed area outside the registered managers accommodation, but could also access the patio area used by others. We discussed this with the provider. They told us that they normally clear up the dog faeces and wash down the patio, but that they had not done this today because they had been busy assisting us with the inspection. They also said that the dogs would not be at the service for much longer. This meant that without constant vigilance dog faeces could be left in areas that were accessed by people and staff, which posed a risk to people's health.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. Safe care and treatment. The provider had failed to control the potential spread of infection.

At our last comprehensive inspection on 21 March 2018, we found that some risks to people's safety had not been properly assessed or minimised. At this inspection we found further evidence of poor risk assessment and planning. People with risks assessments for moving and handling by staff had their needs recorded on recently reviewed risk assessments. However, these risks assessments conflicted with information in other parts of people's care plans or differed from the practice we observed. For example, in one person's general care plan it stated, 'Mobility can stand with one staff'. However, on an updated risk assessment from August 2017 it stated, 'High risks, needs hoist and two staff as X cannot weight bear." This meant that staff may not be following the correct practice when moving and handling.

This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. Safe care and treatment. The provider had failed to assess and take steps to mitigate risks.

When we asked the staff how they meet people's moving and handling needs, they described to us the correct, safe processes. We asked staff to describe how they used equipment like handling belts, bed slide sheets and hoist. They described how they did this safely. We asked staff how they knew the correct methods for each person's moving and handling needs. They told us that they get hands on training for each person by the registered manager. This meant that that their practice was safe, but that they could not rely on the information in people's risks assessments.

The provider had a safeguarding policy that informed staff about their responsibilities to safeguard people and what constituted abuse. Staff received training in safeguarding.

The registered manager followed policies about dealing with incidents and accidents. Should any incidents occur they were fully investigated by the registered manager and steps would be taken to prevent them from happening again. We looked at archived records about a person who had fallen, was admitted to hospital, but subsequently died. The staff involved in this incident had left the service, but from the information available to us at the time of this inspection, we could see that the registered manager had followed the providers policies about disciplinary matters, that they had carried out an investigation into the incident and that they had notified the CQC and the local authority safeguarding team of the incident. Taking the correct actions meant that ongoing risks to others was minimised.

There continued to be enough staff to ensure the care people received was safe and they were protected from foreseeable risks. There had been a recent high turnover of staff. The provider told us they were recruiting to vacant posts. Whilst recruitment takes place the registered manager was staying on site in one of the vacant rooms. This meant that they were available to cover any staff shortfalls and they were on hand to assist care staff. However, our observations and discussion with staff showed that staffing deployment was based on an analysis of the levels of care people needed.

We observed staff answering people's request for assistance and when necessary. There were enough staff available to walk with people using their walking frames if they were at risks of falls. Staff were deployed in appropriate numbers within the service to keep people safe and meet the assessed needs of the 15 people currently living at the service. Staff told us the current staffing levels were consistent and staff told us there were currently enough staff to meet people's needs. We checked the staff rota and saw that the registered manager planned the staffing in advance. Where staff were absent, for example for staff holiday, we could see that other staff worked extra hours and this was marked on the rota. Some shifts not covered in house had been covered by agency staff who had normally worked in the service before. In addition to the care staff, there was a cleaner, cook and maintenance person employed in the service. This meant that levels of care staff hours were consistent.

The management team followed a policy, which addressed the things they needed to consider when recruiting a new employee. The most recent member of staff recruited had been through an interview and selection process. They had completed application forms and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. New staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions, or if they were barred from working with people who needed safeguarding. Making proper checks on staff reduced the risk to people who may need safeguarding.

Arrangements continued to be in place should an emergency occur which included an out of hour's policy, which enabled serious incidents affecting people's care to be dealt with at any time. There was also an emergency accommodation plan in place should the premises be inaccessible. This ensured that people could continue to receive safe and continuous care in case of emergencies.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 21 March 2018 we rated this question as requires improvement. Following this inspection, this question has been rated Inadequate.

At our previous inspection on 21 March 2018 we found that quality assurance processes had not been sufficiently robust to consistently identify and resolve shortfalls in the quality and safety of the service. This meant that areas of the service that we found during that inspection that presented risks to people and the failure to meet regulations were not identified.

At this inspection we found further evidence that the providers governance and audit systems were not operating to minimise potential harm. For example, there was no evidence of medicines being audited by the registered manager or provider. We asked the provider to show us their recent medicines audits. They told us that they had not carried out any medicines audits. This meant that the provider was not aware of the risks being posed to people from the poor management of medicines in the service.

The provider's systems were not effective in identifying whether people's care plans contained the correct information and guidance for staff. For example, a care plan stated that a person was 'Chair fast' although at the time of this inspection they were cared for in bed; The care plan should have stated 'Bed fast'. Mobility was stated as 'Slightly limited' but should now be 'Very limited'. These changes had not been recorded, therefore this care plan was not up to date. In another care plan it stated, 'Person needs to be turned as does not move without staff. It stated the risks control measures were, 'Turn two hourly, airflow mattress maintained by handyman, report changes to the manager'. This was different to the person's tissue viability care plan which stated the person should be turned hourly. In another person's care plan it stated that the person needed bedrails to keep them safe because they had epilepsy. However, there was no epilepsy care plan in place. We discussed this with the registered manager and they told us that the person had not been diagnosed with epilepsy. This meant that records audits were not in place which exposed people to the risks of poor care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. The provider's audit systems were not operated effectively to assess and monitor the quality and safety of the service provided.

The provider had a set of values that they expected staff to work to. Staff we spoke with demonstrated the provider's values. Staff told us they felt part of the team and were able to contribute to meetings and share ideas for the benefit of the people using the service. The management team met with staff in meetings. They discussed the operational effectiveness of the service and any issues or concerns arising with the service they were providing to people. Staff we spoke with were confident with the care provided and told us they liked working at the service. One staff told us, "The registered manager and provider are very approachable and supportive". And, "I'm very happy here. We are a good team".

The provider's policies and procedures continued to reflect current legislation.

Accident and incident forms were being reviewed by the registered manager in order to look for any trends to help in reducing similar incidents and reduce risks to people's safety and welfare. Accident records were completed and highlighted the incident and the action that was taken to prevent similar incidents.

The registered manager continued to understand their responsibilities around meeting their legal obligations for example, by sending notifications to CQC. Notifications are information about specific events that the service is legally required to send us. This ensured that people could raise issues about their safety and the right actions would be taken.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider continued to display their rating at the entrance to the service and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to manage medicines in a safe way. The provider had failed to control the potential spread of infection and to assess and take steps to mitigate risks. Regulation 12 (1) (2) (a) (b) (h) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's audit systems were not operated effectively to assess and monitor the quality and safety of the service provided. Regulation 17(1) (2) (a) (b) (c)