MMCG (2) Limited

Coplands Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Coplands Nursing Home is a care home with nursing operated by Maria Mallaband Care Group (2). It is registered to provide accommodation with personal and nursing care for seventy-nine older people who may also have dementia. At the time of this inspection, there were sixty-six people using the service.

People's experience of using this service:
Several safeguarding concerns and complaints had been reported to us and the local authority before the inspection. These related to the safety of people who used the service and the conduct of some staff. The investigation of these concerns was still ongoing. We also noted some deficiencies in the arrangements for safeguarding people which may put people at risk of harm.

Risk assessments had been documented. These risk assessments covered areas such as the risk of falling, behaviour which challenged the service and choking. We however, noted that some of these risk assessments were not comprehensive and did not include sufficient guidance for minimising the risks.

We examined arrangements for the care of people with behaviour which challenged the service. We found that this was not well managed. In one instance, where a person with behaviour which challenged the service had sustained injuries, we saw no analysis of previous incidents and no subsequent guidance to prevent re-occurrences. Care plans and risk assessments were not updated following these incidents.

Medicines had not always been given as prescribed. We noted that there were two instances when medicines were not given to people. There were discrepancies in the medicines stock of people identified on the day of inspection.

The premises were clean and tidy on the day of inspection. We however, noted that there were deficiencies related to the control of infections and this placed people at risk of harm. A recent visit by the local health authority infection control nurse just prior to this inspection made recommendations for improvements.

Staff were recruited with care and the service had carried out the necessary recruitment checks before care staff could commence work. Staffing levels had been reviewed and this indicated that there was sufficient staff. We however, found that the deployment of staff was not satisfactory. The staff rotas examined did not identify which care staff was responsible for providing one to one care for people who needed it. We had also received complaints that some people were not receiving all the care needed as staff did not always respond to their needs or answer the call bells.

There were deficiencies in the fire safety arrangements as noted in the fire authorities report of 21 October 2019. At the time of inspection, remedial work was nearing completion. We however, noted that the personal emergency and evacuation plans (PEEP) of two people had not been adequately completed to ensure that staff were fully informed in the event of an emergency.

The home had quality monitoring systems. Checks and audits had been carried out. These included checks and audits of care plans, medicines, health and safety checks and checks on the maintenance of the home. The audits were not sufficiently effective as we noted numerous deficiencies which were not promptly rectified.

Following concerns expressed by us and the local authority, the service had voluntarily suspended all admissions into the home and updated their action plan for rectifying deficiencies and improving people's experiences of the service. At the time of writing this report several deficiencies still needed to be rectified.

The registered manager had been suspended and resigned from his post just prior to this inspection. Staff informed us that they had found their management to be unsupportive and morale had been low. An interim manager was in place at the time of this inspection.

Rating at last inspection:
The service had been inspected on 8 February 2018 (published 23 March 2018) and was rated as Good. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Why we inspected:
We undertook this focused inspection due to recent safeguarding concerns and complaints received. This report only covers our findings in relation to the Key Questions Safe and Well-led. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has deteriorated to Requires Improvement.

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

Enforcement:
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 breaches of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014 in relation to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing).

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 this service at a later date to check compliance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not well led.

Details are in our safe findings below.

Coplands Nursing 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 to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide 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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
This inspection was carried out by two inspectors, and a nurse specialist.

Service and service type
Coplands Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission 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. The registered manager was suspended and later resigned just prior to the inspection. An interim manager was present during the inspection. The registered manager applied to cancel his registration soon after the inspection and this application was approved.

Notice of inspection
This was a responsive unannounced inspection, which took place on 3 September 2020. We brought forward this inspection in response to concerns we received regarding the service.

Before the inspection
We reviewed information, we held about the service. This included details about incidents the provider must notify us about, such as allegations of abuse, and accident and incidents. We also reviewed reports about the home provided by the local authority.

During the inspection
We spoke with the interim manager, the nurse practitioner and five other staff. We reviewed six people's care records, which included care plans and risk assessments. We also looked at five staff recruitment files and the staff rota. We looked at records relating to the management of the service which included medicine administration charts, maintenance files, checks and audits.

After the inspection
We spoke with three people who used the service and two relatives. We also spoke with four more staff, the regional director of the company and received feedback from a healthcare professional and two local authority staff.

Inadequate

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 good. At this inspection this key question was rated as inadequate. This meant people were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

● Several safeguarding concerns and complaints had been reported to us and the local authority. At the time of this inspection there were five safeguarding concerns being looked into. These related to the safety of people who used the service and the conduct of some staff. The investigation of these concerns was still ongoing. At this inspection we found that the service had not properly responded to safeguarding complaints and concerns.

● In one instance, there was a delay of more than one month in suspending a staff member who was implicated in the abuse of a person. This meant that people were placed at risk of abuse from the staff concerned. In a second instance, an allegation of abuse was not promptly reported to us. We were not informed until seven days after the allegation was made. In a third instance, where there had been an unexplained injury, staff and people involved were not interviewed when the home was conducting their investigation. Fourthly, in the incident book on 10 February 2020 a nurse made an allegation of staff being aggressive towards a person who used the service, and that the person was transferred unsafely. They also asserted that staff on Eagle Ward used the person's bedroom as a changing room for themselves. There was no record of action taken in response to this. The failure to take proper action to safeguard people and in response to safeguarding concerns and complaints is a breach of regulation 13 (1)(2)(3) (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

●One person who received one to one care monitoring had experienced several falls in the past six months and two of these falls had led to hospital admissions. Another person had a fall from their bedroom window. Prior to this there had been several recorded instances of this person exhibiting behaviour which challenged the service, and this included damage to property. There was no evidence of action taken to analyse the triggers and implement a robust strategy to prevent such incidents and to protect the person from avoidable harm.

● Risk assessments been documented. These risk assessments covered areas such as the risk of falling, behaviour which challenged the service and choking. We however, noted that these risk assessments were not sufficiently comprehensive and did not include sufficient guidance for minimising the risks. One person was at risk of choking and had two hospital admissions for falls. Their care records did not contain a risk management plan or strategy for minimising these risks. In another instance, a person who had behaviour which challenged the service had several instances where they damaged property and acted in a distressed manner. Although the incidents were recorded, there was no comprehensive guidance to staff on observing for triggers to this behaviour, how to care effectively for this person and reduce potential risk to them and

others. With one exception, care staff had also not been provided with training on caring for people with mental healthcare needs. The above is evidence of a breach of regulation 12 (2)(a)(b) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There was a current safety inspection certificate for the electrical wiring. Window restrictors were in place. Weekly checks of the restrictors had been carried out. There were arrangements for fire safety. Fire drills and weekly fire alarm checks had been carried out. The home had a fire risk assessment in place. The fire authorities had carried out an inspection of the premises and their report of 21 October 2019 listed a number of deficiencies which needed to be rectified. At the time of inspection work was nearing completion.

● People using the service had personal emergency and evacuation plans (PEEP) in place in case of fire or an emergency. We however, noted that the PEEPS of two people out of five people examined had not been fully completed to ensure that staff were fully informed in the event of an emergency.

Using medicines safely

● Medicines had not always been given as prescribed. We noted that there were two instances when medicines had not been given to people as prescribed as identified in the home's own audit. On 27 August 2020 there was a discrepancy of 30 tablets in one person's stock of a medicine used to treat a mental health condition and a discrepancy of 15 tablets in another person's medicine used for reducing adverse reactions of the immune system of the body. The service took immediate action and notified the people concerned, their doctor, the local authority safeguarding team and the CQC. Further action taken included refresher training and daily checks on medicines.

● One relative complained that their relative who used the service had not been given their prescribed medicine. Another person who used the service also complained similarly. This meant that people may not be receiving appropriate treatment. The deficiencies associated with the administration of medicines placed people at risk of harm and is further evidence of a breach of regulation 12 (2)(b)(g) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

●The service had a system for recording of accidents and incidents. We however, noted that a person who had experienced several episodes of behaviour which challenged the service did not have an appropriate strategy for managing their behaviour. These incidents were not analysed so that lessons could be learned and access to professional healthcare support be obtained to help lessen these episodes.

● In another instance, the accident form of another person had not been completed following a fall. on 4 August 2020 after which they were taken to hospital. This meant that the causes of the incident could not be examined so that future risks to the person could be reduced.

●The above deficiencies are a breach of regulation 12(2)(a)(b)(Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●The service carried out recruitment checks before care workers could commence work at the service. This was to ensure care workers were suitable to care for people.

● Checks undertaken included two references, permission to work and proof of identity. We saw evidence of Disclosure and Barring Service checks (DBS) on each file that we looked at. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people.

● The manager informed us that the service had adequate staff and their review of staffing indicated this. We were however not confident that the staffing arrangements were sufficiently satisfactory for providing safe care for people. One relative told us that they were not confident that the home had sufficient staff as the care needs of their relative had not been fully met. A person who used the service also reiterated that staff had not been attentive toward them and they did not always respond to the care needs of people. This

meant that people felt neglected and their needs were not met. A visitor to the home also commented that the needs of the person they were visiting had not been met and staff were not always attentive. They stated that staff did not always checked on their relative when they should and their relative felt distressed at being ignored.

● Some people were contracted to have one to one care for certain hours of the day. The rota did not contain details of which staff was responsible for providing this one to one care. We also received feedback from a commissioning authority that staff were not clearly allocated to care for people commissioned for one to one care. One person who received one to one care monitoring had experienced several falls in the past six months. Another person had a fall from their bedroom window although they were on one to one care monitoring. The inadequate deployment of staff is a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The manager and regional director informed us that additional staff including two nurses had been recruited and some were already in post at the time this report was written.

Preventing and controlling infection

●The premises were clean and tidy on the day of inspection. Infection control procedures in place. Information was clearly displayed outside the door and at the entrance of the building. This clearly stated the specific actions to be taken by everybody including staff and visitors. There was controlled access to the building. People were met at the entrance of the building and reception staff ensured that visitors followed the correct procedure before being allowed on the premises. Their temperatures were checked. Personal protective equipment (PPE) such as gloves, masks and hand gel were available at different points of entry.

● A recent visit by the local health authority infection control nurse just prior to this inspection identified several deficiencies.

● One member of staff stated to a care professional that they were required to come back to work after only one week instead of two weeks after having tested positive for the Corona virus Covid-19. This was being investigated by the manager. One person who used the service stated that some care staff did not always wear appropriate PPEs when attending to people. The identified deficiencies placed people at risk of infection. The manager informed us that action was being taken to rectify these deficiencies.

Requires Improvement

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 good. At this inspection this key question has deteriorated to requires improvement. 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.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A formal satisfaction survey had been carried out in December 2019. The feedback received was mostly positive. We however, received feedback from a visitor to the home, a relative and a person who used the service telling us that staff had not been caring or responded to suggestions made by them. They informed us that personal care had not always been provided, request for special foods had not been responded to, staff did not talk to them in a respectful manner and they did not always respond promptly to the call bell. This meant that they were unable to access assistance when needed. The manager told us that he would be speaking with one of the relatives who was unhappy with the care provided. He also told us that more checks on the care provided would be arranged.
- Two other relatives we spoke with told us that communication with the home had been poor and they were not always informed about matters affecting the care of their relatives. One however, stated that there had been some improvement since the recent change in management. The second relative stated that further improvements were needed. One relative also stated that staff did not always answer phone calls or the doorbell. Another relative stated that they were not informed when visitors were not allowed in the home. This lack of communication had caused them inconvenience. The manager stated that he had already taken action to improve communication and had contacted relatives with updates regarding the home. He would also remind staff of the need to answer phone calls and doorbells promptly.
- The manager informed us that he would stress to staff the importance of showing respect and compassion for all people and of protecting their human rights. Refresher training on protecting the human rights of people, valuing diversity and ensuring equality was in the process of being organised.

Continuous learning and improving care

- The manager told us that the service carried out checks and audits in areas such as medicines, incidents and accidents, health and safety and care documentation. Evidence of these were seen by us and we noted that action had been taken to rectify some shortcomings. We however, noted that several deficiencies noted by us and professionals who visited the home had not been identified and rectified by the service. These included two inadequate PEEPs, infection control deficiencies, safeguarding deficiencies and the management of people who challenged the service. With one exception, care staff had also not been provided with training on caring for people with mental healthcare needs.
- The infection control nurse from the local authority had identified several deficiencies such as the lack of a proper system of scheduled and recorded cleaning to prevent infection and ensure that the premises were

kept clean. This had not been identified by the home's own management checks and audits.
● Two people were subject to one to one care monitoring. One had sustained injuries following a fall from their bedroom window. Another had experienced several falls in the past six months. Their care plans had not been updated and an effective strategy implemented to reduce risks to them.
● We noted that although deficiencies in the administration of medicines was identified in the home's audit in January 2020 and at other times, there continued to be deficiencies. The audit on the day of inspection indicated that two people had not been given their medicines as prescribed for several days. This meant that although checks had been carried out, the service continued to have deficiencies. We concluded that the quality assurance system was not sufficiently effective.
● The registered provider failed to have effective quality assurance systems. This placed people at risk of harm and of not receiving quality care. This was a breach of Regulation 17, section (2) (a) (b) (d) (e) (f) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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.
● People did not always receive a high-quality of care. This was reflected in numerous complaints we received about the home from people who used the service, their representatives and some of the staff. Some of these complaints had been referred to the local authority safeguarding team for investigation. Several of the people who used the service and their representatives had complained of poor quality care and a lack of compassionate and attentive staff.
● Some staff complained that morale had been poor, and management was not receptive towards suggestions made by them for improvement. A staff member complained that they felt victimised because of a complaint they made about the behaviour of a staff member. Another staff member stated that management did not promote a positive respectful culture. Three staff however, stated that since the change of management, the interim manager had brought about positive changes.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
●The service had a registered manager who had been suspended and had resigned prior to this inspection. An interim manager was in post who was responsible for the day to day running of the service. There was also a deputy manager and a team of senior staff and nurses supporting the interim manager.
● The service had experienced several failings and morale among staff had been poor. Senior management providing support to the home at the regional director level had been subject to several changes and were not always aware of all the deficiencies.
● In response to concerns, action had been taken to improve the care of people and the management of the home. The service had suspended new admissions into the home until further improvements are made. An updated action plan was in place and changes had been introduced to improve compliance with the regulatory requirements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that people were safely cared for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to take proper action in response to safeguarding concerns and complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to have effective quality assurance arrangements. This placed people at risk of harm and of not receiving quality care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not ensure that staff were adequately deployed to meet the care needs of people.