Amore Elderly Care Limited

Cooper House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Cooper House Care Home on 22 and 29 November 2016 and the visits were unannounced.

Cooper House is a purpose built care home situated in a residential area of Bradford. The home offers care to older people requiring general and specialist dementia nursing care and residential dementia care. Cooper House provides accommodation in 80 single en-suite bedrooms with shower facilities arranged over three floors. There are lounges and dining rooms on each floor, a garden area and car parking to the front of the building.

There was a registered manager in post. 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.

Prior to this inspection we had received a number of concerns relating to management of risks, people's personal care and nutritional needs not being met, lack of staff and management of the service.

When we inspected the service in March 2015 we identified seven breaches of regulations and the overall quality rating for the service was inadequate. When we returned in October 2015 we found some improvements had been made but the service remained in breach of three regulations and the overall quality rating was requires improvement. On this inspection we found some of the improvements we saw on the last inspection had not been sustained and there had been a further decline in the service.

Staff were being recruited safely, however, there were not enough care staff on duty to keep people safe or to meet their needs in a timely way. There were not enough housekeeping staff to ensure the home was kept clean at all times or enough laundry staff to ensure people's clothing was returned to the right people.

A number of people using the service had been assessed as being at high risk of falls. We saw there had been several un-witnessed falls on the second floor and not enough had been done to mitigate the risk of people falling. The design and layout of the building made it difficult for staff to supervise communal areas as well as the corridors. We saw people walking around going in and out of other people's bedrooms with no staff available to redirect them.

Although there were safeguarding policies and procedures in place and staff were able to tell us how they would make a referral they were not identifying omissions to people's care and their safety as safeguarding issues. Following our visit we made six safeguarding referrals to the local authority adult protection team for their consideration.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were being met and medicines were being managed safely.

People told us there was a choice of meals and the food was good. We saw people's weights were monitored closely and high calorie smoothies were provided to people who were nutritionally at risk.

In their direct dealings with people we saw most staff were kind and caring. However, we found practices in the home which showed a lack of respect and compassion for the people who lived there. People were not receiving person centred care which met their needs or preferences.

Staff told us training opportunities at the service were good and we saw from the records the majority of staff were up to date with their training. However, we saw there were times when staff did not have the necessary skills to support people.

There was a complaints procedure in place and formal complaints had been investigated and responded to. However, the registered manager was unaware of the problems with the laundry system which we raised with them.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems.

We found there was a lack of effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. We found shortfalls in the care and service provided to people. We identified seven breaches in regulations – regulation 18 (staffing), regulation 12 (safe care and treatment), regulation 13 (safeguarding), regulation 10 (dignity and respect), regulation 9 (person-centred care), regulation 11 (Need for consent), and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. 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?

Inadequate

The service was not safe.

There were not enough staff to keep people and their property safe or to keep the home clean.

There was not enough being done to reduce the risk of people falling and people were not safe.

Medicines were being managed safely.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always have the training, knowledge or skills to support people appropriately.

The service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People's nutritional and healthcare needs were being met.

Is the service caring?

Inadequate

The service was not caring.

People using the service were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving person centred care which met their needs or preferences.

There was a complaints procedure in place and formal complaints had been investigated and responded to.

There were not enough activities on offer to keep people

occupied.

Is the service well-led?

Inadequate

The service was not well-led.

A registered manager was in post.

Effective quality assurance systems were not in place to assess, monitor and improve the quality of the service. The improvements we found at the last inspection had not been sustained and we identified seven regulatory breaches on this visit.

Cooper House 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 22 and 29 November 2016. The inspection was carried out, on the first day, by three adult social care inspectors and two experts 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. Two adult social care inspectors returned on the second day to conclude the inspection.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. We also asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included 11people's care records, four staff records and records relating to the management of the service.

We spoke with 17 people who lived at Cooper House, 20 relatives, four nurses (days), two nurses (nights), six care workers(days), five care workers (nights), three housekeepers, one laundry assistant, the catering manager, the maintenance manager, the activities manager, a visiting community psychiatric nurse and the Boots pharmacist.

Inadequate

Is the service safe?

Our findings

We asked people who used the service if they thought there were enough staff on duty to support them. One person told us, "Sometimes there aren't enough staff." Another person said, "The staff are so lovely, they work so hard, though they could do with some more." A third person told us, "There are not enough staff, dinner [lunch] starts at 12:00hrs but I often don't get mine until 13:10hrs." They said there were lots of people who needed support to eat, so the food was often cold or frazzled. A fourth person said, "It's alright here, nice staff, but we could do with some more. They just keep coming and going."

We asked relatives the same question. One relative told us, "You can't find anyone [staff] to talk to, you just have to keep wandering around until you find someone." Another relative said, "It would be nice if there were more staff." A third relative told us, "They are light on staff." A fourth relative told us, "They run around like scalded cats. On one occasion I had to run down the corridor to find staff because someone had fallen out of their chair in the activity lounge."

We spoke with staff and they told us the ground floor and middle floor units needed more staff. One care worker said, "The middle floor needs more staff, people can be challenging and it can be chaotic. The nurses have been told to help." Another care worker told us, "There aren't enough staff on the middle floor. The nurses help out now and again with meals, we need more support from them." A third care worker commented, "The nurses on the middle floor need to support the care staff more on the floor helping out with the care."

Staff told us at weekends there was only one nurse on duty on the ground floor whereas during the week there were two nurses. They said the care staff levels at weekends had recently been increased to five instead of four to compensate for one less nurse but told us due to sickness there were often only four care staff and one nurse. The nurses told us with only one nurse the morning medicine round at weekends took them up to 90 minutes longer than during the week. They told us they had to do a stock count of all the controlled drugs daily and said this took two staff about 40 minutes to complete. We saw many of the people on the ground floor had complex health care needs and some were receiving end of life care. Staff confirmed the majority of people required two staff to assist them with care and support and said 16 of the 28 people accommodated on the ground floor required assistance from staff with food and drinks. Staff told us they had raised concerns about the staffing levels at meetings but nothing had been done. One staff member said, "We have enough time to get everything done on the ground floor by working non-stop but not to spend time with people. We have a lot of people on end of life care and would like to be with them more."

The ground floor provided spacious accommodation with communal rooms at opposite ends of the unit. We saw many of people stayed in their bedrooms, whereas others chose to spend time in the communal areas which meant it was difficult for staff to be available to people in all these areas. We saw one person in their room who told us they were in pain and had been for some time. Their call bell was not accessible and they said, "I don't like to trouble staff as they're always so busy. There's not enough of them. I'm so lonely." We alerted the nurse who came promptly and was kind with the person and gave them some pain relief.

When we returned on the second day the registered manager told us they had ordered a device which would ensure the call bell lead was always close to this person's hand as their sight was impaired so they could not always see where it was.

On the middle floor we saw there were two nurses on duty with five care staff, but saw from the duty rotas at weekends there was only one nurse on duty with five care staff. We saw people walking along the corridors going in and out of other people's bedrooms with no staff present to redirect them. A relative told us they noticed the nurses were busy with medicines but added they had never seen the nurses providing support, direction and leadership to care staff.

The registered manager told us staffing was calculated using the provider's dependency tool and were the best staffing levels they had ever had in a care home.

On the second day of the inspection we arrived at the service at 6:45am so we could speak with the night staff. The care staffs on the middle floor told us there should have been an additional care staff member on duty, who would 'float' between the three floors. However, they had telephoned in as being sick and their shift had not been covered. This was later confirmed by the registered manager.

We heard one person shouting out from their bedroom for seven minutes before a staff member attended to them. At the handover between the night staff and day staff there was an un-witnessed accident, where one person sustained a significant injury.

On the second day of the inspection we found day staffing levels on the ground and middle floor had been increased. The registered manager told us how much better it was since they had allocated an additional carer to each floor. We found the atmosphere on the ground floor was calmer and staff were not rushing. Staff we spoke with said the increase in staffing levels had made a big difference and felt they were now able to spend more time with people. The registered manager told us existing staff were providing extra cover but they were in the process of recruiting five more care staff. The day care staff on the middle floor told us it was much better with the additional staff member.

We saw recorded in the minutes from the heads of unit meeting minutes held at the beginning of October 2016, "Residents not to be left unsupervised in lounges or dining room." Over both days of the inspection we saw people who used the service in both the lounges and dining rooms without any staff being present.

A number of relatives we spoke with identified issues with the laundry in relation to clothing going missing or finding other people's clothing in wardrobes or drawers. The laundry assistant told us there was one person responsible for doing the laundry every day. Six days a week it was covered from 8am to 4pm and on the remaining day from 8am to 2pm. All of the laundry was completed 'in house' and laundry staff were also responsible for putting the laundry away.

Some relatives told us they did not think the home was as clean as it could be at times. One relative said, "They need more cleaners." A second relative said, "I have found faeces smeared on the surfaces in the bedroom." One of the housekeepers told us they thought more hours needed to be allocated to the middle floor, as it was difficult to keep on top of all of the cleaning. Whilst we were speaking with them in the lounge, we saw a pressure relieving cushion with dried food on it and there was food and paper underneath the television cabinet.

We concluded there were not enough staff to keep people and their property safe or to keep the home clean. This was a breach of the Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

When we inspected the service in October 2015 we found risks to people's health and safety were not understood and appropriately controlled by the service. At this inspection we found risk management remained poor in particular on the middle floor in relation to falls.

We saw one person with a very bruised face and their relative told us they had fallen out of a chair. We looked at their falls risk assessment and saw it had last been reviewed on 12 November 2016. Their falls diary was blank. The care record showed on 18 November 2016 the relative had been informed of a fall. The relative confirmed this and said they had been told the person had fallen from a chair. Yet daily care notes for 17 November 2016 stated the person had a bump on their forehead and the cause was unknown. The accident report stated the bump was suspected to have been caused by bumping into a hand rail while the person had been cleaning. There was no record of a fall.

We saw two people who used the service opening people's bedroom doors and going into these rooms. One of them told us, "I'm looking for my friend." There were no staff available to redirect them or to engage or distract them. One staff member told us, these two people did this all of the time.

On the second day we were attending the handover meeting between the night and day staff on the middle floor. During the meeting we heard a person shouting and staff went to investigate. We later ascertained two people who used the service were found in a bedroom which belonged to someone else. One of them was on the floor with a head injury, which was bleeding and required an ambulance to be called. What happened was not witnessed by staff. When we looked at the accident records we saw the person who had sustained the head injury had sustained a similar injury only two weeks before, following another un-witnessed fall.

We looked at the accident reports for the middle floor from the beginning of October 2016 to 29 November 2016 and saw there had been two previous un-witnessed falls whilst staff were receiving handover.

The layout of the middle floor is shaped like an 'H' with the lounge situated at the top right hand side and the dining room at the bottom left. It is not possible to observe the corridors from either of these two rooms. We concluded not enough was being done to mitigate the risks of people falling and risks were increased because there was a lack of staff supervision. This was a breach of the Regulation 12 (1) 2 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service if they felt safe. One person told us, "The only people you're not safe from are the other residents. We have to lock our rooms to keep stuff safe."
We asked visitors if they felt their relatives were safe at the home. One visitor told us, "Yes, the security is good and they change the codes [to the digital locks] regularly." Another relative told us, "I worry about other residents wandering into the bedroom all the time, staff just walk past the door and with the exception of one member of staff don't make any attempt to ask them to leave – some people can be 'violent' and I worry about mother's safety."

A number of relatives reported various items had gone missing from bedrooms which included a new set of sheets and ornaments.

We saw there were safeguarding policies and procedures in place and these were also on display. We spoke with four members of staff about their understanding of safeguarding and what they would do if they thought people who lived at the home were at risk. All of them told us they would not hesitate to report any

concerns to the manager, Care Quality Commission or the Adult Protection Unit.

However, our observation of people's individual experiences led us to make six referrals to the adult protection team in Bradford regarding our concerns about omissions to people's care and their safety.

One person's care records showed visiting restrictions were in place. Our discussions with the registered manager and the records we reviewed were not clear about how the person had been involved or whether they had the mental capacity to make this specific decision. The registered manager told us an application for a DoLS had been made in April 2016 and they were awaiting a decision. There was no evidence to show that other options had been considered and we were concerned the decision made may not be the least restrictive option or that this decision had been made in the best interest of the person. For this reason we made an additional safeguarding referral. This was a breach of the Regulation 13 (2) (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our review of staff files showed robust recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. All necessary checks had been completed before the staff member started work. This included a criminal record check through the Disclosure and Barring Service (DBS) and a minimum of two written references, one of which was from the last employer. The registered manager told us how people who used the service were involved in the recruitment process and their views of each applicant were gathered and considered as part of the decision making process. These were recorded alongside detailed interview notes. We saw systems were in place to check nurses maintained their registration with the Nursing and Midwifery Council. The staff we spoke with told us the recruitment process was thorough and confirmed they had not been allowed to start work until all the relevant checks had been completed.

The accommodation at Cooper House is arranged into three separate units. All of the bedrooms were single occupancy with en-suite toilets and showers. Each floor had its own lounge and dining areas and there was a hairdressing salon on the ground floor. We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems.

We saw at the last food standards agency inspection of the kitchen they had awarded them 5* for hygiene. This is the highest award that can be made. This showed us effective systems were in place to ensure food was being prepared and stored safely.

Staff were able to tell us the action they would take if the fire alarms sounded. This meant in an emergency staff knew what to do to keep people safe. We also found personal emergency evacuation plans (PEEPS) were up to date.

We asked people who used the service how their medicines were managed. One person told us, "It's always on time." Another person told us, "They are spot on with the medication," explaining they had been taking a lot of tablets but these had been cut down.

The pharmacist who supplied the home with their medicines was undertaking a medicines audit during our inspection. They told us they had been carrying out quarterly audits as there had been a number of concerns but said this had now been reduced to six monthly due to the improvements which had been made. They said they thought medicines were managed safely now. We were provided with a copy of the pharmacist's report when we returned on the second day. This showed some minor recommendations had been made but no immediate or serious concerns had been identified.

We looked at a sample of medicines on all three floors All medicines were stored securely and the temperatures of the storage areas, including the medicines fridges, were checked to make sure they were within the recommended limits.

We looked at the medication administration records (MARs). Most people had printed MARs which had been supplied by the pharmacist. We saw two handwritten entries on one MAR which had not been signed by two members of staff. However, the entries had been correctly transcribed so there was no risk to the person and the staff member we spoke with told us this would be addressed. When people were prescribed medicines to be taken 'as needed' (PRN) we found there was guidance, in the form of PRN protocols, for staff about when to offer this medicine to people.

Some medicines are classified as controlled drugs because there are particular rules about how they are stored and administered. We checked the storage, the records and stock level of one controlled drug and found this was correct.

Requires Improvement

Is the service effective?

Our findings

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 are called the Deprivation of Liberty Safeguards (DoLS).

We found, although staff had received training, they did not fully understand the principles of this legislation. For example, we spoke to the registered manager about the blank consent forms we found in people's files in relation to having their photograph taken. He told us the local authority was happy for relatives to sign these but CQC were not unless the relative had lasting power of attorney (LPA) for care and welfare. We discussed with them the need to address the issue where relatives did not have LPA by using a best interest process, involving all interested parties.

One person was receiving their medicines covertly, yet when we reviewed the care records for this person there was no legal framework in place which would allow medicines to be administered covertly. Whilst we saw a GP had stated they wished for medicines to be administered covertly to ensure good health was maintained we saw no other evidence to demonstrate the MCA 2005 was being complied with. There was no evidence of a best interest process, no evidence of a pharmacist's advice, no information with the MAR to state the person was taking their medicines covertly or to how to disguise the tablets and no plans to review the practice. We discussed this with the unit manager who immediately took steps to address these issues. This was a breach of the Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us opportunities for training was good, however, they said most of the training was computer based with a test at the end. One person said that you just kept doing the test until you got it right. Some staff we spoke with had not completed Mental Capacity Act or Deprivation of Liberty training.

Training information we received from the registered manager on the second day of the inspection showed 94.7% of staff employed were up-to-date with training. The remainder included staff whose training was due to expire shortly as well as training that was assigned but had not yet been completed. The registered manager confirmed most of the training was online and included assessments which staff had to complete to confirm their understanding. The registered manager explained the safeguards built into the system which alerted managers according to assessment results. For example, if staff failed to achieve the pass score or had made repeated attempts to do so. Face to face training was provided in areas such as moving and handling, basic life support, first aid and fire safety. We saw evidence of this training in the staff files we reviewed. We saw all staff who were involved in medicines management had completed competency assessments in the last 12 months. We saw where issues had been identified; the assessments had been repeated to make sure improvements had been made.

The registered manager told us all new staff completed a corporate induction over a three to six month period and worked in a supernumerary capacity shadowing more experienced staff members before being counted in the staff numbers. This was confirmed by one recently employed staff member we spoke with who described their induction and the shadowing they had completed. They said they thought the induction was good and prepared them for their role. We saw induction records in the staff files we reviewed. New staff without any previous care experience or qualifications then progressed to the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they needed to provide safe and compassionate care.

Staff we spoke with told us they received supervision but were not sure about the frequency of these support sessions. No one thought they received an annual appraisal. One member of staff told us they felt supported by the registered manager and how they had been relieved of a particular task they found very stressful.

The registered manager told us all staff received supervision every two months. They told us themes were identified for discussion such as pressure area care. We saw supervision records in staff files which reflected this and also showed staff practices, training and support were discussed. We saw evidence of an appraisal in one staff file.

We asked people who used the service about the meals at Cooper House. One person told us, "The meals are lovely." A second person told us, "The food is very good." A third person said, "I get my meals and the papers and have no grumbles about the food." A fourth person told us, "The meals are pretty good." A fifth person told us, "I am well fed and they [staff] know what I like."

One relative commented, "The meals are not bad the chef comes out and tells us if [Name] doesn't like something they will make what they want, like the other day when they wanted fish fingers." Another relative told us, "The food always smells nice."

One person praised the chef who they said had helped them a lot. They said the food provided was very good and wanted to know how they could make some of the meals when they returned home which they were due to do in the near future. They said the chef had given them lots of tips about how to cook things and they were looking forward to trying this out when they were back home.

We spoke with the chef who demonstrated a detailed knowledge of people's dietary needs and preferences. They showed us the 'Dietary summary sheets' they had developed. This listed every person who lived at the home together with and specific dietary needs. For example, diabetic, soft, coeliac, low and high fat. Copies of these sheets were in each dining room for staff to refer to. They also had information about specific likes/dislikes and food allergies.

We saw people's weights were being monitored and the chef told us they were informed when people had lost weight so they could provide additional fortified foods. High calorie smoothie drinks were then provided in the morning and afternoon.

We saw people who had been assessed as being nutritionally at risk had food and fluid charts in place to enable staff to check they were getting enough to eat and drink.

When we inspected the service in October 2015 we found the quality of the meal time experience varied across the three different units and we found the same on this inspection.

We observed breakfast on the top floor. The tables were set with tablecloths, cutlery, crockery, glasses and serviettes. We saw the care worker offering people choices of both food and drink. People were also consulted about whether or not they wanted sugar in their hot drinks or on their cereal. The care worker asked if people wanted their food cut up and if they wanted additional drinks. One person was offered a 'pinney' to protect their clothing. The person declined the offer and this was not pursued any further. Background music, which one person had chosen, was playing and the mealtime was relaxed and unhurried.

We observed the lunchtime meal on the middle floor. A relative told us staff did not always put protection on people when they were eating and they were left with food on their clothes. We saw care workers put clothing protectors on some people, but they ran out of them and a member of staff went to the laundry to get more, however, by the time they returned people had already spilt food on their clothing. There were no serviettes and some people wiped food from around their mouths with their clothing. When one member of staff asked another about the serviettes they were told, "They've gone walk about." On the second day, at breakfast time there were still no serviettes available. One person asked for one and was given a piece of blue paper hand towel. This showed us a lack of organisation and planning for the meal.

We saw care workers did not offer people a choice of cold drinks and everyone was given blackcurrant cordial. For the main meal people were shown two different meals and asked to choose. They were not consistently offered help with cutting up or eating their meals, though some people clearly required support. Some meals went cold as people struggled to eat them independently.

We saw one of the nurses answered two phone calls during lunch, whilst assisting one person with their meal. These were not work related calls and were a distraction from the support they were offering. We concluded people were not being treated with dignity and respect at mealtimes.
This was a breach of the Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the eleven care records we looked at we saw people had been seen by a range of health care professionals, including GPs, community matrons, district nurses, opticians and podiatrists. We spoke with a community psychiatric nurse who visited two people every fortnight. They described the home as very good and thought it was well run. They said staff knew people well, informed them appropriately and promptly about any changes in the person's mental health and acted on advice provided. This showed us people's health care needs were being met.

Inadequate

Is the service caring?

Our findings

We asked people if they liked the staff. One person told us, "The staff are wonderful." Another person told us they were often left in a wet bed and said their call bell was often out of reach. They said, "They leave me till last in the morning. I don't like lying in the wet. They're busy and don't come." This person's relative told us they had raised concerns about them not being taken to the toilet at night and had been told this would be addressed. We looked at the chart in the person's room which showed when the person had been taken to the toilet. This showed there were long periods of time between toilet visits and times when the person was found to be wet. For example, on 18 November 2016 the person had been taken to the toilet at 3.50pm, 7pm and 8.30pm and on the last two occasions the person was wet. The next time they were recorded as being assisted to the toilet was 10am on 19 November 2016 when they were noted to be 'very, very wet'.

We asked relatives for their views, one relative told us, "You can't fault the nurses [names on the ground floor] they are brilliant and out on the floor working with staff." Another relative said, "Some staff are excellent and some are lazy. You can't teach people how to be compassionate."

A third relative said, "The care is not great. I've had to put up notices to remind them [the staff] what to do for my relative. They don't change them for bed at night and they are in the same top all day and night as they are bed bound – there are lots of times when they are put in clothes that aren't theirs – even though I've labelled all their things. There were someone else's underpants in [Names] drawer. I've given up telling them and just thrown them on the floor, in the hope that they'll notice. Sometimes the curtains are still closed when I come during the day. They've put a full, heavy glass of cordial out of their reach and they couldn't lift it anyway! They just don't do the little important things properly, though they're pleasant enough. [Name] doesn't get shaved often enough and they cut their hair yesterday and there are still clumps of it on the carpet [this was pointed out to one of the inspection team]. They put an ornament in front of the TV receiver, which blocked the remote, so [Name] couldn't use the TV – which is their only pleasure. [Name] phoned me to come up to change the batteries and I had to come in the evening. [Name] was lucky that their phone worked as they [staff] consistently fail to charge it, even though I have reminded them and it's in a notice on the wall. The food is ok, but goes cold as [Name] either doesn't get help to eat it or they put it where [Name] can't get at it."

A fourth relative told us, "[Name] was a very smart lady and has nice clothes in their wardrobe. Sometimes when we visit they look scruffy or are in their nightwear."

A fifth relative said, "[Name} looks scruffy sometimes and looks like they have slept in their clothes. Lots of things have gone missing out of their bedroom."

A sixth relative said, "[Name] has never been shaved when I go to visit. The laundry is a nightmare things go missing and I have seen another resident wearing one of [Name's] shirts.

A seventh visitor told us the shoes their relative was wearing were not theirs and their own shoes were missing. They also said their relative's wardrobe was almost empty and although they had brought lots of

clothing it had all gone missing. They said [Name] liked to wear jeans but staff had asked them to get jogging pants because these would make it easier to change [Name's] clothing. The relative had brought four pairs which had gone missing as well as underwear, socks and shirts. They said "There is no dignity in wearing other people's clothes."

On the middle unit we saw eight of the twelve men living there had not been shaved. Some had more than one day's growth of beard. We asked one of them if they were growing a beard and they told us they wanted it, "Cut off." We asked the unit manager about this and they told us, this may be because they had refused. We spoke with two visitors who told us they had often noticed the men had not been shaved.

We found other practices which showed a lack of respect for people. For example, we saw one person had their name sticky taped to the side of their glasses.

We saw another person sitting in the hallway and they had a dessert spoon in their sock. We saw the unit manager walk past them and a care worker who did not notice this. A third care worker did notice and went and spoke with the person, and made a joke about them having the spoon. On the second day of the inspection we saw the same person sitting in the hallway. The unit manager arrived for their shift and walked past them without speaking to them, although we heard other staff speak to them as they went past. This was a breach of the Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some staff did not have the knowledge or skills to provide care and support to people. For example, a new member of staff was unaware of the names or needs of people, yet was left in sole charge of one of the lounges. There were a couple of occasions when they spoke a little sharply to people who were repetitive in their requests and needs saying to them, "You've had your breakfast, it's now dinner time!"

We were attempting to have a conversation with a person in their bedroom but the person was distressed. We asked one of the care staff if they could spend some time with the person and perhaps find something for them to do to engage their attention. The care worker was clearly at a loss as to what to do, partly because they were trying to do two other things but also because they did not know what to do. The care worker repeatedly asked the person if they wanted to go to the lounge for a cup of tea but this was making the person more distressed. After a couple of minutes another care worker came along, put their arms around the person and gave them a hug and immediately their demeanour changed.

We looked at this person's care plan which talked about offering reassurance but did not provide any detail. It also referred to 'de-escalation techniques' but again with no detail. We asked the unit manager on this floor if staff had received training regarding de-escalation techniques and they told us they had not. We asked about dementia training and they said it was done 'on line' and added there was no post training discussion to help staff to understand how to apply the training to practice.

We saw one person being transferred from their wheelchair to a lounge chair. They were gently encouraged to make the transfer and two members of staff assisted. However, they fell almost immediately to the floor on being helped to stand and had to be hoisted from the floor into the chair. They were told that it was their slippers which had caused the fall and that their relative should buy them some new ones for Christmas. There appeared to be no acceptance or understanding that it may have been how the staff 'managed' the transfer that might have contributed to his fall. We concluded staff did not always have the training, knowledge or skills to support people appropriately. This was a breach of the Regulation 18 (1) (2) (b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw in their direct dealings with people staff were kind and patient. It was clear some staff knew people very well and were aware of their individual preferences. We saw staff getting down to people's level when they were sitting down in order to make eye contact before asking them a question.

Staff meeting minutes showed staff were working towards the Gold Standards Framework accreditation. We saw staff showed compassion, understanding and sensitivity when dealing people who were receiving end of life care and this extended to family and friends. For example, we saw the relatives of one person were gathered with them in their room and the registered manager had set aside a small lounge solely for their use where they could retreat and grieve in private.

Inadequate

Is the service responsive?

Our findings

One relative told us the response times to the call bells was poor and they had waited for 40 minutes on one occasion for staff to attend. We also saw on one feedback form a visitor had set the call bell off by accident and it had taken 20 minutes for staff to respond.

One visitor told us they had arrived at 10:15am and had asked the nurse, who was giving out the medicines if they could get someone to come and change their relative as their trousers were wet (with urine). We spoke with the visitor at 11:05am and they were still waiting for a member of staff to come and assist. At 11:20am the inspector pressed the call bell to get staff assistance. Staff came and took the person to their bedroom. The visitor said it was not at all unusual to have to wait for staff and they had once waited an hour for staff to come to assist. They continued to tell us their relative had been continent in hospital because staff had taken them to the toilet.

We went to the person's bedroom with their visitor and saw the staff had changed them and one care worker had a pair of jogging bottoms in their hand. We asked them if the jogging bottoms were wet and they said 'no.' At which point they opened out the trousers to show a large wet patch. The visitor commented, "You see, they lied to you, they do that to me all the time."

The same visitor told us the shoes their relative was wearing were not theirs and their own shoes had gone missing. They added their relative liked to wear jeans but staff had asked them to provide jogging bottoms as these were easier to change. They told us they visited every day and often their relative had not had a shower.

Another visitor told us they had complained several times because their relatives basic personal hygiene needs were not being met.

A third visitor told us, "I have asked the nurses to make sure [name] gets a bath, as they are doubly incontinent. All I see on the records is assisted wash or shower."

A fourth relative told us, "[Name] is still in same clothes she had on yesterday, they are not helped to wash or bath every day, half the time I have to help them wash & dress. We are paying a lot of money and not getting the care. I often have to change the bedding because staff haven't done it."

We met with a person who had a PEG as their condition meant they were unable to take food and drinks orally. A letter in their care records dated 5 May 2016 from the speech and language therapist (SALT) team showed the person had asked to have tasters of food and hot drinks. The letter stated as the person had capacity and understood the risks involved it had been agreed these would be provided as this would increase the person's quality of life. The letter gave detailed instructions about the type of food and fluids that could be given in this way. When we spoke with the person they told us they only received a warm drink very occasionally and had not been offered any taster foods. This was confirmed by their relative who told us they had recently attended a meeting with the registered manager to discuss this and it had been agreed

their relative would be provided with taster foods and hot drinks, yet this had not happened. We discussed this with the registered manager at the end of the first day's inspection and when we returned on the second day we were told this had now been put in place. However, we were concerned that actions agreed with health care professionals to improve this individual's quality of life had not been actioned for six months until we intervened. This demonstrated people were not receiving person centred care which met their needs or preferences. This was a breach of the Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found individual care plans were in place for people which detailed what action care workers should take to ensure people's needs were met. However, we found some people's care needs were not being responded to in either a timely or person centred way.

One relative said they had complained and things had improved for a while but said the improvements had not been sustained.

We saw the complaints procedure was on display on the notice board in reception. We asked people and relatives if they would feel able to raise any concerns or complaints. One person told us, "I know who the manager is and would be able to complain." Another relative told us they had raised issues with the registered manager and they had since been resolved.

A number of people we spoke with raised issues about the laundry telling us clothing went missing or that other people's clothing was put away in their rooms.

The complaints log showed four complaints had been received this year. We reviewed the records for each of these complaints and found all had been fully investigated. We saw written responses had been sent to the complainant which detailed the findings and, where the complaint had been upheld, an apology and any actions taken to prevent a re-occurrence. However, we noted concerns people told us they had reported about missing laundry were not reflected in the complaints log.

We asked people what activities were on offer to keep them occupied. One person told us, "The activities co-ordinator is excellent and had taken us to St Anne's and organised a summer fair." Another person said, "The hairdresser comes in and she's very good. In the summer we can go out and sit in the garden and we have some nice outdoor fayres." A third person told us, "Sometimes we have activities, but it's not every day."

There were activity boards on all floors which were consistent and duplicated one another – these were well ordered, clear and outlined what was provided throughout the week. The activity coordinator worked 40 hours over the week and had an assistant who worked 20 hours a week. The coordinator demonstrated enthusiasm, skill and high level interaction with people. They provided a mix of in house and outside activities, including theatre trips and organised external 'acts' and social events, which were inclusive for families.

On the middle floor we saw there was very little on offer to keep people occupied. One relative told us there was no stimulation and people were, "Just parked." We saw a member of care staff sitting in the lounge, who made no attempt to engage anyone in conversation or in an activity. On the second day the television was on in this room, which no one was watching. We asked a care worker about this and they told us it was just 'background noise.' Because of the lack of engagement people were walking up and down the corridors, which for some was increasing their risk of falling. One visitor told us their relative wiped up the dishes when they took them home, but there was no opportunity for them to do this at Cooper House.

We discussed the lack of occupation for people at the end of the first day of the inspection with the registered manager. On the second day of our visit they told us the hours had been increased for one of the activity organisers who had been part-time and was now working full-time.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in March 2015 we found the provider did not have suitable arrangements in place to regularly assess and monitor the quality of the service provided and to identify, assess and manage risks. We told the provider they must make improvements and be compliant with the regulation by 31 July 2015. When we inspected the service again in October 2015 we found some improvements had been made, however, we found significant differences in the quality of the service. For example, between the middle floor and ground floor, which we concluded were caused by different management styles on these two floors. These inconsistencies should have been addressed by a robust quality assurance system which ensured all units were working to the same standards. At that time the service remained in breach of the regulation, good governance.

The manager who was in charge at our last inspection had left the service and a new registered manager had been recruited. We asked people who used the service, relatives and staff about the management of the service and found their views were mixed.

One relative said, "Management are a disaster they have never spoken to her or me and spend half their time smoking." Another relative told us, "[Name of registered manager] is a bully and I am frightened to say anything. They have had meeting after meeting with staff and I have heard them shouting, "I want this……" A third relative spoke positively about the registered manager and said they were "very responsive." A fourth relative told us they had never seen the registered manager on the middle floor before the day of our inspection.

One member of staff told us," [Name of registered manager is strict and runs a tight ship. They are supportive and you know exactly where you are with them. Everything has to be 100% as they have very high standards." Another member of staff said, "It was a big change when they first started but they have put us in the right direction." A third member of staff said, "[Name] of registered manager has understood what this home needs in terms of leadership. They have been very clear about what they expect and nine out of ten times it gets done." Another staff member said, "Although some things have improved [the registered manager] doesn't always deal with things. We've raised concerns about staffing and nothing has been done. I wouldn't recommend this home to a relative or as a place to work."

The registered manager was supported by a deputy manager and unit managers on each of the three floors. Again on this inspection we found significant differences in the quality of the service. We found the ground and second floor units were being well-managed, with the unit managers involved in the direct care and support of people who used the service. The majority of the concerns highlighted in this report were in relation to the management of the middle floor.

It was very clear to the inspection team on the first day of the inspection there were not enough staff on duty on the ground or middle floors to keep people safe or to provide them with the care and support they needed in a timely way. This was discussed with the registered manager after lunch who appeared surprised at our findings saying these were the best staffing levels they had ever had. We also advised them there were

not enough activities taking place to keep people occupied.

When we returned on the second day we found the registered manager had put an additional care worker on both the ground and middle floors and had increased the hours of one of the activities staff by 20 hours per week. They told us how much better it was since they had allocated an additional care worker to each floor. We were concerned the organisation's dependency tool which they used to determine staffing levels had not identified the need for more staff and that staffing levels had only been increased because of our intervention.

We saw dining experience audits were completed, however, concluded these were not effective as the dining experience for people who lived on the middle floor was poor. On the first day of the inspection we did not see mid-morning drinks served on the middle floor. One relative told us, "I worry because I rarely see the morning drinks trolley." Another visitor made the same comment and told us they made a cup of tea for their relative before they left. On the second day of the inspection we went to the second floor at 6:45am and saw no one was offered a hot drink when they got up. This had not been picked up though the audit process.

We asked the registered manager if low level concerns were logged as a matter of course so that any common themes or trends could be identified. They told us they were not. We spoke to the registered manager about the issues people had identified with the laundry. They told us no one had raised any issues with them about this. If concerns were being logged by staff then the issues people raised with us about the laundry would have been clear.

People who used the service and relatives told us there was often a long delay before staff responded to the call bells. The registered manager told us the system could be interrogated to see how long it took for staff to respond. We asked them if they looked at the response times routinely and they told us they did not but if a relative questioned the time it took staff, they would look at the system then.

We looked at the call bell log for one person and saw there had been a number of occasions when their call bell had been ringing for over 20 minutes before staff attended to them. We spoke with them and they told us there had been a fault with the call bell but this had been rectified. However, we saw the most recent record showed staff response times had been up to 14 minutes. The registered manager told us the company policy was that calls bells should be responded to within three minutes. Following the second day of the inspection the registered manager contacted us to tell us an engineer had come out to look at the system and faults had been identified which meant the records on the computer were not accurate. We contacted the engineers who confirmed there was a problem and a number of the display units needed to be replaced. They also said a quote for this work had been given to the provider in May 2016. We were concerned the issue with the call bells had not been identified and resolved before our inspection.

We saw monthly accident and incident audits were being completed, however, these only gave an account for each particular month and were not identifying any trends over a longer period of time. We also noted a number of falls were un-witnessed, however, no details about where staff were at the time of these accidents was being recorded.

We also saw dementia care audits were being completed, however, concluded these were not effective as people living on the second floor were not receiving person centred or dignified care and support. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw regular meetings were held with staff, some of these were for specific roles such as kitchen staff or

night staff, whereas others were for all staff. The minutes showed a variety of issues were discussed such as training, infection control, care documentation and keyworkers. However, there was little evidence to show that the views of staff attending the meetings had been sought or discussed. We discussed this with the registered manager who told us staff were invited to raise issues at the meetings but they did not do so. However, some staff told us they had raised concerns about staffing levels but we found this was not reflected in any of the minutes of meetings held this year.