Copper Beeches Limited

Copper Beeches

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Copper Beeches on 9 October 2017. The inspection was unannounced. The home is a situated in Collingham in Nottinghamshire and is operated by Copper Beeches Limited. The service is registered to provide accommodation for a maximum of 20 older people. There were 18 people living at the home on the day of our inspection visit.

We carried out an unannounced comprehensive inspection of this service on 14 and 16 June 2017. Breaches of legal requirements were found. After the comprehensive inspection we took action against the provider and issued two Warning Notices to ensure that improvements were made in relation to the safety and governance of the home. The provider was required to be compliant with the notices by 4 September 2017 (safety) and 9 October 2017 (governance). We undertook this focused inspection to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Copper Beeches on our website at www.cqc.org.uk.

At this inspection we found that the provider had not made the all of the required improvements and remained in breach of these legal regulations. We also found a breach of the Care Quality Commission (Registration) Regulations) 2009. You can see what action we told the provider to take at the back of the full version of the report.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found that the service was still not safe. People were exposed to the risk of harm and action had not been taken to protect them from risks associated with their care and support. Risks associated with falls, moving and handling and pressure ulcers were not effectively assessed or managed.

Equipment was not always used safety. We found a number of unsafe practices in relation to the use of bedrails. Risks resulting from environmental hazards, such as windows and portable heaters, were not safely managed, consequently we found that people were exposed to the risk of harm.

Improvements had been made to ensure that people received their medicines as prescribed. However, where people were prescribed creams; these were not always applied as required. Improvements had been made to the cleanliness of the environment and effective food hygiene practices were now followed.

Since our last inspection action had been taken by the provider to ensure that the risk of people experiencing improper treatment or abuse were minimised. There were enough staff to provide care and

support to people when they needed it. Safe recruitment practices were followed.

The service was still not well led. Auditing systems were not effective in identifying or addressing risks to people who used the service and this placed people at risk of harm. There were concerns with the competency of the management of the home.

Opportunities for people living at the home to provide feedback on the service were still limited and people told us that communication required improvement. In contrast, staff felt supported and were able to express their views in relation to how the service was run. The provider was not conspicuously displaying their rating in line with our requirements and CQC was not notified of significant events as required.

The provider was responsive to our feedback and took swift action to respond to our concerns and address the risks to people who used the service.

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. This is because the service has been rated as 'inadequate' in a key question over two consecutive inspections.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 still not safe.

People were exposed to the risk of harm and action had not been taken to protect them from risks associated with their care and support. Equipment was not always used safety and environmental risks were not safely managed.

Improvements had been made to ensure that people received their medicines as prescribed. However, where people were prescribed creams these were not always applied as required.

There were enough staff to provide care and support to people when they needed it and safe recruitment practices were followed.

Improvements had been made to the cleanliness of the environment and effective food hygiene practices were now followed. There were systems and processes in place to minimise the risk of abuse.

Is the service well-led?

Inadequate

The service was still not well led.

Auditing systems were not effective in identifying or addressing risks to people who used the service and this placed people at risk of harm. There were concerns with the management and leadership at the home.

Opportunities for people living at the home to provide feedback on the service were limited. Staff felt supported and were able to express their views in relation to how the service was run.

The provider was not conspicuously displaying their rating in line with our requirements and CQC was not notified of significant events as required.

The provider was responsive to our concerns and took swift action to respond to our concerns and address the risks to people who used the service. We could not improve the rating for well led from inadequate because to do so requires consistent

good practice over time. We will check this during our next planned comprehensive inspection.

Copper Beeches

Detailed findings

Background to this inspection

We inspected Copper Beeches on 9 October 2017. The inspection was unannounced. 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 done to check that improvements to meet legal requirements planned by the provider after our 14 and 16 June 2017 inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and well led. This is because the service was not meeting some legal requirements.

The inspection team consisted of one inspector, an interim inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law such as such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit we spoke with five people who used the service and two relatives. We spoke with five members of care staff, the head of care, the deputy manager, the registered manager and the provider.

To help us assess how people's care needs were being met we reviewed all, or part of, nine people's care records and other information, for example their risk assessments. We also looked at the medicines records of three people, three staff recruitment files and a range of records relating to the running of the service, for example audits. We carried out general observations of people's care and support; we also looked at the interactions between staff and people living at the home.

Requires Improvement

Is the service safe?

Our findings

At our June 2017 inspection we found people were not adequately protected from risks associated with their care and support. This resulted in us finding risks to the health and safety of people using the service. Following our last inspection we took enforcement action against the provider and issued a Warning Notice to ensure improvements were made in this area. During this inspection we found that the requirements of the warning notice had not been fully met and we had ongoing concerns about the safety of the service.

Bed rails were still not used safely or effectively. We found four instances where bedrails were not safe. For example, one person's care plan specified that they required bedrails to ensure their safety. However we observed that they only had a bedrail on one side of their bed. We spoke with the registered manager about this and he told us that beds were usually pushed up against the wall with the brake on. This was not a safe method of preventing people from falling from their bed and posed a risk that the person may fall between the bed and wall. In addition to this, we reviewed the bedrails risk assessments and found that these did not identify risks associated with bedrails. For instance, another person had gaps at the top of their bedrail which posed a risk that they may become entrapped. This risk was not identified in the bedrails risk assessment and subsequently had not been mitigated. This failure to identify and address risks associated with bedrails placed people at risk of serious harm. We raised these concerns with the provider during our visit and they took immediate action to order new beds with bedrails for people.

At our June 2017 inspection we found that people were not adequately protected from risks arising from the environment. We identified further concerns during this inspection. During this inspection the boiler was malfunctioning and consequently portable heaters were in use. These heaters posed a specific risk to people who were independently mobile and in particular those who did not have capacity to ensure their own safety; we found that these risks had not been affectively assessed. For example, records showed that one person had experienced two recent falls one of which was in their bedroom. During our inspection we observed that they were alone in their bedroom with a portable heater on, there were not sufficient control measures in place to mitigate the risk of the person falling and sustaining burns from the surface of the heater. Furthermore, a generic risk assessment related to the use of portable heaters stated that staff should closely monitor people to prevent the risk of burns. However, we reviewed overnight checks for two people and found that they were only being checked two hourly, this was not sufficient to reduce the risk of potential burns. This failure to effectively mitigate the risks associated with the use of portable heaters exposed people to the risk of burns.

Adequate precautions had not been taken to mitigate the risk of people falling against or through windows and this exposed people to the risk of harm. We found that windows throughout the first floor were in a poor state of repair and were not all adequately glazed to ensure people's safety. For example, one window was damaged resulting in the side of the glass being exposed and the glass being lose, other windows on the first floor were not glazed with safety glass or covering some were fragile and lose. During our inspection we observed that one person who had advanced dementia and who was independently mobile was left unattended in their bedroom on the first floor of the building for a significant period of time. Although staff checked on their wellbeing periodically there were no control measures in place to reduce the risks

associated with unsafe windows. The failure to ensure the safety of windows placed people at risk of serious harm.

People living at the home were not protected from the risk of pressure ulcers or skin damage. We found that the care plans of people who had been assessed as being at high risk of pressure ulcers contained insufficient information to inform safe support. For example, one person had been assessed as being at high risk of pressure ulcers and during our inspection we observed that they had an open wound on their leg. Although records showed that the wound was being dressed by the district nursing team we found that their care plan did not contain any information for staff about how to care for the wound or what to do if it worsened. This placed the person at an increased risk of deterioration of the wound. We also found that guidance to promote the prevention of pressure ulcers was not always followed. Another person's care plan specified that they required assistance to change position every two hours throughout the night to maintain their skin integrity. We reviewed records and found that these did not evidence that care had been provided as required. For example, there were no records of repositioning for two of the seven days prior to our inspection. This meant that we could not be assured that all practicable steps had been taken to protect people from the risk of pressure ulcers.

When people were prescribed creams for application on a particular part of their body there were not clear details of how, where and why these creams should be applied and staff did not consistently record the application of these creams. This meant we could not be assured that people's creams were applied as required and there was a risk of people developing sore or injured skin.

People were placed at an increased risk of harm due to insufficient moving and handling risk assessments and a lack of guidance related to safe moving and handling. During our inspection we observed this lack of guidance had resulted in the use of unsafe moving and handling practices. We observed staff assisting one person to stand in an unsafe manner. One member of staff placed their hand in the person's arm pit and pulled them up whilst a second member of staff used the back of the person's clothing trousers to pull them up. This was not a safe method of moving and handling and placed the person at an increased risk of harm. We checked the person's care plan and found that this did not contain a sufficiently detailed description of their mobility needs. Records showed that staff had identified a deterioration in the person's mobility and had requested input from a physiotherapist. However their care plan had not been updated to reflect this and consequently no interim plans had been put in place to safely support the person's mobility in the short term. We also viewed other people's care plans and found that they did not contain sufficient detail about how to use mobility equipment. This lack of effective risk assessment and information related to moving and handling put people at risk of harm resulting from poor or unsafe moving and handling practices.

The quality of risk assessments, care plans and recording in relation to falls management was insufficient and put people at risk of harm. Although falls risk assessments had been completed these did not accurately reflect people's needs or detail what action had been taken to mitigate the risk of falls. For example one person had a very recent history of multiple falls, a falls risk assessment had been completed but it did not specify what measures had been put in place to reduce the risk of falls. During our inspection visit we observed that the person spent the day in their bedroom. Records showed staff were checking on the person every two hours. Although they had a movement sensor mat in place this was tucked under their bed and turned off. This posed a risk that the person may fall in their room and not be attended to for up to two hours. This meant that we could not be assured that all practicable steps had been taken to reduce the risk of the person sustaining further falls.

All of the above information was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we remained concerned about the serious risks outlined above. Consequently, we wrote to the provider and asked them to ensure that urgent action was taken to address these risks. The provider was responsive to our concerns and provided an action plan and supporting evidence to show appropriate action had been taken to reduce the above risks to people living at Copper Beeches. Windows were made safe, new bedrails implemented and care plans and risk assessments were reviewed to ensure that they clearly reflected people's needs. The local authority visited the service following our inspection visit and confirmed that this action had been taken to ensure people's safety. However, it remains of concern that these risks had not been identified, assessed and remedied prior to our inspection.

During our June 2017 inspection we found that people were not always protected from institutional abuse as they were assisted to get up and dressed very early in the morning. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that this was no longer the case and the service was no longer in breach of the legal regulations in this area. We arrived at the service at 6.20am and found that there was no one up in communal areas. Staff were assisting one person with personal care upon our arrival. We observed that staff dressed the person and then returned them to their bed, staff explained this was the person's choice.

Prior to our June 2017 inspection we received concerns that people who used the service were at risk of emotional abuse and distress as a result of witnessing acts of physical violence occurring between staff. At this inspection we received no further concerns about this and during the course of the inspection the provider took action which prevented any further occurrences.

At our inspection in June 2017 we found several concerns relating to the management of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that improvements had been made to the way medicines were stored and managed. People and their relatives told us that they got their medicines as needed. We found that medicines were well organised and stored safely. Medicines records were completed accurately to demonstrate that people had been given their medicines as prescribed. Staff had been trained in the safe handling and administration of medicines and had their competency assessed to ensure their ongoing capability.

During this inspection we found that improvements had been made to the management of risks associated with Legionella. Legionella is a bacterium that can develop in stagnant water and can lead to a fatal form of pneumonia. Since our June 2017 inspection, a legionella risk assessment had been put in place and we saw evidence that frequent checks of the water supply were being undertaken.

During our June 2017 inspection we found that the service was not always clean or hygienic and food hygiene practices were not followed. During this inspection we found that improvements had been made in these areas. We observed that food was stored appropriately and was date marked to ensure that people were not served food which was unsafe to eat. Improvements were underway to improve the cleanliness of the environment. For example, the kitchen was significantly cleaner and improvements were being made to other parts of the building, such as the installation of new washbasins in people's bedrooms.

During our last inspection we found that safe recruitment practices had not always been followed.
This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the provider had made improvements in this area. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. Proof of identity and

references had been obtained prior to employment and were retained by the provider. This meant that the necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

We recommend the provider considers ways to further develop their recruitment processes to ensure that all practical steps are taken to ensure the safe recruitment of staff.

People told us that there were enough staff to meet their needs and keep them safe. A relative of one person told us, "There always seems to be enough staff around and [relation] can get up and go to bed when they like." The staff we spoke with told us that staffing levels were usually sufficient and said that the staff team worked together to cover any last minute absences. During our visit we observed that there were enough staff present to meet people's needs and people were assisted in a timely manner. Staff were deployed effectively to ensure that they were available to respond to people's requests for support. Records showed that shifts were staffed to the levels determined by the provider. This meant that people could be assured that they would be supported by sufficient numbers of staff to meet their needs and ensure their safety.

Inadequate

Is the service well-led?

Our findings

During our June 2017 inspection we found that governance systems were not effective in ensuring that Copper Beeches met the fundamental standards. This resulted in us finding risks to the health and safety of people using the service. Following our last inspection we took enforcement action against the provider and issued a Warning Notice to ensure that improvements were made in this area. During this inspection we found that the requirements of the warning notice had not been fully met and we had ongoing concerns about the leadership and governance of the service.

It is of significant concern that a number of serious risks to the health and safety of people living at Copper Beeches had not been identified prior to our inspection. Despite audits having been conducted by the provider and registered manager, a number of concerns that we found during our inspection had not been identified and consequently no action had been taken to safeguard people from harm. This demonstrated the ineffectiveness of the governance and oversight processes in place at Copper Beeches.

At our June 2017 inspection we found that there were not sufficient systems in place to ensure the safe and effective running of the service. During this inspection we found the provider had introduced some new audits however these were not fully effective in identifying issues and this resulted in a failure to identify risks to people who used the service. New care plan audits had been effective in identifying some concerns but action had not been taken to prioritise high risk areas. For example, we reviewed three of the eight care plan audits completed by a representative of the provider and two of these identified that care plans did not contain sufficient information about people's mobility. However during inspection we did not see any evidence that demonstrated work had started to improve the quality of information about how to assist people with their mobility. This failure to take swift action on known insufficiencies in care planning placed people at increased risk of harm; during our inspection we observed an incident of unsafe moving and handling practices which placed the person at an increased risk of potential harm.

Care plan audits had also identified that risk assessments were not always completed accurately or effectively. In response to this the provider had planned further training for staff completing risk assessments. No other actions had been noted to ensure the accurate completion of risk assessments. Consequently during our inspection we found that these failings in risk assessments exposed people to the risk of harm. For example, we found that bed rails risk assessments were not effective in assessing and mitigating the risks associated with bedrails, this had resulted in the unsafe use of bedrails and placed people at risk of serious harm.

The approach to quality assurance was reactive rather than proactive and the improvements made since our last inspection were limited in scope. For example, during our June 2017 inspection we identified issues with bedrails. At this inspection we identified further concerns with bedrails. We shared this with the provider who informed us that they had addressed the issue in relation to beds cited in our June 2017 report but had not looked at others in the service. Neither the registered manager nor provider had conducted a full audit of bed rails following our June 2017 inspection and consequently they had not identified the issues that we found. This reactive response to quality assurance placed people at risk of harm.

There was no effective system in place for analysis and investigation of accidents and incidents across the service. The registered manager completed a basic matrix of falls on a monthly basis. However, we found that not all falls were recorded on this and even when falls were recorded there was no evidence of any action having been taken to reduce the risk of repeat events. For example, prior to our inspection we were informed that one person required hospital treatment as a result of falling from their wheelchair. This fall was not recorded on the monthly falls analysis and we found that the person's care plan and risk assessments had not been reviewed in light of the incident. This meant that we could not be assured that adequate steps had been taken to learn from incidents to try and prevent future occurrences. This failure to analyse and learn from adverse events did not assure us that all reasonable steps had been taken to protect people from the risk of future falls and subsequent harm.

Systems for involving and including people and their families in the running of the service were limited. Although we found that some improvements had been made since our last inspection, such as, addressing concerns raised in a survey conducted in early 2017, people were still not fully involved in the running of the service. There had been no meetings for people who used the service or their families since our June 2017 inspection; the registered manager told us they had not had time to prioritise this. This lack of involvement was reflected in comments made by both people who used the service and their families. One person commented, "We should know about these things (the outcome of CQC inspections) after all it's our home isn't it." They also told us they had not been informed about other things around the home such as maintenance issues and planned building work. The relative of another person told us, "It's (the home) much of a muchness really. It's clean and tidy, but they don't keep me very well informed."

Leadership at Copper Beeches was poor and during our inspection we found a number of concerns related to the competency of the registered manager. Although some improvements were evident at our October 2017 inspection these were, on the whole attributable to the provider and a registered manager of another service (owned by the provider) who had been supporting the service. We did not have confidence in the registered manager to ensure the safe and effective running of the service. We identified concerns about the registered manager's ability to identify and act upon risks to people living at Copper Beeches. For instance, the registered manager told us that he was aware that some of the bed rails placed people at risk of falls or entrapment but he had not taken action to escalate these concerns to the provider. This failure to act upon known risks exposed people to the risk of serious harm. Feedback about the management of the service from people who used the service and their families was mixed. One relative we spoke with talked positively about the manager and said, "I believe the manager to be good, I have a good relationship with the management. I think it is well led here." In contrast, the relative of another person commented on their experience of sharing important information about the care of their loved one with the management of the service. They told us, "Oh you just go around in circles."

All of the above information was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we remained concerned that about leadership and governance at the service as outlined above. Consequently, we wrote to the provider and asked them to ensure that urgent action was taken to address these issues. The provider was very responsive to this and acted swiftly to address our concerns. We were provided with an action plan and evidence that appropriate action had been taken or was underway to reduce the risks to people living at Copper Beeches. This included making changes to the management of the service and improving and strengthening the auditing systems. Further work is needed to ensure the effectiveness and sustainability of these new systems and processes.

During this inspection we found that the provider had not ensured that we were notified of incidents at the

service, which they are required to by law. There had been a failure to notify us of events that impacted on the running of the service; for example heating failure. They had also failed to inform us of any Deprivation of Liberty Safeguards (DoLS) authorisations (a safeguard to ensure that the freedom of people living in care homes is not unnecessarily restricted). A failure to notify us of incidents had an impact on our ability to monitor the safety and quality of the service. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and on the providers website, 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. During this inspection we found that the provider had not displayed their most recent rating in the home. We discussed this with them and they informed us this was an oversight and advised us that they would rectify this. The provider had displayed the rating on their website.

Staff felt supported in their roles and told us the management team were friendly and approachable. Staff were able to offer feedback during supervision meetings and team meetings. Records showed that staff meetings took place regularly and were used to address issues and for the management to provide feedback to the staff team.

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 18 Registration Regulations 2009 Notifications of other incidents Notifications of events that stop the service and authorisations of DoLS were not submitted to the Commission as required. Regulation 18

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with their care and support or risks arising from the environment. Equipment was not used safely and unsafe moving and handling practices were witnessed. Regulation 12 (1) (2)

The enforcement action we took:

We took action to cancel the registration of the manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Auditing systems were not effective in identifying or addressing risks to people who used the service. There were concerns with the management and leadership at the home. Opportunities for people living at the home to provide feedback on the service were limited. Regulation 17 (1) (2)

The enforcement action we took:

We took action to cancel the registration of the manager.