Copper Beeches Limited

Copper Beeches

Inspection report

138 High Street
Collingham
Newark
Nottinghamshire
NG23 7NH

Tel: 01636892789

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

Summary of findings

Overall summary

We inspected Copper Beeches on 14 and 16 June 2017. The inspection was unannounced. The home is a situated in Collingham in Nottinghamshire and is operated by Copper Beeches Limited. The service is registered to provide accommodation for a maximum of 20 older people. There were 19 people living at the home on the days of our inspection visit. This was the services first inspection since they registered with us.

During this inspection we found multiple breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

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

People's medicines were not always given as prescribed or managed in a safe way. Risks to people's health and safety were not always managed appropriately or safely. Risks associated with the environment were not always assessed, the environment was not always clean and hygienic, and basic food hygiene practices were not always followed. Although people told us they felt safe, people were not always protected from abuse and improper treatment. People were not supported by staff that had been safely recruited.

There were enough staff available to meet people's needs and ensure their safety. Staff received an induction to their role and had access to ongoing training to meet people's needs.

The principles and application of the Mental Capacity Act were not always understood or followed where people lacked capacity to make decisions for themselves.

People had enough to eat and drink and were provided with assistance as required, however people's feedback about the quality of the food was varied and action had not been taken to address this when issues were raised. People's day to day health care needs were met, but there was a risk that action may not be taken in response to changes in people's health, as staff did not always have access to information about their health conditions and how to support them with these.

People's views about their care and support were not consistently acted upon which meant people's preferences were sometimes not met. There was a risk that people may not have access to advocacy services if they required this to help them express their views.

Staff understood how people communicated and they were supported to maintain their independence. Staff understood the importance of treating people with kindness, dignity and respect and we observed this in practice. Staff also respected people's right to privacy.

People told us they received inconsistent support from staff, care plans did not always contain adequate detail of the support people required and staff were not always aware of people's specific needs. People could not always be assured that they would receive support that was based on their individual needs, as some routines were in place to suit the needs of the staff at the service rather than the people living at the home.

People had the opportunity to get involved in social activities. People knew how to complain and complaints were documented, investigated and action was taken to address concerns raised.

The service was not well led and we identified a number of shortfalls in the way the service was managed. There were not sufficiently robust or comprehensive systems in place to ensure people were provided with safe and effective care that met their needs. Appropriate action was not taken by the provider to investigate incidents which posed a risk to the health and wellbeing of people who used the service. Swift action was not taken in response to known issues and people's feedback was not used to drive improvements.

Given the issues identified above 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.

Systems to reduce the risks associated with people's care and support were not always effective.

People were not protected from risks associated with the environment and the service was not clean and hygienic in all areas.

People did not always receive their medicines as prescribed and medicines were not stored or managed safely.

People were not always protected from abuse and improper treatment.

There were enough staff to provide care and support to people when they needed it. However, safe recruitment practices were not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

Staff received training and support to enable them carry out their duties effectively and meet people's individual needs. Staff were provided with regular supervision and support.

People were supported to have enough to eat and drink; however the dining experience was not always a positive one as people told us the food quality was poor.

People's day to day health needs were met. However, there was a risk that people may not receive appropriate support with specific health conditions.

Is the service caring?

Requires Improvement

The service was not always caring.

People's views about their care and support were not consistently acted upon which meant people's preferences were sometimes not met.

There was a risk that people may not have access to advocacy services if they required this to help them express their views.

People received support from staff who cared about their wellbeing. People told us they were treated with dignity and had their right to privacy respected.

People were supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be assured that they would receive person centred care which met their needs and reflected their preferences.

People were provided with opportunities for social activity.

People were supported to raise issues and staff knew how to deal with concerns if they were raised.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective. Timely action was not taken in response to known issues.

Appropriate action was not taken by the provider to investigate incidents which posed a risk to the health and wellbeing of people who used the service.

Opportunities for people living at the home to provide feedback on the service were limited and where people did provide feedback, this was not used to drive improvement.

Staff felt supported and were able to express their views in relation to how the service was run.

Copper Beeches

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, to look at concerns we received about the service and to provide a rating for the service under the Care Act 2014.

We inspected the service on 14 and 16 June 2017. The inspection was unannounced. The inspection team consisted of one inspector.

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

During our inspection visit we spoke with five people who used the service and two relatives. We spoke with four members of care staff, a member of the catering team, the activity coordinator, the head of care and the registered manager.

To help us assess how people's care needs were being met we reviewed six people's care records and other information, for example their risk assessments. We also looked the medicines records of nine people, five staff recruitment files, training records and a range of records relating to the running of the service for example audits and complaints.

We carried out general observations of care and support also looked at the interactions between staff and people. In addition to this 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.

Inadequate

Is the service safe?

Our findings

During our inspection visit we found several concerns relating to the management of medicines. Prior to our inspection we received concerns in relation to the competency of staff who administered medicines. We reviewed records and found evidence support this concern. Medicines records showed that on two occasions, medicines had been administered by a member of staff who had no training in the safe administration of medicines. We discussed our concerns with the registered manager who told us that the head of care was always present when this member of staff administered medicines. Records we looked at showed that this was not accurate. For example, staff rotas showed that the head of care was not working on the shifts where we identified the concerns. This put people at risk of receiving unsafe support with their medicines. We shared this concern with the local authority and this remained under investigation at the time of writing this report.

People could not be assured that they would be given their medicines as prescribed. We found two occasions where medicines had been signed for, but not administered. For example, one person missed a dose of medicine which was used to manage a heart condition. This meant people were at risk of harm as the provider had not ensured they received their medicines as prescribed. When people were prescribed a pain relief skin patch, guidance included with the medicine stated the patch should be applied to a different area of the body for each application. However, records did not show where on the body the patch had been applied. This meant people were at risk of experiencing side effects such as skin irritation. When people were prescribed medicines to be taken 'as and when required' there was not always guidance in place detailing what these medicines had been prescribed for or when they should be taken. This meant that staff did not always have clear information about when to give people these medicines and posed a risk that they may not be administered when needed.

Medicines were stored securely within the manufacturers recommended temperature ranges. However, medicines stored in the medicine trolleys were not always well organised and we found discontinued medicines remained in the trolley. This increased the potential of a medicine error. Liquid medicines were not always dated to show when these had been opened. This meant it was not possible to determine whether the medicine was being used within the manufacturers recommended shelf life. We also found a medicine was still in use beyond its expiry date, and so may no longer have been effective. We discussed this with the registered manager who was not aware of the issues we identified but told us that they would take action to make improvements.

Risks associated with people's care and support were not always effectively assessed or managed. For example, equipment in place to reduce the risk of pressure ulcers was not always used correctly. Two people had a specialist mattress to reduce the risk of skin damage. We found that neither of these mattresses were set appropriately, which may have reduced their efficiency. This failure to ensure the proper use of pressure relieving equipment put people at risk of developing pressure ulcers. We discussed this with the registered manager who told us they had been advised about settings by the company supplying the mattresses, however we found there was no record of this advice. Following our inspection visit the provider advised us that the error with the pressure mattresses had been corrected. We will check this at our next inspection.

Records showed that another person had recently lost a significant amount of weight, there was no evidence that any action had been taken in response to this. The registered manager told us that they thought that there may have been an error in recording the person's weight. There was no evidence that this had been explored any further or action taken to ensure the person was correctly supported. This meant that the person was at risk of further unplanned weight loss and potential malnutrition.

Bed rails were not always used safely or effectively. For example one person's care plan stated they required bed rails to reduce the risk of them falling from their bed. We observed that this person had a bed rail on one side of the bed, but only had a 'grab' rail on the other side (a grab rail is a smaller rail used to hold onto for support). This would not have been effective in preventing them from falling from their bed and could have caused them to become entangled in this had they fallen. We discussed this with the registered manager who informed us that the person had broken their previous bedrail twice, so a grab rail was now used, the registered manager was not aware that the grab rail would not prevent falls and may heighten risk. This failure to use bed rails safely, put people at risk of harm. Following our inspection visit, the provider advised us that bed rails were now being used safely. We will check this at our next inspection

Risks associated with people's behaviour were not managed safely as staff did not have access to personalised guidance about how to support people whose behaviour could be challenging. We were informed by a member of staff that three people living at the home could sometimes be resistive to personal care resulting in behaviour that may put them or others at risk. We checked their care plans and found that these contained no guidance for staff on how to support these people with their behaviour and this was confirmed by the registered manager. This lack of information had resulted in people receiving inconsistent and potentially unsafe support. For example, one member of staff told talked us through how they supported a person using reassurance, standing back and talking to them in a certain way. In contrast, another staff member told us that there were times when it was necessary to "hold [person's] hands to prevent them from hurting people." The failure to ensure staff had access to guidance and information about how to support these people meant that they experienced support which was inconsistent and potentially unsafe, as this may have resulted in injury to the person. Following our inspection visit the provider advised us that behaviour assessments had been put in place. We will check this at our next inspection.

People and staff were not adequately protected from risks arising from the environment. We identified risks in relation to legionella. Legionella is a bacteria that can develop in stagnant water and can lead to a fatal form of pneumonia. There was no legionella risk assessment in place and there was no evidence that infrequently used water outlets were flushed to prevent the growth of legionella. This meant that not all steps had been taken to reduce the risk of legionella developing in the water supply. This risk was exacerbated due to the age of the building and in addition, people living at the home were at increased risk of developing Legionnaires disease due to their age. The provider has indicated that a legionella risk assessment has been conducted following our inspection. We will look at this further at our next inspection to see how it was implemented and to check that appropriate actions were taken.

People were put at risk of eating food which was not safe to eat because basic food hygiene practices were not followed. We found that food was not stored safely. For example, we observed loose vegetables stored on a heavily soiled, carpeted floor which was in close proximity to an external door. This could pose a risk of pest infestation or contamination of the foods. We also saw out of date food in the kitchen, for instance we found an item of food which was starting to mould and the 'best before' date was 15 days prior to our inspection visit. This meant that people were placed at risk of eating food which was not suitable for consumption.

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

Although people and their relatives told us they felt that they, or their relations were safe at Copper Beeches we found that people were not always protected from abuse and improper treatment. People were not protected from institutional abuse. Prior to our inspection we received a concern that people were assisted to get up and dressed very early in the morning. On 14 June 2017 we arrived at the service at 06:20am and found that four people were up and dressed and the two night staff on shift were assisting a fifth person to get dressed which meant some people were likely to have been got out of bed at least one hour earlier. Three of the four people were in communal areas and were asleep which indicated that they remained tired. We looked at the care plans for these people to see whether they chose to be woken up so early. One of the care plans indicated that a person usually awoke around 7am, yet they were up, dressed and asleep in an arm chair upon our arrival at 6.20am. We spoke with a member of night staff who told us that they checked who was up at 5am and started getting people up accordingly. This member of staff was not able to explain why one person, who could not consent to getting up and who was asleep on our arrival, was up and dressed. We talked with the registered manager about this and they told us that people would be attended to earlier than their preference if for instance they required personal care. We were not provided with any reason why these people were not supported to remain in bed to return to sleep after being assisted with personal care.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate steps had not been taken to ensure people were protected from staff that may not be fit and safe to support them as safe recruitment processes were not always followed. Three of the five staff files we viewed were missing important information. Staff files did not always contain information about the staff member's employment history. For example, we reviewed the recruitment file of one staff member and found that there was no employment history provided in the application form and no record of employment history elsewhere. In another staff file, we found that it was unclear who had provided the professional reference obtained for the staff member. This meant that the provider did not have all the relevant information to make a decision about the suitability of the staff member. Following our inspection visit the provider advised us that improvements had been made to staff files. We will check this at our next inspection.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured that the service was clean and hygienic. We saw that areas of the service were not cleaned to an adequate standard. For example, the kitchen was not in a hygienic state, cupboards used to store cooking equipment were sticky and contained dust and crumbs, the microwave was heavily soiled with food debris and on areas of the floor there was a build-up of food remains and other residue. Cleaning equipment in the kitchen, such as the mop buckets and dust pans were heavily soiled and did not facilitate the effective cleaning of the kitchen area. We also observed other areas of the service where effective hygiene practices were not followed. For example, bin liners were not used in some bins and light pulls in toilets were heavily soiled which posed a risk of cross contamination. Some of the above issues had been identified in an audit conducted by the local infection control team in December 2016. Although improvements had been made in some areas, such as the installation of a sluice (used for disposing of waste), the cleanliness of the environment still posed a risk to people's health. Following our inspection visit we shared our findings with the local infection control team and the environmental health team.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Prior to our inspection visit we received concerns that people who used the service were at risk of emotional abuse and distress as a result of witnessing acts of physical violence occurring between staff. The local authority was investigating these concerns and this was ongoing at the time of writing this report.

Feedback from people living at Copper Beeches about staffing levels and the availability of staff was positive. Although some people commented that staff could sometimes appear "rushed" they also told us that staff were normally available to respond to their needs in a timely manner. One person who spent most of their time in their room told us that if they pressed their call bell, staff normally attended quickly. The staff we spoke with told us that staffing levels were usually sufficient and said that the staff team worked together to cover any last minute absences. One member of staff told us, "I have no concerns about staffing levels, shifts are covered or [head of care] steps in." 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. Records showed that shifts were staffed to the levels determined by the provider. This meant that people could be assured that they would be supported by sufficient numbers of staff to meet their needs and ensure their safety.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (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 not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests. Whilst care plans contained some assessments of people's capacity, mental capacity assessments and best interest decisions were not always in place as required. Decisions made in people's best interests were not always clearly recorded. For example, we arrived at the service at 6:20am and found that three people were up, dressed and were asleep in communal areas. Records showed that two of these people lacked the capacity to make some decisions. However, there was no documentation in place to demonstrate that their capacity to make the decision about getting up early had been assessed or that this was in their best interests. There was no evidence of any discussion with the people closest to them, to assess if this was their preference. This meant people's rights were not always promoted as the provider was not always acting in accordance with the MCA.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate and some of these had been granted. However, where people had DoLS in place, the management and staff team did not have a knowledge or understanding of conditions imposed to ensure their wellbeing. For example, a DoLS authorisation granted for one person included a specific condition which stated that the local authority must be notified should there be any changes to the restrictions imposed upon the person. However, neither the registered manager nor the staff were aware of this condition. Although the level of restrictions upon this person had not changed, it meant there was a risk that appropriate action may not be taken to safeguard the person's rights should their circumstances change.

Whilst training records showed that staff had training in the MCA, staff we spoke with demonstrated a mixed understanding of the Act. Whilst some staff were able to explain the principles of the Act other staff had a very limited knowledge. For example one member of staff told us, when we asked them about the MCA, "It's about their mental health, things like dementia and depression." This limited knowledge could expose people to the risk of receiving care and support that did not reflect their wishes and of staff making decisions that may not be in their best interests.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured that they would receive effective support in relation to their health. Records showed that people had regular appointments with health professionals such as the optician, dentist, and district nurses. However, there was a risk that people may not receive the support they required with specific health conditions, as staff did not have access to sufficiently detailed information. For example, one person had been hospitalised in recent months as a result of infection, despite this, their care plan contained no information about the risk of reoccurrence or signs and symptoms to enable staff to identify the early signs and access healthcare. This lack of information placed people at risk of not receiving the support they required with their health.

People gave mixed feedback about the food at Copper Beeches. Whilst some people were positive about the food, other people were not. One person told us, "The food is good," and another person said, "[The cook] knows just how I like my porridge." In contrast one person said, "The food is not to my taste so mainly I buy my own." Another person said, "The food quality is poor." We viewed records of the provider's most recent satisfaction survey in February 2017 and found that people had also provided mixed feedback about the quality of the food. For instance, some people felt that the food was not always served at the correct temperature. The registered manager told us that action had not yet been taken to address this. This meant that the dining experience was not always a positive one for people as the quality of the food was not consistently good. We saw that staff supported people who required assistance with their meal in a calm and unhurried way and people had access to drinks and snacks throughout the day. The kitchen was provided with information about people's dietary requirements and we saw that these were met. For example, one person needed their food to be pureed due to a risk of choking and we saw this was given in line with guidance in their care plan.

People who used the service told us that they felt that staff were competent and skilled. One person told us, "Yes, staff know what they are doing." This was also reflected in the comments made to us by the relatives of people living at the home. New staff were provided with an induction period when starting work at Copper Beeches. The registered manager told us that staff induction included training and shadowing experienced staff members to learn about the needs of people using the service. We also saw that staff completed an induction checklist when starting at the service which ensured that they were provided with essential information about the service such as health and safety and fire procedures. Training records showed that almost all staff had completed the training identified as compulsory by the provider. This included; safeguarding, moving and handling and health and safety. We also saw that some staff had undertaken training in relation to the specific needs of people who used the service such as dementia and falls awareness. The registered manager told us that staff who had not yet completed these courses were booked to attend future dates. Staff had access to regular supervision and support. Staff we spoke with told us that they felt supported and they had frequent supervision meetings. The registered manager told us that supervisions took place regularly for each member of staff and records confirmed this to be the case. This meant that staff received training and support to enable them to care for people.

Requires Improvement

Is the service caring?

Our findings

People's views about their care and support were not consistently acted upon. For example, one person told us that they had expressed a preference to move into an alternative room, despite there being a suitable room available, no action had been taken to fulfil this person's wishes. This demonstrated that action was not taken to ensure people's preferences were responded to.

Concern for people's wellbeing was not always handled with care and compassion. Three people we spoke with told us that they felt lonely at Copper Beeches and commented that they had limited contact with other people who used the service. We discussed this with the registered manager who informed us that they had contacted some people's GP's to see if they were depressed. This did not assure us that action would be taken to explore and address other possible reasons for people's loneliness.

During our visit we observed that there was no information about advocacy displayed in the service and there were no links with local advocacy services. This meant people may not be enabled to access an advocate to support them to express their views if they wished to. Advocates are trained professionals who support, enable and empower people to speak up. The registered manager explained that although they were not aware of a local advocacy provider they would find out about local services if needed.

People and their relatives were positive about the staff team at Copper Beeches. One person told us, "I'm happy with everything, the staff are good." Another person said, "They (staff) have bent over backwards (for me)." One person's relative told us "The staff here are kind and caring, we always check with [relation] when we visit and they have never told us anything to be concerned about." We observed positive interactions between staff and people living at the home. Staff told us that they had developed relationships with people and had an understanding of what mattered to people and how to support them. One member of staff told us, "It's about how you approach them. For example with [person's name] you have to be quiet, gentle and patient." We observed another member of staff assisting a person to eat, they explained their actions to the person, worked at their own pace and provided reassurances. People were supported by staff who were kind, patient and gentle.

Staff had an understanding of how people communicated and used this information to involve people in day to day decisions relating to their care and support. For example, one member of staff described how they supported a person to be involved in their care, they told us, "Certain times of day are better for [person] than others, if you go to them in the morning this is better, they can become sleepy and confused in the afternoon." Another member of staff explained how they used non-verbal cues to help understand another person's needs, they told us, "[Person] can't tell you anymore but it they hold their stomach we know this means they may be in pain." This meant people were supported by staff who understood how they communicated and involved them in day to day decisions relating to their care and support.

Prior to our inspection visit we received concerns that people's right to privacy was not respected at all times. The local authority was investigating these concerns and this was ongoing at the time of writing this report.

During our inspection visit people told us that they felt staff respected their privacy, one person told us, "(Respect my privacy) I should think so." Staff shared examples of how they worked to maintain people's privacy and dignity such as closing doors and curtains when supporting people and ensuring people were covered during personal care. We observed that staff were mindful of ensuring people's dignity, for example a staff member took action to adjust a person's clothing to ensure they were fully covered. People's families told us there were no restrictions on them visiting their loved ones.

People were supported to maintain their independence. People and their relatives told us that staff promoted and encouraged their independence. The relative of one person told us, "They let [relation] do what they can themselves and they are there when [relation] needs them. [Relation] has improved so much since they arrived." Staff told us they aimed to promote people's independence. One member of staff described how they supported a person's independence, they told us, "We pop in and remind [person] of certain points. They clean their room, make their bed and can manage their own care, they just need reminders." We also spoke with the activities coordinator who told us that they encouraged and supported people to do a range of exercises to help maintain their physical abilities. This meant that people were supported by staff who encouraged them to maintain their independence.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support that did not meet their needs. People who used the service commented on the inconsistent approach of the staff team. One person told us, "Staff are gentle, but I have to tell them what to do." Another person commented, "Most of the staff are good, but it depends who you get really." Each person who lived at the service had a care plan, these contained information about people's preferences, details of support they required and risks associated with their care and support. Whilst some care plans were adequate, others lacked important information. For example, we reviewed the care plan of one person who had moved in to the service five weeks prior to our inspection visit. Preadmission assessment forms were blank and their care plan was very basic. Other forms including risk assessments, were blank, and lacked meaningful detail to inform the support provided by staff. We discussed this with the registered manager and on the second day of inspection the head of care showed us a care plan and risk assessments they had been writing. This information had not been made available to staff. This meant that the provider had not ensured that staff had the information that they required in a timely way and this put people at risk of receiving inconsistent support that did not meet their needs.

People did not always receive support that was responsive to their needs. Some people told us that they sometimes had to wait for assistance and this was confirmed by our observations. One person told us, "I choose what time I wake up, but not what time I get up, I just have to lie here and wait for staff to help me." We observed that another person was left sitting at a dining room table for a period of an hour and a half before they were offered any breakfast.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with opportunities for social activity. The service had a dedicated activity coordinator. They told us they had an activities programme which was based on people's interests. We reviewed records which showed that the activities coordinator met with people on a monthly basis to discuss their social and recreational preferences and needs and this involved people's families where appropriate. They had a good knowledge of people's preferences and were mindful to ensure that those people who were not able to express a preference were equally involved and included. For example they talked about one person and told us, "They don't get involved in group activities but I think they like me to chat to them and do things one to one." During our visit we observed people were encouraged to join in activities, such as a game of skittles, and saw that staff supported people and encouraged their participation. The activities coordinator told us that they arranged trips in the community, such as boating trips, and also invited members of the local community into the home for coffee mornings. In addition to this, external entertainers visited occasionally. The activities coordinator also spent time with people who chose to stay in their bedrooms. They told us they visited these people and chatted with them as well as supporting them to pursue their interests. For example, they supported one person to tend to their bird table so that they could watch the birds whilst they were in their room.

People and their relatives knew how to raise concerns or complaints and felt confident to do so.
There was a complaints procedure on display in the service and systems were in place to ensure that complaints were responded to in a timely manner. Records showed that complaints had been documented, investigated and responded to appropriately. For example, a family member had raised concerns about the lack of activities at weekends, the registered manager had responded to this by deploying an additional staff member at weekends to coordinate activities. Staff we spoke with were aware of their role in recording any concerns received and communicating these to the management team. This meant the provider had a system to ensure complaints were appropriately managed.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Throughout our inspection of Copper Beeches we identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, safeguarding people from abuse and improper treatment, the safe recruitment of staff, the cleanliness of the premises, the implementation of the Mental Capacity Act 2005, practices that were not person centred. This led to multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems in place to monitor and improve the quality of the service were not comprehensive or effective. Although there were some audit systems in place, these had not been effective in identifying or addressing the issues we found during our inspection visit. For example, a monthly medicines audit had not identified concerns relating to medicines management found during our inspection. We reviewed the medicines audits for the four months prior to our inspection and found that no issues were identified at any of these audits. This resulted in people being placed at risk, as there were insufficient systems in place to ensure the safe management of medicines. There was no system in place to monitor and audit the quality of care plans. Consequently we found that care plans were of variable quality and this had resulted in people experiencing inconsistent support. The lack of effective systems to check on the quality and consistency of care plans meant there was a risk that people's care was not being delivered safely and in line with the regulations.

Swift action had not been taken in response to known issues. For example an audit had been conducted by the infection control team in December 2016. The provider had submitted an action plan in response to this and although we saw that action had been taken in some areas improvements in other areas had not been made in the timescales specified by the provider. The action plan stated that action would be taken to undertake a legionella risk assessment by the end of February 2017, however this was still outstanding at the time of our inspection visit. Following our inspection visit we made the infection control team aware that there were still outstanding issues in relation to infection control. As a result the infection control team conducted an audit of the service on 5 July 2017. This identified 33 areas where improvement actions planned from the previous infection control audit were still outstanding. This failure to take action on issues relating to the health and safety of the service exposed people to the risk of harm.

The provider did not have sufficient systems in place to monitor the quality and safety of the service. During our inspection visit we viewed an annual quality audit report which was dated March 2016. The registered manager informed us that no further formal quality assurance visits by the provider, had taken place since then. This absence of formal governance and quality assurance processes meant that the provider had not identified and consequently not addressed the areas of concern found during our inspection visit.

The provider had not taken appropriate action to investigate potential risks relating to the health, safety and welfare of people living at Copper Beeches. Prior to and throughout our inspection of Copper Beeches we received concerns that people who used the service were at risk of emotional upset and distress as a result of witnessing acts of violence occurring within the service between staff. We requested that the provider took urgent action to investigate this. The action taken by the provider did not assure us that they had taken appropriate steps to enable the effective investigation of the concerns received.

The provider had not ensured that comprehensive records were kept in relation to staff employed at the service. For example the Disclosure and Baring Service (DBS) check for one staff member evidenced that they had previous criminal convictions. DBS checks are used to assist employers to make safer recruitment decisions. There was no evidence in the staff file that the potential risks to people who used the service had been considered to ensure the member of staff was safe to work with vulnerable adults. We discussed this with the registered manager who informed us that they had considered the conviction and had concluded that there was no risk. They told us there was no written record of their assessment of risk which meant we were therefore unable to make a judgement about the robustness of the risk assessment. This failure to maintain records meant we were unable to access important information to inform our judgement about the safety of the service.

People's feedback was being sought, however this was not always being used to drive improvement. For example, we saw records of surveys which had been completed by people living at the home in February 2017, a number of these cited concerns about the quality of the food served but there was no action plan associated with this to address these concerns. The registered manager told us that no action had been taken yet as the survey was still underway and they planned to analyse the results at the end of the month, resulting in a four month delay in addressing issues raised by people living at the home. This meant that people could not be assured that their feedback would addressed in a timely manner and used to improve their experience of the service. In addition, the registered manager told us that that regular meetings were held for people who used the service, however we were not provided with any evidence of recent meetings and people we spoke with were unable to recall having attended any meetings. This meant that there were limited effective ways for people to provide their feedback on the service.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Following our inspection visit the provider advised us that improvements were planned to auditing systems, such as the introduction of new care plan and recruitment audits. We will check the impact of this at our next inspection.
There was a registered manager in place at the time of our inspection visit. They told us that they were in the process of making a number of improvements to systems and processes such as care plans and audit systems and this had resulted in some temporary disorganisation. They offered assurances that they would act upon our findings and "get things sorted." The registered manager told us that they had a vision for the service which included making it more dementia friendly, they told us that they had already started to do this by putting up signage around the building and using coloured crockery (the contrast aids people living with dementia to see food more easily).

Staff felt supported in their roles and told us the management team were friendly and approachable. One member of staff told us, "[Registered manager] is approachable, I would go to him if I had concerns about anything," whilst another member of staff commented, "I wouldn't be here if it wasn't a good place to work. Everything here is good, we look after people well." A third member of staff said, "(The managers) have been really good, really supportive." Staff were able to offer feedback on the service in a number of ways including in supervision meetings and team meetings. Records showed that staff meetings took place regularly and were used to address issues, discuss outcomes of audits and to help maintain professional standards. Staff had identified some training needs in a recent meeting and the registered manager had taken action to arrange this. This meant that staff were able to influence some aspects of the running of the service.

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 15 HSCA RA Regulations 2014 Premises and equipment The premises was not maintained to an appropriate hygiene standard. Regulation 15 (1) (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected from risks associated with their care and support or the environment. Bed rails were not used safely. Basic food hygiene practices were not adhered to. Medicines were not always managed or stored safely. Regulation 12 (1)

The enforcement action we took:

We issued a warning notice telling the provider to take action on areas of concern

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality and safety of the service were not effective. Timely action was not taken in response to known issues. Appropriate action was not taken to investigate incidents which posed a risk to the health and wellbeing of people who used the service. The provider had not acted on feedback from people who used the service for the purposes of continually evaluating and improving the service. 17 (1)

The enforcement action we took:

We issued a warning notice telling the provider to take action on areas of concern