# Ideal Carehomes (Number One) Limited

# Coppice Lodge

## Inspection report

117 Coppice Road
Arnold
Nottingham
Nottinghamshire
NG5 7GS

Tel: 01159649511
Website: www.idealcarehomes.co.uk

Date of inspection visit:
05 January 2017
06 January 2017

Date of publication:
31 January 2017

## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

This inspection took place on 5 and 6 January 2017 and was unannounced. Coppice Lodge is run by Ideal Care Homes (Number One) Ltd. The service is registered to provide accommodation for 64 older people. There were 26 people living at the service on the days we visited. The service is split across two floors each with communal living spaces, there were 13 people living upstairs and 13 people living downstairs.

We carried out an unannounced comprehensive inspection of this service on 6, 7 and 12 October 2016. Breaches of legal requirements were found in relation to safeguarding people from abuse, consent, safe care and treatment, staffing and governance. We took action to ensure the necessary improvements were been made to make sure people received safe care and support.

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

We conducted this inspection to follow up on the breaches identified in our October 2016 inspection and to look at the overall quality of the service.

Although some improvements had been made, risks in relation to people's care were still not always planned for appropriately to ensure that people received safe care and support. People were not consistently supported to mobilise safely.

Improvements had been made to ensure that people were safeguarded from abuse. People felt safe in the service and were supported by staff who knew how to recognise and respond to allegations of abuse.

Improvements had been made to the management and administration of medicines. People received their medicines as prescribed and medicines were stored and administered safely. Improvements had also been made to the deployment of staff and there were enough staff to provide care and support to people when they needed it.

We found that improvements had been made to staff training and supervision. Staff felt supported and received training to help them carry out their duties effectively and meet people's needs. Safe recruitment procedures were followed.

Some improvements had been made in relation to supporting people who did not have capacity to make certain decisions, however people's rights under the Mental Capacity Act 2005 were still not fully protected. Where people had capacity they were enabled to make decisions about their support and were asked for their consent by staff providing care.

People were treated with dignity and their right to privacy was respected. Staff supported people with care and compassion and had positive relationships with people who used the service. People were enabled to make choices about how they spent their day and had the opportunity to get involved in activities in the home.

People did not always receive the support they required as staff did not always follow guidance in care plans. Although some improvements had been made to care plans further improvements were needed. There was still a risk that people may receive inconsistent support as staff did not have access to accurate, up to date information about the support people required.

The provider did not have effective systems in place to monitor and review the day to day support provided by staff and this resulted in negative outcomes for people who used the service. Swift action was not always taken by senior staff to communicate and act upon known issues.

The management team were open, approachable and well respected by people who used the service, families and staff. People who used the service and staff were involved in giving their views on how the service was run. People and staff felt able to share ideas or concerns with the management.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, consent, person centred care and good governance.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was still not safe.

Risks in relation to people's care and support were still not assessed or planned for appropriately. People were not consistently supported to mobilise safely.

People received their medicines as prescribed and medicines were managed safely.

People felt safe in the service and there were systems and processes in place to minimise the risk of abuse.

There were enough staff to provide care and support to people and safe recruitment practices were followed.

### Is the service effective?

**Requires Improvement**

The service was still not consistently effective.

People made decisions in relation to their care and support. However, people's rights under the Mental Capacity Act (2005) were not always protected.

Staff received training and support to enable them carryout their duties effectively.

People had access to healthcare and people's health needs were monitored and responded to. On the whole people were supported to eat and drink enough.

### Is the service caring?

**Good**

The service was caring.

People received compassionate care from staff who knew them and cared about their wellbeing.

People were involved making choices relating to their care.

People were treated with dignity and had their right to privacy respected.

## Is the service responsive?

**Requires Improvement**

The service was still not consistently responsive.

People did not always receive the support they required as staff did not always follow guidance in care plans. Care plans did not all contain accurate, up to date information about the support people required.

People were given opportunities to get involved in social activity and were supported to maintain relationships with family and friends.

People were supported to raise issues and concerns and there were systems in place to respond to complaints.

## Is the service well-led?

**Requires Improvement**

The service was still not consistently well-led.

The provider did not have effective systems in place to observe and review the day to day support provided by staff and this resulted in negative outcomes for people who used the service.

Swift action was not always taken to act upon known issues.

People who used the service and staff were involved in giving their views on how the service was run and felt able to share ideas or concerns with the management team.

The management team were open, approachable and well respected by people who used the service, families and staff.

# Coppice Lodge

**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 check that improvements to meet legal requirements planned by the provider after our October 2016 inspection had been made and to look at the overall quality of the service.

We conducted an unannounced comprehensive Coppice Lodge on 5 and 6 January 2017. The inspection team consisted of one inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During our visit to Coppice Lodge we spoke with six people who used the service and the relatives of seven people. We spoke with two members of care staff at length and an additional three members of staff briefly, the cook, the care manager and the registered manager. We also spoke with two visiting health and social care professionals. We looked at the care records of five people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and the provider.

We observed care and support in communal areas. 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.

Requires Improvement

# Is the service safe?

## Our findings

During our inspection in October 2016 we found that improvements were needed to ensure that people were protected from risks associated with their care and support. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we saw that although some improvements had been made further improvements were still required and consequently people were placed at continued risk of harm.

People were not always supported to move and transfer in a safe way. Whilst we saw that some people were supported with their mobility safely this was not always the case. Care plans contained information about how to support people with their mobility and included details of any equipment such as slings and hoists that needed to be used, however staff were not always following this guidance. We observed one person being supported to transfer by staff using a sling and hoist. The person appeared distressed and as they were lifted it was apparent that the sling was too large for the person and they looked uncomfortable. We checked the person's care plan which stated that a medium sling should be used. A member of staff confirmed that they had used a large sling to transfer the person. This put the person at risk of injury. We spoke with another member of staff who informed us that they had recently raised their concerns with a senior member of care staff about the size of the sling for this person but action had not been taken to rectify this.

People were still not protected from the risk of developing pressure ulcers. Risk assessments related to pressure area care were not always assessed correctly. For example, one person's care plan contained a risk assessment which should have been used to work out the risk of the person developing a pressure ulcer. This was completed incorrectly because staff had not taken into account recent changes in the person's physical health. This meant that the final score was incorrect which may mean that the person would not be provided with the support required to minimise the risk of skin damage. Records showed that this person required prompting and support to elevate their legs 'at all times' in order to prevent deterioration of a health condition and consequent skin damage. This was not detailed in the person's support plan and we observed that the person was not prompted to elevate their legs for a four hour period. This placed the person at risk of skin damage.

In addition to this staff did not always follow guidance in care plans to reduce the risk of pressure areas. One person was a high risk of pressure ulcers, their care plan stated that they required assistance to change position every hour. There were no records that this person was supported to reposition at the required frequency and we spoke with a member of staff who told us, "We don't reposition [person] anymore." This placed the person at risk of developing a pressure ulcer. Another person required support to change position every two hours however records kept did not evidence that the person was repositioned at the required timescales.

As a result of our previous inspection the provider had introduced a new risk assessment to in relation to the risk of people falling from their bed. However we found that this assessment was still not effective in assessing the risk of people falling from their bed as it did not take into account all the necessary

information or clearly state control measures in place. We reviewed three of these assessments and found that they were not personalised and did not evidence that people's individual needs had been taken into account. For example one person had recently fallen from their bed, the risk assessment did not take this information into account, nor did it state the control measures in place to reduce the impact of a fall. Although we saw that controls measures were in place for this person the lack of a robust risk assessment and clear information about how to reduce the likelihood of falls placed the person at risk of inconsistent support and potential harm.

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

Following our visit the registered manager informed us that action had been taken to ensure people were supported to mobilise using the correct equipment, care plans and risk assessments had been reviewed and updated and a staff meeting had also been held to ensure that staff were aware of how to support people safely.

Despite the above people we spoke with told us they felt safe when staff supported them. One person told us, "I've got my walker so I feel safe, it's all I need." One person's relative told us, "[Relation] has a wheelchair to move around in and they (staff) hoist them. They've had no falls at all." Another relative told us, "[Relation] has the equipment they need."

Records showed that there had been an overall reduction in the incidence of falls since our last inspection. Care plans had been reviewed and, for the majority of people, contained information about the risk of falls and measures in place to reduce the likelihood of falls and lessen the impact. People had appropriate equipment in place and referrals had been made to the falls team in line with the provider's policy. Where people required prompts to use equipment, such as walking frames, staff were aware and prompted people as required. There was a system in place for the routine analysis of accidents and incidents and evidence that action was taken to reduce the likelihood of further incidents for some people.

During our previous inspection we found that people were placed at risk as the systems and processes in place to safeguard people from harm were not always followed. This was a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the required improvements had been made in this area.

People felt safe at the Coppice Lodge. All of the people we spoke with told us they felt safe, one person said, "It's safe. I can lock my door when I am out and when I am in bed." People's relatives also felt that their relations were safe at the service. A relative we spoke with said, "[Relation] is as safe as houses here, it feels like they care." Another relative told us, "[Relation] is safe as they can be, especially with dementia. It's nice and secure."

There were systems and processes in place to minimise the risk of abuse and care staff had received recent training in safeguarding adults. Staff we spoke with had a good knowledge of how to recognise different forms of abuse and understood their role in reporting any concerns or allegations to the registered manager. Staff were confident that any concerns they raised with the management team would be dealt with properly. One member of staff told us, "I would tell the manager, I definitely have confidence (in managers). I have no concerns about that." We saw records which confirmed the registered manager had taken appropriate action in response to previous issues and made referrals to the local safeguarding team as required. The management team also conducted investigations into incidents and used this to improve practice within the service.

During our previous inspection we found that people were not protected from the use of avoidable restraint. During this inspection restraint was not being used and therefore we were unable to make a judgement in this area.

In our October 2017 inspection we identified that improvements were needed to the staffing levels and staff deployment. This was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we saw that sufficient improvements had been made in this area.

Feedback from people living at Coppice Lodge about staffing levels and the availability of staff was mixed. One person told us, "They (staff) are not bad at all at coming (when call bell used)." A relative of someone living at the service told us, "There are plenty (of staff) about that I see." Another relative said, "It (staffing levels) seems to be good at the moment, it seems like double the number now." However other people told us that they felt there were times when staffing levels were stretched. One person told us, "They are quite short but try so hard. The middle of the day is especially busy". A relative of someone using the service said, "They cope very well but they could do with more (staff)." Another person's relative told us, "They can be tight at weekends."

During our visits we observed that there were enough staff present to meet people's needs and people were assisted in a timely manner. Staff were deployed effectively to ensure that they were available to respond to people's requests for support. The staff we spoke with told us that staffing levels were normally sufficient. Records showed that shifts were staffed to the levels determined by the provider.

Safe recruitment practices were followed. The management team had taken the necessary steps to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. Proof of ID and appropriate references had been obtained prior to employment and were retained in staff files. Where people had declared previous convictions the management team had conducted an assessment related to this to ensure that the staff member would be safe to support people.

During our October 2016 inspection we found that people could not be assured that their medicines would be stored, handled or administered safely. This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the required improvements had been made in this area.

People told us that they had received their medicines as prescribed and at the right time. One person said, "They stay with me for my tablets." Another person told us, "They always wait with me, even though I can manage okay." One person's relative told us, "I've no worries about how they manager [relation's] tablets." We observed staff following safe procedures when handling and administering people's medicines.

People's medicines were stored safely and people were receiving their medicines as prescribed. Medicines systems were organised and records were completed accurately to show when people had been given their medicines. Each person had a medication sheet which included a photo of the person, allergies and the person's preferences for taking medicines. There were clear protocols in place for 'as required' medications which contained detailed information about when these medicines should be given. We found that one person had not been given their medicine as prescribed because they were out of the service. We discussed this with the registered manager who informed us that there were specific processes in place to ensure that people received their medicines if they were going to be out and explained this must have been an error. The registered manager informed us they would be following up this with the staff team to prevent this from

happening again.

Staff had received training in the safe handling and administration of medicines and records showed that all staff with a responsibility for administering medicines had had their competency to deliver medication assessed recently. Medicines audits were carried out monthly to ensure medicines were being managed safely and these were effective in identifying issues.

People were protected from risks associated with the environment. We saw there were systems in place to assess and ensure the safety of the service in areas such as fire and legionella and control measures were in place to reduce these risks. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were personal evacuation plans in place detailing how each person would need to be supported in the event of an emergency.

Requires Improvement

# Is the service effective?

## Our findings

When we inspected the service in October 2016 we found that people's rights under the Mental Capacity Act (MCA) (2005) were not protected. This was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that although some improvements had been made further improvements were still required to ensure people's rights were fully protected.

The 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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were still not protected as the principles of the act were not correctly applied. Although the registered manager had taken action to implement some decision specific mental capacity assessments for example relating to medicines these assessments did not clearly detail how the person's capacity had been tested.

In addition to this mental capacity assessments and best interest decisions had still not always been undertaken as required. For example one person lacked the capacity to consent to the presence of a motion sensor in their room which monitored their movements, there was no mental capacity assessment in place for this decision. Another person was not able to consent to the content of their care plan and other aspects of their care and treatment, but there were no mental capacity assessments relating to this. A consent form had been signed by the person's relative 'on behalf' of the person but there was no indication that this relative had any legal powers, such as a Health and Welfare Power of Attorney, to provide consent on behalf of the person. This did not respect people's rights under the MCA. The registered manager informed us that improvements to the assessment of people's mental capacity were 'ongoing'.

This was an ongoing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this we found that staff knowledge of the MCA had improved since our previous inspection. Staff were able to confidently explain the purpose of the MCA and had a good understanding of how to support people who may lack capacity. One member of staff told us, "We always give people a choice, but sometimes we have to make decisions for people, it can change day to day."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA in relation to DoLS, and whether any conditions on authorisations to deprive a person of their liberty were being met. The management team had a good understanding of DoLS and applications for DoLS had been made where appropriate to ensure that people were not being deprived of their liberty

unlawfully. Where DoLS had been granted, up to date authorisations were in place and the conditions on the DoLS were being complied with.

Where people had capacity they were supported with decision making and we observed that staff spoke with people and gained their consent before providing support or assistance. The people we spoke with told us that staff always asked for their consent. One person told us, "They will ask me first before doing anything," another person told us, "They do the right things and ask me and explain."

In our October 2016 inspection we found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff were did not receive adequate training. During this inspection we saw that the required improvements had been made in relation to staff training.

People received care and support from staff who had the skills and qualifications to support them safely. People who used the service told us they felt that staff were well trained and competent. One person said, "The service is excellent. The new ones (staff) try hard and shadow the older ones." Another person told us, "I can't fault them in anyway."

The registered manager told us that a lot of work had been done since the last inspection to ensure that staff training was up to date. We saw records which showed that staff had up to date training in a number of areas including safeguarding, dementia awareness, equality and diversity and the mental capacity act. Staff we spoke with told us they had done a lot of training recently and they felt that they been given the training they needed to ensure they knew how to do their job safely. Staff also had training relating to the specific needs of people using the service such end of life care and dealing with behaviour which may challenge them. The registered manager told us that members of the management team were attending training provided by the local authority to enable them to deliver safeguarding adults training to the staff team.

Staff were provided with an induction when starting work at the service. The registered manager told us that new staff had a two week induction period, which involved training, shadowing experienced staff members and reading care plans. Staff feedback about this positive. We spoke with a recently recruited member of staff who told us that they felt competent to support people following their induction.

The registered manager told us that staff did not currently complete the Care Certificate but added that the provider had plans to introduce this in the near future. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

People were supported by staff who received supervision and support. Staff we spoke with told us that they felt supported and they had had recent supervision meetings. We saw records which confirmed that staff had regular supervision meetings with their line manager.

People were not always supported in a way that ensured they ate enough. Care plans contained information about the support people needed to eat a healthy diet and reduce the risk of weight loss, however, staff did not always follow this guidance. For example one person's care plan stated that the person preferred small portions as large portions could put them off, they also required prompting and encouragement to ensure they ate enough. Records showed that this person had recently lost a significant amount of weight. We observed a mealtime and saw that they were not served a small portion, they commented, "It's an awful lot." They were not prompted or encouraged to eat and their plate was cleared away once they had eaten approximately a third of their meal. This did not facilitate effective nutritional intake and put the person at risk of further weight loss.

In spite of the above we found that on the whole people were provided with effective support in relation to nutrition and hydration. People's weight and BMI were assessed regularly to determine whether people were at risk of weight loss. We saw that where changes or concerns were noted action was taken. For example one person's weight had decreased, this had been identified and the staff team were monitoring the person's weight and food intake and had contacted the GP to request specialist support. Where people were prescribed nutritional supplements to prevent weight loss records showed that these had been provided.

People told us that they enjoyed the food and were given a choice of food and drink. One person said, "The menu comes round the day before and we get lots of options. I like my fresh veg." Another person commented, "The food is alright and it is always hot when it comes to my room. They ask us our choices. If we are hungry in the evening we can ask for a snack." A relative told us, "[Relation] eats well, which amazes me. I've no worries." Another relative told us, "[Relation] needs help to drink but they (staff) are often popping in and out."

During our visit we observed meal times in all three units. Most people appeared to enjoy their food. One person did not want what they had chosen and staff respected this and offered the person an alternative. People were offered drinks and snacks throughout the day, including those people who chose to stay in their rooms. When people required specialist diets these were provided and the kitchen staff had clear information about people's dietary needs.

During our last inspection we found that people could not always be assured that they would receive effective support with health conditions. During this inspection we found that improvements had been made to care plans which now included personalised information about people's health conditions and guidance for staff on how to recognise that a person's health condition may be worsening. However, we found that for one person information about their health conditions was still unclear. Their care plan contained confusing and contradictory information about their health needs. We spoke with a member of staff about the person's health needs and they told us, "I'm not sure (what condition person has) if it's not in the care plan." This placed the person at risk of not receiving the appropriate support. We discussed this with the registered manager who told us that the person's care plan would be reviewed.

People told us that they had good access to healthcare services. One person said, "The optician comes and checks us over and the Chiropodist came yesterday. I go out to see the dentist." A relative we spoke with told us, "They are good at getting the doctor out to [relation]." Another relative said, "They've been very quick off the mark getting the doctor to [relation] a few times."

People were supported with their healthcare needs. The registered manager told us that they worked closely with a range of healthcare professionals to ensure people's healthcare needs were met. This was supported by records which showed that people had access to a range of health professionals including district nurses and tissue viability nurses. We spoke with a nurse from the local care homes team who explained that they had developed a relationship with the staff and management at Coppice Lodge to try and prevent inappropriate GP visits and hospital admissions. They told us they had daily phone contact with the management team and said, "It feels like we are a team, we are communicating every day. They have the patient's interests at the heart of their care." Another visiting health professional told us that staff had acted upon their advice to provide effective support.

A number of people had been referred to the Dementia Outreach Team (DOT) for support and where people were at risk of developing a pressure ulcer or had developed an ulcer, staff had sought advice from the district nursing team and we saw that the district nursing team visited regularly and their advice was

incorporated into support plans.

Good

# Is the service caring?

## Our findings

The atmosphere at Coppice Lodge was calm, relaxed and homely and people were supported by staff who were kind and caring. During our visit we saw many examples of warm, positive interactions between staff and people who used the service. People told us the staff were kind and caring and treated them with respect. One person said, "They'll do anything for you and are always so good with us." Another person commented, "They are a lovely lot of staff, I wouldn't want to leave here." People's relatives were also positive about the approach of the staff team at Coppice Lodge. One person's relative said, "Definitely they care, It's not just a job to them." Another relative told us, "I haven't found anyone I can't take to, they are all fantastic."

We observed respectful, friendly relationships between staff and people who used the service. During our visit staff treated people with warmth and kindness, they were polite and friendly and there were many examples of positive interactions. One person who used the service told us, "I do feel good with them (staff)." We observed staff took the time to sit and chat with people and shared mealtimes with people who lived at Coppice Lodge during our visit.

Staff responded quickly when a person displayed behaviour which may have disturbed other people. They spent time sitting and talking with the person which appeared to calm them and reduce the impact on others. Staff were also quick to act when another person became upset, they responded to their request to go outside by taking them to the garden and then provided ongoing reassurance upon their return.

Staff knew people well and it was clear that they had a good knowledge of people's support needs and their likes and dislikes. People's care plans contained personalised information about people's interests and preferences and detailed information about people's life history. For example one person's care plan included information about their hair and make-up routine.

People's spiritual needs were taken account of and supported. One person told us, "They have communion in the quiet lounge once a month for a few of us." A relative said, "[Relation] goes off to church on Sundays with a few church friends." People's care plans contained information about people's religious and spiritual needs.

People felt involved in decisions about their support and this was reflected in people's comments. One person told us, "I choose when to get dressed or have a shower." Another person said, "I go to bed when I choose." During our visit we saw that staff routinely checked with people about their preferences for care and support. We saw that people were offered choices about how and where they spent their time, what they ate and their involvement in activities. Staff we spoke with had a clear understanding of their role in ensuring that people had choice and control and respected people's choices.

Staff had a good understanding of people's communication needs and tailored their support accordingly. There was clear information in people's care plans about how people communicated and how staff should communicate with them. Information about planned meals was displayed around the service in a written

and pictorial format in an attempt to communicate this to people, however we saw that this information was sometimes inaccurate and confusing as the pictures did not reflect what was actually served. We spoke with a member of staff who told us, "It never changes, it's always on breakfast, we are getting a blackboard soon." Records showed that this had been picked up a recent audit conducted by the provider and there was an action plan in place to make changes.

The registered manager told us that no one who used the service was using an advocate at the time of our visit. Advocates are trained professionals who support, enable and empower people to speak up. The registered manager explained that they had made links with the local advocacy service and were waiting for delivery of information leaflets. They told us that that if they thought someone might need an advocate they would talk to the person about this and make a referral.

People were enabled to be as independent as possible. People who used the service told us that staff encouraged their independence and supported them to do as much as they could themselves. One person said, "Oh yes, I get to do as much as I can." Another person told us, "They (staff) certainly do let me try as much as I can." One person's relative commented that staff "encourage [relation] to do as much as they can." Care plans contained information about what people could do themselves and areas where they needed support and we saw that staff encouraged people's independence throughout our visit. The registered manager told us about one person who they were supporting to gain more physical independence with an aim of them being able to get out into the local community more often. They described how they were working with external professionals and the staff team at Coppice Lodge to help the person achieve this goal.

People we spoke with told us that staff respected their right to privacy. One person said, "They knock even if my door's open and always draw the curtains even though I am not really overlooked." Another person said, "They knock and wait as I lock my door to have some privacy." The relative of someone who used the service said, "They most certainly respect [relation]'s dignity, with closing the curtains and asking us to leave the room."

A member of staff we spoke with described the actions they took to ensure people's privacy including, knocking on people's doors, ensuring doors and curtains were closed during personal care and ensuring people were covered by their clothes when being supported to transfer using a hoist. We observed that people's privacy was respected throughout our visit. People were supported to spend time alone if they wished and were able to lock their bedroom doors if they chose to. The registered manager told us that they had plans to develop a dignity champion role within the staff team.

People were provided with compassionate support as they came towards the end of their life. Care plans contained information about people's wishes for the end of their lives and where people were nearing the end of the life additional care plans were put in place to ensure that they received the care, support and treatment they required. Records showed that external health professionals were consulted about and involved in the care and treatment of people at the end of their lives. We spoke with one member of staff who took pride in the end of life care provided at Coppice Lodge, they described that when someone was in their last few hours of life the staff would ensure that the person was never left alone and always had a member of staff or their family with them. We saw letters that bereaved family members had sent to the service conveying their experiences of the end of life care. One family member thanked the staff team for their 'care, compassion and obvious affection' shown at the end of their relation's life.

Requires Improvement

# Is the service responsive?

## Our findings

During our June 2016 inspection we found that people were at risk of inconsistent support as care plans were not always accurate or up to date. During this inspection whilst we found that some improvements had been made to care plans further improvements were required. Furthermore we found that staff were not consistently using care plans to inform the way they supported people who used the service.

People did not consistently receive the support they required as staff did not always follow guidance in care plans. One member of staff we spoke with told us that they did not rely on care plans to inform people's care and support and instead learnt from other members of staff. This lack of knowledge of people's current needs had an impact on people's support. For example one person's care plan stated that they wore glasses and often forgot to wear them and required prompts from staff. We observed that this person was not wearing their glasses for a period of approximately three hours during our visit. We asked a member of staff about this who took action to find the person's glasses and encourage them to wear them. When the person put their glasses on they said, "Oh that's better I can see now." Another person's care plan stated that the person preferred small portions of food as they found large portions unappetising, this was not taken into account when lunch was served and the person commented, "I don't want this, I'm not ready for all this food."

People were at risk of receiving inconsistent support as information in people's plans was not always accurate. We found that information in some care plans was contradictory and confusing. For example, one person's care plan stated that they required staff to check on their well-being every 15 minutes, however a risk assessment in the person's care plan stated that they needed checks every 30 minutes. Another person's care plan contained contradictory information about how to respond to the person in particular situations. One page of the plan stated that if the person behaved in a certain way staff should 'retract from [person]'. However later in the care plan it stated that staff should respond to the behaviour by talking to the person and asking them to explain what they were trying to say. This put people at risk of receiving inconsistent support that did not meet their needs.

Care plans were not always updated to reflect people's changing needs and this resulted in people not getting the support they required. Records showed that one person had a health condition which meant that they should be prompted to elevate their legs 'at all times'. Their care plan had not been updated to reflect this information and we observed a period of four hours in which the person was not prompted to elevate their legs. This put the person at risk of a deterioration of their health condition.

Some people who used the service sometimes communicated through behaviour which others may find challenging. Care plans did not clearly detail how staff should respond to support the people and minimise the impact on others. Whilst staff responded appropriately to people throughout our visit the lack of guidance for staff put people at risk of receiving inconsistent support. One member of staff we spoke with was unsure whether or not one person's care plan contained information about how to support the person with their behaviour and told us that they had developed their own way of working with and responding to the person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed the above with the registered manager who told us that the team had worked hard since our previous inspection to update and improve the care plans. They acknowledged that the care plans were still in 'a work in progress' and they informed us following our visit that some care plans had been amended, staff training had been booked and staff had been reminded of the importance of reading care plans.

Despite the above people told us that they received the care they required and felt it was flexible to meet their needs and preferences. One person said, "I'm easy going as far as I'm concerned. I get my care the way I like it." One person's relative told us, "They know [relation] so well and often notice changes in [relation] before we do."

When possible people were involved in planning their own care and support. The registered manager and staff told us that people were offered the opportunity to get involved in reviewing their care plans. People's relatives commented positively on their involvement in people's care and support. One person's relative told us, "[Registered manager] came and did the paperwork in hospital with us. We had a review a few weeks ago." Another person's relative commented, "They are very good at telling me what is going on and any changes needed in [relation]'s care."

People were supported to have control over their day to day support and routines were flexible to accommodate people's requests. Throughout our visit people were consulted with about aspects of their support and given choices about things such as food, drink and how they spent their time.

People were enabled to take part in social activities. People told us that there were a variety of activities on offer and they had enough to do. One person said, "We have singers come in, I like to listen from the lounge. I quite like the bean bag games and ball throwing. Otherwise I do my word searches of watch TV." Another person told us, "There's something on most days but we are not forced to join in. A few of us sit and chat so I don't really get bored." A relative we spoke with told us, "[Relation] has a great time and joins in anything. They've even been on outings which are very good," another relative told us, "There's something on every day, the entertainment is fantastic."

The provider employed a regional activities coordinator who visited the service once a week and arranged a programme of activities. There were posters throughout the service which advertised planned activities such as singers, craft activities and other visiting entertainers. On the day of our visit a singer was visiting the service and people were offered a choice about whether or not they wanted to participate. The entertainment was accompanied by a choice of well-presented drinks and sweet snacks and we saw people who used the service and staff dancing and enjoying the entertainment together.

The registered manager told us that at Christmas people had been supported to share a wish on their 'Christmas wish tree'. Many people had wished to go for a pub meal and the registered manager told us that a small group of people had recently fulfilled this wish. For those people who were unable to leave the service the staff team were planning to use the pub room at Coppice Lodge to host a pub meal event for people and their families to attend.

We spoke with a visiting health professional who expressed some concerns about the sustainability of meaningful activities as the service grew and as people's needs became more complex. They told us, "Issues have previously arisen from people having a lack of purpose and being unoccupied. They have a blank canvas now to build activity into the carers' role." The registered manager told us that they had already

identified this as an area for development and had started working with the staff team to build their confidence in facilitating a programme of activities to run alongside the external entertainment. One member of staff we spoke with was passionate about developing activities and told us, "Yes we are doing more activities for people, we do two planned activities a day with people now." They shared photos of activities that had recently been facilitated by staff which showed people engaged in creative and sensory activities.

People were supported to maintain relationships with people who mattered to them. People's friends and relations were welcomed into the home and we saw a number of visitors during our visit. People spent time together in communal areas and smaller quiet lounges gave people the option of more privacy. One relative we spoke with said, "We can come here anytime, they are very good in that way." Another person's relative told us, "They have nothing to hide here as we can turn up at any time of day or night."

People could be assured that complaints would be taken seriously and acted on. People told us that they felt able to make a complaint, knew how to do so and were confident that any concerns would be taken seriously. One person said, "I feel I can speak up if I need to." A relative of one person told us, "Truthfully, we have never had to complain." People who used the service and their relatives told us that when they had raised issues action had been taken. There had been two complaints raised since our previous inspection, records showed that action had been taken to resolve these to the satisfaction of the complainants.

Staff we spoke with knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to the manager. Staff told us they were confident that the management team would act upon complaints appropriately. There was a complaints procedure on display in the service informing people how they should make a complaint.

Requires Improvement

# Is the service well-led?

## Our findings

During our October 2016 inspection we found an ongoing lack of effective leadership and governance at Coppice Lodge which resulted in negative outcomes for people who used the service. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that improvements had been made in relation to leadership, governance and quality assurance but some further improvements were still required.

The provider did not have effective systems in place to observe and review the day to day support provided by staff. At times this resulted in people not receiving the support they required as staff were not always following care plans. Although the registered manager and care manager conducted daily 'walk arounds' of the service these did not pick up issues such as people not being supported to move safely. This lack of effective oversight placed people at risk of unsafe and inconsistent support.

Following our October 2016 inspection many changes and improvements had been made in response the to the concerns we identified, however we found that some of these changes had been implemented in a tokenistic way that was not based on people's individual needs. For example new mental capacity assessments had been implemented to try and ensure that people rights under the MCA were protected however the provider had not taken a personalised approach to this. We found that where people lacked the capacity in some areas of their life the provider had only assessed people's capacity in relation to medicines and the Deprivation of Liberty Safeguards. The provider had not considered individual circumstances to ascertain the need to assess a person's capacity, for example if a person required, but was unable to consent to, a motion sensor to track their movements.

We also saw that a generic approach had been taken to assessing the risk of people falling from their beds. New risk assessments had been implemented across the service, however we saw that the forms were prepopulated with standardised statements, for example all forms specified that the person should be checked every 30 minutes when in their room. The risk assessment scoring had also been conducted in a tokenistic manner with all of the forms we viewed being scored at the same risk level despite differing risk factors. This put people at risk of receiving unsafe support.

Responsive action was not always taken by senior staff to communicate and act upon known issues and this left people exposed to potential harm for unnecessarily periods of time. For example a member of staff told us that they had reported an issue of someone being supported to move in an unsafe manner 'a couple of weeks' prior to our visit. During our visit we observed that this unsafe practice was still happening. We spoke with the management team who were unaware of the issue as it had not been reported to them by the senior member of staff.

During both our June 2016 and October 2016 inspections we identified issues with the quality and safety of the care planning system in place at Coppice Lodge. During this inspection we found that although some improvements had been made to care plans to try and streamline the process and improve the quality of information, care plans still contained errors, omissions and contradictory information and did not promote

the delivery of person centred and safe care.

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

Following our inspection visit the management team took swift action to develop an action plan based upon the feedback we shared. They informed us that action was underway to improve care plans, risk assessments and mental capacity assessments, to provide additional staff training and to ensure that senior staff were aware of their responsibility to act upon concerns raised by staff.

The registered manager also had an awareness of other issues within the service and had started to put plans in place to address these. For example during our visit, we spoke with a community health and social care professional who expressed some concerns about the pre-assessment processes at Coppice Lodge resulting in inappropriate referrals. The service had taken referrals for a number of people who had complex support needs related to their mental wellbeing and associated behaviours. Coppice Lodge was not able to meet these people's needs and this had resulted in alternative placements being sought for people. We spoke with the registered manager about this who told us that they had identified this as an issue and they were planning to strengthen their pre-assessment and referral processes by having closer contact with the dementia outreach team and they would also be discussing all referrals with their regional manager.

People were happy living at Coppice Lodge. One person told us, "I'm very happy here, it's such a nice clean place." People's relatives were also positive about the service. One relative told us, "I really can't say anything negative about the place, I would hope to come here if I got dementia." Another relative said, "It's a fabulous place, the staff, entertainment, meals. We've got our names down. Can't fault it."

People who used the service and their families were supported to have a say in how the service was run. Regular 'social committee' meetings were held for people using the service and their families to discuss how the service was run. Records showed that these meetings were well attended and used to discuss things such as activities, menus and suggestions for changes and improvement. These meetings had also been used to enable people who used the service to decide upon who should be awarded employee of the month. Regular surveys were conducted to enable people to share their views, we saw that the most recent survey was focused on food and the quality of care provided. One person who used the service also told us that they were sometimes involved in interviewing and choosing new staff, they said, "[Registered manager] asks me to sit in on some new staff interviews. I ask questions. [Registered manager] said it was good as I ask things that she had not thought of asking."

The registered manager was passionate about providing a caring service to people living at Coppice Lodge. There was a clear management structure in place to support the registered manager. The provider had recently invested in developing leadership at the service by appointing a care manager. We spoke with the care manager who described their role as working alongside the registered manager to ensure high quality care. In addition to this two new deputy managers had recently been recruited and there were heads of department in place who were responsible for areas such as catering, maintenance and house- keeping. There were systems in place to ensure effective communication within the staff team including daily meetings for heads of department and senior care staff. A series of checklists had been implemented to ensure that all regular management tasks had been completed, these records were then checked by the registered manager. The management team had taken assertive action to manage staff performance and make changes to the staff team following our previous inspection and feedback from people who used the service and staff was positive about the impact of these changes.

People who used the service, their friends and relatives and staff were exceptionally positive about the passion, support and enthusiasm of the management team, in particular the registered manager. One person who used the service talked about the registered manager and told us, "She's smashing and very easy to chat to. She gets things done too." Another person told us, "She always comes round first thing in the day and pops round later. She has sorted people out here and things are certainly happening for the better." One person's relative told us, "She's great, very friendly. She tells me how [relation] is which is very good. It makes us feel close to the place. She goes way above her job, we feel like family." Other people used words such as "marvellous", "approachable", "down to earth" and "reassuring" to describe the management and staff team."

Community health and social care professionals were positive about the leadership and management of the service too. One professional talked of the registered manager saying, "She has asked for intervention at an early stage and then followed advice as needed. There has certainly been an improvement about the feel of the home." Another professional said, "[Registered manager]'s door is always open. It's a pleasure to come to Coppice Lodge. They've worked so hard to improve things."

Staff were also positive about the management team at Coppice Lodge. They told us they were happy working at Coppice lodge and felt valued and supported in their role. One staff member described a recent themed evening which had been attended by directors of Ideal Care Homes (Number One) Limited, they told us, "We were all ready to serve (food to) them (directors) but when they arrived they said "no sit down we are serving you" it felt amazing." This member of staff went on to tells us about a bonus incentive run by the provider which provided regular financial rewards to staff based on their performance. Another member of staff explained how they had felt supported by the management team when they had a need to take some time off work.

Staff were given an opportunity to have a say about the service in regular staff meetings. Records of these meetings showed that these were used to provide feedback to the team, to share information and to address issues within the service. Staff we spoke with told us they felt well supported and would feel comfortable in reporting any issues or concerns to the management team. One member of staff described a time when they had raised an issue with the management team and it had been acted upon quickly and effectively.

During our previous inspection we found that governance and quality assurance systems were not effective in ensuring the safe and effective running of the service. During this inspection we found that improvements were underway in this area.

Records showed that the registered manager conducted a range of audits across the service such as the environment, care plans, weight charts, safety and infection control. These were effective in picking up issues in some areas but had not identified all the issues we found during our inspection such as an ongoing failure to comply with the MCA and inconsistencies in care plans. Where issues had been identified in the audits, actions were recorded as having been taken. The service had an ongoing improvement plan in place and this was reviewed regularly by the provider's regional director.

Accidents and incidents were now analysed monthly to identify trends and to assess if any changes needed to be made. The registered manager also kept a narrative of actions taken in response to incidents. For example, one person had sustained multiples falls and we saw records to show that they had been referred to the local falls management team.

Systems had been implemented to establish processes which would improve the running of the service. The

management team had improved and updated training and supervision records and they had also implemented a system for tracking DoLS applications. These organised systems enabled the management team to monitor things such training needs and progress with DoLS applications to help ensure the effective running of the service.

Records showed that the regional director visited the home on a weekly basis to review audits and to monitor the quality of the service, they also conducted a full audit of the service every six weeks. Records showed that these audits were effective in identify most issues in the service and action plans were developed as a result of the provider's audits. The regional director had been proactive in sharing the outcome of audits with CQC.

We checked our records which showed that the registered manager had notified us of events in the service. A notification is information about important events which the provider is required to send us by law.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive care and support to meet their needs.<br><br>Regulation 9 (1) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People's rights under the Mental Capacity Act 2005 were not fully protected.<br><br>Regulation 11 (1) (3) |