Cooperscroft Care Home Limited

Cooperscroft Care Home

Inspection report

Coopers Lane Road
Potters Bar
Hertfordshire
EN6 4AE

Tel: 01707644179
Website: www.cooperscroftcarehome.co.uk

Date of inspection visit:
29 March 2016

Date of publication:
06 May 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Cooperscroft Care Home is a purpose built home that is registered to provide residential accommodation, nursing and personal care for up 60 older people some of whom are living with dementia. At the time of our inspection 56 people were living at the home.

The inspection took place on 29 March 2016 and was unannounced which meant the provider or manager did not know we were coming. We previously inspected Cooperscroft Care Home in September 2015. During that inspection we found that the provider was not meeting the required standards. This was because there were not always enough experienced and skilled staff to meet the needs of people, and staff who were caring for people living with dementia did not always have sufficient training. In addition people were not supported to pursue their hobbies and interests. At this inspection we found the required improvements had been made and the service now met the required standards.

The home had 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. Shortly after our previous inspection in September 20162015?, the provider changed their legal entity requiring a new provider registration following a reorganisation of the company.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Cooperscroft Care Home and a number of these were pending an outcome.

People told us they felt safe living at Cooperscroft Care Home. Staff were aware of how to keep people safe and risks to people's safety and well-being were identified and managed. Incidents and accidents were reported and investigated by the manager, however they were not always robustly analysed for patterns or trends to ensure people were protected from harm. Where people's needs changed staff ensured these were responded to and managed in a safe manner. There were sufficient numbers of staff deployed to support people, although people told us that at certain times staff were not always available to them. The registered manager was aware of this and had acted to increase levels in the home. There were suitable arrangements for the safe storage, and administration of people's medicines, including controlled drugs, and people's medicines were regularly reviewed.

People were asked for their permission before staff assisted them with care or support. Staff had the skills and knowledge necessary to provide people with safe and effective care and demonstrated this throughout the inspection. Staff received regular support from management which helped them feel supported and

valued. People received appropriate support and encouragement to eat and drink sufficient quantities and people's nutritional needs were assessed and monitored effectively. People had access to a range of healthcare professionals when they needed them and feedback from health care professionals was positive and supportive of the care provided at Cooperscroft Care Home.

People's privacy and dignity was promoted. People told us they were treated with kindness and compassion by staff who listened to them. Staff knew people's individual needs and were able to describe to us how to provide care to people that matched their current needs.

People and staff told us the culture in the home was open, supportive and transparent. Staff told us that since the appointment of the new registered manager the atmosphere and culture in the home had improved. People's care records were regularly updated to provide a comprehensive account of a person's needs and care. Arrangements were in place to obtain feedback from people who used the service, their relatives and staff members about the quality of care services provided. People told us they felt confident to raise anything that concerned them with staff or management. Arrangements were in place to regularly monitor and review the quality of the care and support provided for people who lived at Cooperscroft Care Home. People's care records were not always reflective of their current needs; however the registered manager was aware of this and was in the process of making improvements to address any areas of concern.

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 consistently safe.

People were not always supported by sufficient numbers of staff.

Incidents and accidents were reported and investigated by the manager.

Medicines were managed safely and people received their medicines when prescribed.

Is the service effective?

Good

The service was effective.

People were supported to eat and drink sufficient amounts, and their weights were regularly monitored and reviewed.

People received support from staff who were appropriately trained and supported to perform their roles.

Staff sought people's consent before providing all aspects of care and support, capacity assessments had been carried out for specific decisions where appropriate.

People were supported to access a range of health care professionals to help ensure that their general health was being promoted.

Is the service caring?

Good

The service was caring.

People were treated with warmth, kindness and respect.

Staff had a good understanding of people's needs and wishes.

People's dignity and privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People were supported to engage in a range of activities.

People were given the support they needed, when they needed it, and were involved in planning and reviewing their care.

People's concerns were taken seriously and they were encouraged to provide feedback to the management team.

Is the service well-led?

Good

The service was well led.

People's care records were not always reflective of their current needs, however the registered manager was aware of this and was in the process of making improvements to address any areas of concern.

The provider used sufficiently robust arrangements to monitor, identify and manage the quality of the service people received.

People had confidence in staff and the management team and felt they listened to their views and opinions, and gave people the opportunity to comment of areas for the home to improve.

Cooperscroft 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 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 inspection took place on 04 April 2016 and was unannounced.

The inspection team was formed of one inspector and specialist advisor whose specialism was nursing for people living with dementia. We were also accompanied by an expert by experience who is a person who has experience of using services like Cooperscroft Care Home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires the provider to give some key information about the service, what the service does well and improvements they planned to make. We also reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed staff supporting people who used the service, we spoke with 10 people who used the service, nine people's relatives, eight members of staff, the registered manager and interim deputy manager. We also spoke with two visiting health professionals. We received feedback from the local authority health and community services. We also 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 talk with us.

We reviewed care records relating to six people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and various management records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Cooperscroft Care Home. One person said, "I've been to several Homes, and this is best because it's safer; when I go to bed, I know I am perfectly safe". A second person said, "I'm now safe, settled and content. It's nice here." A visiting relative told us, "[Person] is not unhappy, they are safe."

Staff were able to describe to us what constituted abuse, and what signs they looked for when providing personal care to people, such as unexplained bruising or abrasions. Staff told us they monitored people's moods and observed them for changes in their personality, such as becoming subdued or withdrawn. They told us that they would immediately report any concerns to the management team and would complete the appropriate incident reports to escalate their concerns. One staff member told us, "Anything that may cause the residents harm is abuse, even not changing a pad in time is neglect and I would definitely report that, and the staff member who hadn't done it." Staff were confident that the manager would respond if any form of abuse was suspected.

Staff confidently explained how their whistleblowing procedures worked, and they would have no hesitation about reporting unsafe practise to the management. Staff were aware of external agencies to report their concerns to in addition to the company's internal whistleblowing procedure. One staff member said, "If I had a niggle or worry about a colleague I would go to the manager, or if I thought they were to blame I'd come to you [CQC] or the local council." Information about safeguarding adults from abuse was made available around the home to people and visitors, and gave them telephone numbers people could contact to report concerns, or for further information. Training records we looked at demonstrated that staff had all received updated training in relation to safeguarding people from abuse and whistleblowing.

Incidents and accidents were reported by staff to the management team. The manager maintained a log of these and investigated each incident accordingly taking action to review people's care where required. We found when people's needs changed staff assessed the risks to the person and ensured the risks to their wellbeing were managed. For example, when people's mobility needs deteriorated, staff considered the least restrictive options to support them, and where bed rails were required, this was carefully assessed and the risks considered. Where there were concerns particularly around pressure staff ensured the appropriate equipment was provided and the person's skin integrity was monitored. For example, one person had developed a sore on their ankle; staff had ensured the person was provided with a pressure relieving mattress and repose boot to support the healing of the wound. Appropriate care plans were in place which were regularly reviewed and they demonstrated to us that the wound had nearly completely healed.

People told us there were sufficient numbers of staff deployed and that this had improved since our last inspection. However, we found that the allocation, deployment and supervision of staff was not always robust and left staff short-handed at times. For example, on the floor where people living with dementia and nursing needs were cared for, the vast majority of people required two staff to provide personal care. We were told by the nurse in charge that one of the care staff had been sent to the kitchen to assist. However, this had left the floor short of one member of staff, placing the remaining staff under pressure. When we

spoke with the registered manager about this, they were under the impression that the staff member was only required to assist in the kitchen for breakfast. However, our observations were throughout the day that staff were under pressure and only able to meet people's basic needs. This meant it was difficult to meet people's individual needs on this unit on the day of our inspection. For example, we observed one person sitting in a chair in another person's room reading through their book. The other person was asleep in bed, and staff were unaware that this person was in there. Had there been an additional staff member available, they would have been able to support this person appropriately.

However, the registered manager had regularly completed dependency tools for people living in the home to ascertain the number of care hours they required. They told us they staffed the home to meet this ratio. They showed us how once they were in post, they reviewed the staffing levels and increased this to meet people's growing needs. On Clover unit they had increased the staffing levels by two carers to meet the needs of people. However, the unit for people living with dementia had not received the same increase. One person said, "It is rare to be short, but there is the odd day when they [Staff] are running around like headless chickens." Staff told us there were usually enough staff on duty, however they had busy periods but overall the numbers were sufficient. One staff member told us, "Overall yes there are enough, we are lucky in that respect, but occasionally I think the [registered] manager could move some down particularly in the morning to help." Our observations on the day of our inspection were that the home was generally peaceful, calm and staff carried out their duties in an unhurried and relaxed manner.

However, we also saw that on the nursing dementia unit, where one staff member was assisting elsewhere, staff were hurried which led to a task orientated approach to care. We looked at the dependency tool used to calculate the care hours required and found that in many instances, due to the method used to calculate people's dependency needs, those people with less needs were attributed more care hours than those with a more complex care requirement. The registered manager agreed that the tool created anomalies and would develop an improved system.

People told us they received their medicines when they needed them. One person told us, "They are always on time when I need them, and if I need a painkiller then all I need to do is ask." We observed medicines that were required to be given with or just after food were administered at the right times as prescribed. People who were prescribed 'As required' medicines for symptoms such as pain were asked whether they felt they needed a tablet and staff acknowledged their decision. Only trained staff administered medicines and they were able to carry this task out undisturbed. When medicines were handed to people, staff ensured they were taken in their presence, and only signed the medication administration record (MAR) once they were satisfied they had been consumed. This meant that staff were not distracted and could be assured people had taken their medicine safely. We checked the MAR records for eight people and found no errors or omissions in the record to suggest people had missed a dosage. People who were prescribed medicines to assist with their mood or behavioural needs were regularly reviewed by the doctor. Staff also used their knowledge of people to ensure they were not unnecessarily, 'sedated'. For example, one person was prescribed a sedative three times daily to manage their mood. The nurse felt this could be controlled more positively if the medicine was given at a particular time of day and only once. They discussed this with the doctor who agreed and amended the prescription. This helped to ensure the person was able to join in the day's activities without being over medicated and manage their mood later in the day positively when staff had identified this was their particularly difficult time. However, we found that when people were prescribed a half dosage of a tablet, for example a 2.5 mg tablet, staff had broken a 5mg tablet in half and retained the other half for administration later. Once a tablet is removed from the packaging and not used it must be destroyed. We spoke to the registered manager about this who took action to ensure this practise did not continue.

Good

Is the service effective?

Our findings

People told us they thought the staff were sufficiently trained to support them. One person we asked told us, "They all seem to get on with the job at hand in a professional and efficient manner and are confident in doing so."

Staff told us they were well supported by the management to provide care to people. They told us they received a comprehensive induction and ongoing training and development once they had passed their initial probationary period. Many of the staff team were long standing employees, having been working at the home for many consecutive years. They told us that they had received annual refresher training in areas such as safeguarding, mental capacity, moving and handling and dementia care.

Staff told us that they felt able to approach any senior member of the staff team including the manager for support. They told us that they received regular supervision and an annual appraisal of their performance. One staff member said, "I love working here that's why I gave up my other job, training is really good and I feel supported and I will be able to start my care certificate soon."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were involved in making decisions about their care and their consent was sought prior to support being given. When people were considered to lack capacity they were assessed and a best interest decision was made. Decisions were made through consultation with the registered manager, relatives and a relevant professional. Where people then required a DoLS authorisation to maintain their safety, for example, in the need of bedrails to prevent them failing from bed, the appropriate applications had taken. Staff and the management team demonstrated to us their understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. We saw that the registered manager had completed the relevant assessments and had forwarded these to the relevant local authorities and were awaiting an outcome. This meant that at the time of our inspection people were not unlawfully deprived of their liberty and the registered manager had sought the least restrictive option.

People were positive about the food they were provided with. We observed staff offer people a choice of meals at lunchtime, and people were provided with ample drinks and a range of fresh fruit and snacks throughout the day. When meals were served to people who may be living with dementia at lunchtime, staff visually showed them an example of each meal on offer. Even so, where people did not want either option, staff readily sought to find them an alternative option. We saw that the chef observed lunch on different units and sought feedback on the quality of meals provided to people. One person said, "The food used to

be bad, but now is excellent.". A second person said, "The food is normal and so far I have no complaints."

Where people required assistance with eating, this was done in a sensitive and caring manner, at a pace the person was comfortable with. Meal times were split, allowing for two servings, which meant those people who required one to one assistance were able to be supported to eat in a patient and attentive way. This meant that people received sufficient amounts to eat because staff had the time to encourage and support them appropriately.

We spoke with the chef who was knowledgeable about people's individual nutritional needs. They provided a freshly prepared menu that was based on people's preferences and catered for any special requirements such as diabetic diets or allergies.

Where people were at risk of weight loss or who had experienced weight loss, both care staff and kitchen staff were aware of this. People were weighed routinely and their care records were updated and reviewed regularly. People at risk of weight loss were monitored more frequently and referrals were made for specialist support around their nutritional needs. We spoke with staff who were aware of those people at risk, and were able to describe to us how they supported their dietary needs.

People told us they were supported by a wide range of healthcare professionals when they needed them. One person said, "They are very quick, very quick indeed to jump on anything and get the doctor along to us." We saw that people were able to freely access professionals such as GP's district nurses, chiropodists, opticians and dentists. One health professional said, "I feel that people are well cared for, the staff work extremely diligently to meet whatever needs they may have, and are well supported by the management, although, they are at times pushed hard to meet their daily commitments."

Good

Is the service caring?

Our findings

People told us that the staff were caring and treated them in a dignified manner. One person said, "They [staff] typify what a caring attitude should be towards people, they should bottle the secret." One person's relative said, "The carers are above and beyond the call of duty and are kind and caring." A health professional said, "Things have improved dramatically and the approach of the whole staff team is one of kindness, compassion and respectfulness that is borne from a place of care."

People were treated in a dignified manner that protected their privacy and maintained their independence. People were not rushed in the morning to get ready for the day and could choose to stay in bed longer if they wished. One person was supported over a period of hours in the morning to get ready for the day. Staff told us this would begin with staff sitting the person up in bed over a period of three to four hours, and gently getting them ready periodically throughout the morning as this was their wish and they did not want to be rushed. When people were brought to the communal areas, they were clean, well-groomed and presentable. When staff were required to assist people or enter their rooms they did so in a dignified manner and with minimal fuss, knocking on closed doors or calling out when they entered awaiting a response. When people were assisted this was carried out away from people, behind closed doors, and sensitively. One person told us, "I have never been made to feel uncomfortable or embarrassed when the carers help me, and I have not seen them do so to others."
Where family was important to people, these formed part of their plan to encourage family to visit. People and their relatives told us there was no restriction upon them visiting their relatives. The registered manager told us that they had facilities available in the home for families to use if they travelled long distances or if their loved one was receiving end of life care. This allowed them to stay closer to the person at those particularly important moments.

Care was centred on people's individual wishes and preferences. Throughout the inspection we saw that staff offered people the choice of where to spend their time and with whom they wished, where to sit for lunch, what drinks they wanted to have and when, and whether they wanted to socialise or be left alone. This demonstrated that people were able to make their own choices about how they spend their day and received their care. One person once assisted with their care in the morning was then taken to the ground floor to spend the day with their friends as that is where they had spent most of their time in the home prior to recently being transferred to a different unit due to a change in needs. A second person said, "I'll sit here for a while and when I think of something I want, then I'll ask, but they always deliver."

People told us they felt staff listened to their views about their care and treatment. Care records were written clearly identifying what was important to people and how to meet their needs. Staff were confidently able to describe how to provide care to people that was individualised. Staff were friendly and cordial in their involvement with people and visitors. People told us their relatives were able to visit freely whenever they wanted to and that maintaining relationships with families and friends was important to them.

The registered manager had recently introduced the services of a local advocacy service into the home to support people with their day to day affairs, or if they wanted to raise any concerns. Information about these

services had been prominently displayed in the home. The registered manager told us in addition to the range of professionals involved in people's care, they were arranging a discussion for people and relatives to attend that was comprised not only of health professionals but also was due to include a solicitor. This would assist people in asking questions about the care they should expect to receive, and also about important legal matters that they may require assistance with.

Good

Is the service responsive?

Our findings

People, their relatives and health professionals told us that their individual care needs were met. One person said, "They do what's needed, how I want them to do it, generally when I want them to." A second person said, "The carers are above and beyond the call of duty."

Staff were aware and able to describe to us how they accommodate people's needs. People told us that they were able to contribute to the assessment and review of their needs. They said that staff completed a thorough assessment of their needs and that both themselves and their family were consulted. Care records we looked at contained a biography of the person and what was important to them, alongside an assessment of the person's health and well-being needs that considered what they could do for themselves. For example, people were encouraged to wash and dress with minimal support from staff to maintain their dignity and independence. Where people had more complex needs, such as pressure area care, staff were aware of how and when people required repositioning, and also how to support their particular nutritional and fluid intake needs.

Where people needed additional equipment to support them, staff acted quickly to get this in place. For example, staff noted a small mark developing on a pressure area. Concerned that this may develop further, they acted in a preventative manner and ordered pressure relieving equipment, a profiling hospital bed, special boots and developed a plan of care that monitored the condition. This wound was healing well when we reviewed the records.

When people moved into the home staff had compiled a history of the person's life including areas such as relationships, interests, religion, previous employment, and hobbies. These summaries of people were informative and in the majority of cases, well written, with enough detail to provide an insight into people's lives and their particular individual interests. Care staff with told us, "It's helpful to know what a person's life has been so we can connect with them now."

People were provided with a range of different social activities, and supported to pursue their own hobbies and interests. Activities we saw on the day were well attended, with people from across the home convening in the communal areas for quizzes and discussions. There was a strong activities team working in the home who had produced an activity planner for the month, showing daily activities such as games, quizzes, gardening talks, dominoes, reading club, dog therapy, bingo, cards, current affairs, and films in the cinema. Where people preferred to pursue their own interests, staff supported them to play games such as cards or dominoes or to read quietly in the lounges. However, people also told us that staff were not as attentive to their individual needs if they were either bed bound or chose to not join in with communal activity. One staff member said, "We can't always give people the socialising care they require like talking or a bit of pampering, it's okay if you can move, but not for those who can't." These comments and observations were generally in relation to one unit, however our observations on the day of inspection were that on other units staff constantly popped in and out of people's rooms, chatted informally and attempted to keep people occupied. The registered manager said they were aware of needing to connect with people at risk of isolation and were currently looking to make improvements in this area.

People told us they felt confident to raise their concerns or complaints with the management team. Everybody told us they were happy with their care, the facilities and with any aspect of the service provided. Information was made available that informed them how to raise a concern and what to expect when they did so. The home had a complaints log and each complaint raised had been investigated and responded to. One person told us, "My relatives have seen other homes and they say this one is the best in the area, the Home operates an 'open door' policy."

Good

Is the service well-led?

Our findings

People and staff told us the registered manager was visible and promoted an open culture. People were positive about the changes that the registered manager had made since being in post. They told us the management team were approachable and listened to their views and opinions. One person told us, "I think [Registered Manager] is doing a sterling job and should be commended, I know if I was to comment or suggest on anything to be improved they would listen."

The management team in Cooperscroft Care Home were clearly visible throughout the inspection, offering support and guidance to staff. People and staff told us they felt the chain of accountability in the home was clear and apparent, and the registered manager met the unit managers? regularly each day for an update from each of the units regarding people's care needs and any other issues. Team meetings were regularly held for staff and a forum was held for people and their relatives to discuss any concerns and be updated regarding any developments in the home. The registered manager had recently completed a survey to enable people, their relatives and staff to share their views about the home. The results were in the process of being reviewed so we were unable to look at these, however, as the registered manager was new in post, they told us they would be able to use the results to help identify areas for improvement.

A system of assessing, monitoring and improving the quality of care people received was in place. In addition to the usual audits of care records, medicines, health and safety and infection control, the provider had requested an independent assessment of the home to be carried out. This assessed the home in a similar manner to that of the CQC inspection and identified issues in areas such as MCA assessments, lack of team meetings, and best interest decisions were recorded in care plans. The registered manager had responded to each concern in turn and was in the process of completing the actions set. In addition the local authority had carried out a review of the service in March 2015. They had identified areas of improvement, such as involving people in their care, ensuring medicines are stored safely, and updating people's care records when their needs changed. We found at this inspection that action had been taken to address many of these areas.

On a weekly basis, the registered manager completed a report that was sent to the provider. This looked at key areas such as hospital admissions, staffing issues, pressure ulcers and complaints. The results of this report were discussed at a senior team meeting at the beginning of each week and where actions were needed; the provider ensured this was communicated to the registered manager. The provider carried out regular audits of the home through visits, however would also use this information strategically so the quality team could focus their visit on a specific area. For example, where there was an increase in chest infections for people, the team would focus on this particular area. Additionally, night visits were completed regularly by the management team. This meant that the registered manager and provider utilised a robust system of monitoring and responding to issues to ensure people received care that was safely delivered. Where issues were identified, the registered manager had plans in place to address the concerns.

We found that people's care records overall had been well maintained and amended as people's needs changed. Care records were at the time of the inspection in the process of being reviewed, and a new care

planning format was being introduced. For example areas that were being addressed were around improving the content of daily records of care, updating medicines records where administered on an 'as required' basis and further developing care plans for end of life care with the support of specialists. Staff and people all told us that there was too much paperwork, and the registered manager agreed and told us since being in post this is an area that they have sought to improve.