

Larchwood Court Limited

Copperfields Residential Home

Inspection report

42 Villa Road
Higham
Kent
ME3 7BX

Tel: 01474824122
Website: www.larchwoodcourt.co.uk

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Copperfields is a residential care home providing personal care to 16 people. The service can support up to 20 people in one adapted building. People using the service were older people, some people were living with dementia and other people had a learning disability.

People's experience of using this service and what we found

Most risks to people had been identified and processes ensured mitigation was in place to reduce them. This included ensuring appropriate healthcare professionals were involved in people's care. However, some risk assessments did not fully reflect the guidance provided by the healthcare professionals. Behaviour management plans needed to be further developed to help staff better understand triggers and strategies to support them consistently and safely. Accessible stair ways presented a potential risk to some people. Individual risk assessments had not been completed to assess this risk and stair gates were not in place.

Some checks to ensure the safety of the home environment had been in place but had lapsed recently following the departure of a staff member who had previously been responsible for these. Safety critical servicing and repairs of equipment continued to be completed by external contractors.

Medicines were not always managed safely. The storage of some medicines and management of bottled liquid medicine did not meet national guidance. However, people received their medicines as prescribed, medicines were booked into the service appropriately and unused medicine was disposed of safely. We have made a recommendation about the management of some medicines.

The registered manager and provider completed checks of the environment and audits of the quality of service provided. However, these were not sufficiently robust to identify the concerns found at this inspection so were ineffective in their use.

There were enough numbers of staff to support people. Recruitment of staff had been problematic and the home was heavily reliant on agency staff to fill vacancy gaps.

Staff had received safeguarding training and people were protected from abuse. Potential safeguarding matters were brought to the attention of the registered manager and had been referred to the local authority safeguarding team appropriately.

There were appropriate measures in place for the prevention and control of infection. However, some wooden fixtures were showing signs of wear which made them difficult to clean effectively. The service was working within current infection control guidance and staff were wearing personal protective equipment (PPE) as required. The service was clean and chemicals were being stored safely.

Opportunities for people to voice their views about the home had been limited, although plans were now in place for this to happen. The provider and registered manager were working through an action plan to

improve the quality of the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture by promoting choice and control, independence and inclusion. However, staff faced challenges in making sure people's support focused on them having as many opportunities as possible to gain new skills and become more independent. This was because they supported people with a learning disability and older people. These two groups had different and complex needs which the service did not always find easy to balance.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was Requires Improvement. (Published 28 February 2020) and there were multiple breaches of regulation. The service remains rated requires improvement. The service has been rated requires improvement for the last two consecutive inspections.

Why we inspected

We received concerns in relation to the management of staff, low staffing levels and poor mandatory staff training levels. Further concerns received related to medication management, inadequate and inconsistent care planning documentation and risk assessments, the provider not consistently reporting accidents and incidents and concerns about the safety of the home environment. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Copperfields on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to good governance at this inspection. We have made two recommendations about risk assessment processes, the management of medicines and staffing.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Copperfields Residential Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by two inspectors.

Service and service type

Copperfields 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the provider less than 24 hours' notice of the inspection. This was to check if any staff or people at the service had tested positive or had symptoms of COVID-19 and to discuss arrangements for the inspection and PPE required.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. The registered manager engaged in an Emergency Support Framework (ESF) call with a CQC inspector prior to the inspection. This is a supportive conversation CQC has held with providers or registered managers of all services during the COVID-19 pandemic crisis to check how they were managing. We used all this information to plan our inspection.

During the inspection

We spoke with five people who used the service about their experience of the care provided. We spoke with four members of staff including carers, housekeeping staff as well as the registered manager and provider. We 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 a range of records. This included five people's care records and a selection of medication records. We looked at two staff files in relation to recruitment. We asked the registered manager to send a range of documents by email to support the inspection. This enabled inspectors to spend less time in the service, to support restrictions to reduce infection during the COVID-19 crisis.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We reviewed a range of documentary evidence including training records, meetings, auditing and monitoring documents.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks were not always safely managed. Some risk assessments lacked detail provided by healthcare professionals. For example, one person with diabetes no longer required their blood sugar levels to be regularly checked to reduce their anxiety and monitor their condition. This advice had been provided by specialist diabetes nurses but was not recorded in the person's risk assessment around their condition. A risk assessment for another person did not include guidance that softer food options should be given if the person did not respond to verbal prompts to slow down when eating. Although staff were aware of these instructions, the incomplete records provided potential for inconsistent care.
- Some people experienced behaviour which could be challenging to others, staff and themselves. There was little guidance to help staff understand triggers and strategies to support people consistently and safely when they became agitated. On some occasions, behaviour had resulted in poor experiences for other people to the extent that safeguarding authorities were informed.
- Where people were independently able to walk around the home, risk assessments had not been completed to assess if they were safely able to use the stairs and, if required, reduce the risk.
- Monthly hot water temperature checks had not been completed since July 2020. There was no historical data to suggest problems with high water temperatures. However, this did not meet with the provider's policy or support safe practice to reduce risks of scalding. Where equipment should be certified as safe to use, certificates were not always in place. For example, there was no safety certificate for a gas fuelled tumble drier. The condition of some furniture was poor, with detached drawer fronts and a wardrobe door broken from its hinges. Some replacement furniture had been ordered and some awaited repair. We have received assurance that repair and replacement of furniture is underway.

We recommend the provider ensures risks to people and the environment were appropriately recorded and mitigated.

- Otherwise, where people were at risk of skin breakdown, pressure reducing equipment and monitoring was in use and reviewed. Risk assessments and guidance set out how to support people with specific health conditions, how to recognise changes in their condition and what staff should do. Where people were at risk of falls or required support with swallowing, nutrition or their mental health, referrals had been made to relevant health care professionals.

Using medicines safely

At our last inspection we made a recommendation about the positioning of medicated skin patches. Although improvement had been made in this aspect, we have identified that the management of medicines

does not meet current guidance in other areas.

- The storage temperature of controlled medicines was not monitored. Controlled medicines are tightly controlled by the government because they may be abused or cause addiction. This was because they were stored away from stocks of other medicines. The temperature of the medicines fridge had been monitored until recently, but was no longer monitored. This was because the form used to record medicine storage temperatures and been updated and the fridge monitoring section had been omitted in error.

We recommended the provider updates their practices around the storage of medicines to ensure it meets current national guidance.

- Otherwise, records showed people received their medicine when required. Medicine administration record (MAR) charts included a recent photograph of the person together with details of any medicine the person was allergic to. Medicated skin patches were applied in line with treatment instructions to decrease the risk of skin irritation, or possible skin breakdown. Staff checked the stock levels each time they administered medicines to check they were correct.
- Where some people received PRN (prescribed medicine given as and when required), there were clear guidelines in place about when to give the medicine and what to do if it did not have the expected effect. The reason for administering PRN medicines was recorded on the MAR chart. Staff received training in the safe management of medicines, and competency checks reviewed their understanding and safe practice. However, that this was not always effective due to the issues we identified with storage and the management of bottled medicines.
- A secure room was used to store the main supply of medicines. Room temperature checks were completed regularly which ensured they were stored in line with national guidance. There was an effective system for booking in new medicines, maintaining a stock count and disposal of unwanted medicines.

Staffing and recruitment

- There were enough staff to meet people's needs. People told us they felt there were enough staff and our observations found staff responded to people as needed, such as when they needed assistance to eat or reassurance. One person told us, "If I need some help there is always staff here, they come soon enough". People looked clean and cared for, and care records reflected that people received the support they required. The provider used a dependency tool to calculate the numbers of staff needed based on people's support requirements. We identified occasions where staffing had increased to meet people's changing needs.
- However, the home had several care staff and ancillary staff vacancies. Recruitment of staff had been problematic and the home relied heavily on agency staff. The registered manager supported people five mornings a week to help address staff shortages. In addition, as they lived on-site and at night, they usually acted as the sleep in member of staff to support the wake night member of staff if required in the case of an emergency. Sleep-in staff sleep at the workplace, so they are available to support people during the night if needed. Wake night staff stay overnight and work as they would during the day.
- We discussed barriers to staff recruitment with the provider and registered manager. They partially attributed this to factors such as public transport difficulties and the COVID-19 pandemic. We found while the home operated with adequate staff in terms of meeting people's needs, it was unstable and not sustainable. Although the registered manager and provider shared daily oversight of the service, other demands on their time to make up care staff deficits meant their oversight of the service was not wholly effective. The provider acknowledged recruitment and retention of staff was an area requiring improvement. They were actively seeking to recruit permanent staff and conducting exit interviews to understand staff retention difficulties.

- We reviewed recruitment practices. Checks on permanent new staff included obtaining a person's work references, identity, employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through hygiene practices. We had some concerns around areas of the environment that created an infection control risk. These related to the poor condition of some basin vanity units in some bedrooms. This was because some protective surfaces were worn or chipped exposing the porous wooden substructure. This would absorb liquids, making surfaces difficult to clean. We noted similar concerns with a bathroom radiator cover and a wooden plinth used to raise the height of a toilet. These were discussed with the provider and added to the home's maintenance plan.
- We were not assured that the provider was using PPE effectively and safely. While staff were using PPE effectively and safely, we however noted that the provider did not always wear a face covering when in the home.

We have signposted the provider to resources to develop their approach in these areas.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. One person commented, "I would rather be at home, but I am safe living here". The provider and registered manager reported any safeguarding concerns and worked with appropriate authorities to address issues identified.
- The provider had a safeguarding policy in place which was regularly reviewed. The registered manager was aware of their responsibilities and dealt with any concerns appropriately.
- Staff had received training in safeguarding and were aware of their responsibilities. Staff told us how they were able to recognise potential signs of abuse and they felt comfortable reporting safeguarding issues.

Learning lessons when things go wrong

- Accidents and incidents were recorded and monitored. This was so action could be taken to reduce the chance of reoccurrence.
- The provider reviewed all accidents and incidents so the care people received could be reviewed. Lessons learned from these events were discussed at staff meetings. For example, the introduction of a pressure mat to alert staff for a person at risk of falls.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider failed to ensure there were effective systems to assess, improve and monitor the quality of care. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, the provider failed to notify the Care Quality Commission of notifiable incidents. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. The provider failed to notify the Care Quality Commission of notifiable events. This was a breach of Regulation 14 (Notification of absence) of the Care Quality Commission (Registration) Regulations 2009.

At this inspection, some improvement had been made and the provider was no longer in breach of Regulations 14 and 18. However, improvement had not been made in relation to the governance of the service and the provider was still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- A process was in place to check the quality of care and safety. However, checks were not wholly effective. Checks had not identified missing information from risk assessments or the potential benefit of positive behaviour plans for some people.
- A lack of contingency planning meant key safety checks had lapsed when key staff were no longer available to undertake them, such as water temperature checks. Although room checks had taken place, both the registered manager and provider were unaware of the extent of furniture which required repair or replacement. This demonstrated a lack of management oversight.
- While the provider had sought to recruit staff to work at the service, this was largely unsuccessful. The registered manager regularly supplemented care staff duties which had resulted in a decrease of their oversight in the day to day running of the service, for example, in relation to stringent and effective auditing.

The failure to assess, monitor and improve the quality and safety of the service is a continuing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- However, the management team had fulfilled other areas of their roles and responsibilities. They had assessed and planned how staff would be protected in the event of a COVID-19 outbreak at the service. The provider had displayed the Care Quality Commission quality rating in the service and on their website, so people, visitors and those seeking information about the service were informed of our judgments. The registered manager understood the duty of candour requirements. They knew when they were required to notify CQC of events that had happened at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives were engaged with the service through meetings and survey questionnaires. The last relatives meeting had been held in December 2019. Resident meetings had not previously taken place. However, the provider recognised some people were now interested in having meetings and had planned for these to take place. One person told us, "It would be good to decide together the entertainment and things to do". A relative commented, "Communication can always be improved, but actually I think it is good".
- Staff had worked hard to ensure people were not unsettled by the measures in place to protect them from the risk of contracting COVID-19. They had spoken with people about the need to restrict visitors and why PPE was in use. Families were kept updated and the service allowed visits to a restricted area within the service.
- The registered manager held staff meetings where staff could raise issues and information could be shared. Staff told us they found these helpful, explaining, "It provides a forum to ensure a common understanding".

Working in partnership with others

- The manager worked with other professionals to support people to stay as safe and well as possible. For example, they had ordered a stock of COVID-19 test kits, so they could test staff and people regularly. Where people needed support from other health care professionals, referrals had been made. These included, occupational and speech and language therapists as well as the community mental health team.
- People were referred to advocacy services when they needed to make important decisions about their lives.
- The registered manager was part of a local registered managers group which they used to gather information around best practice. They also kept up to date on local challenges and ways to overcome them. They knew who they could contact for support with issues or concerns, including CCG staff and the local authority safeguarding 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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective systems to assess, improve and monitor the quality of care and mitigate risk. Reg 17 (1)(2)(a)(b)