Ideal Carehomes (Number One) Limited

Coppice Lodge

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected this service on 26 and 27 November 2015. The inspection was unannounced.

Coppice Lodge is a purpose built care home providing accommodation for people who require personal or nursing care to up to 64 older people. The service has four separate units; two providing residential care and two providing care for people living with dementia. At the time of our visit, 51 people were accommodated at Coppice Lodge.

On the day of our inspection Coppice Lodge did not have a registered manager. The new manager had been in post for three weeks and was not yet registered with CQC. 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 found the provider was not meeting the requirement to keep people safe as there were not always sufficient

Summary of findings

numbers of staff available to meet people's needs which meant people were left unattended for long periods of time. People were not always supported to maintain healthy nutrition.

Thorough pre-employment checks had not always been carried out. Some staff lacked references and DBS checks. However the manager had identified this and was addressing the issue.

People were not always treated with dignity and respect and did not always have opportunity to express choice in the care or engage in meaningful activities.

Risks to people were assessed and measures put in place to reduce risk. However these assessments were not always updated and did not always reflect the current situation.

People's care records were not always updated to reflect the person's current need and information was sometimes contradictory.

People received their medicines as prescribed. However medicines were not always being stored safely to ensure they were still effective. Fridge temperatures had not always been recorded.

Where people lacked capacity to make a decision, processes were in place to ensure that mental capacity act (MCA) assessment guidance was followed. The manager demonstrated good understanding of deprivation of liberty safeguards (DoLS) guidance. However we found not all staff were aware of MCA and DoLS guidance.

Systems were in place to allow people, their relatives and staff the opportunity to give feedback about the service. However we found these had not always been used and the feedback not acted on.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 not always safe.

There was not always enough staff to meet people's needs and calls for assistance were not responded to promptly.

People were not always protected from the risk of avoidable harm as staff had not received regular safeguarding training.

Medicines were not always stored correctly.

Thorough pre-employment checks were not always carried out for all staff.

Is the service effective?

Requires improvement

The service was not always effective

Staff did not always receive suitable training to help them carry out their duties effectively.

Mental Capacity Act and Deprivation of Liberty Safeguarding applications were in place but not always updated.

People did not always receive support to ensure they maintained healthy nutrition and hydration as staff did not always have time and had not received appropriate training.

People's mobility and access needs were well met by the design and layout of the building.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always treated with dignity and respect and we saw examples where people's dignity was not maintained.

People were generally treated with kindness, compassion and told us they were happy with the care they received.

People were not always supported to maintain their independence and did not always have the opportunity to express choice about their care and routine.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some people's needs were not met in a timely manner.

People did not always receive personal care when required.

People were not always involved in the planning or review of their care.

Summary of findings

People did not always have the opportunity to engage in meaningful activities

Complaints were handled efficiently and investigated thoroughly.

Is the service well-led?

Requires improvement

The service was not always well led.

Systems were in place to monitor the quality and effectiveness of the service but these had not always been followed.

People had not always had the opportunity to express their opinions about the service.

There was an open culture amongst staff at the service.

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 27 November and was unannounced.

The inspection team consisted of two inspectors and a specialist nurse advisor. Prior to the inspection we reviewed evidence we held about the service including 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 the inspection we talked with five people who used the service and four relatives and spoke with a visiting district nurse, a student nurse and dementia service outreach worker. Following our inspection we spoke with the local authority and the Clinical Commissioning Group.

We also spoke with five members of care staff, the manager and deputy manager. We looked at the care records of four people who used the service, medicines records, staff training and recruitment records, as well as a range of records relating to the running of the service including audits carried out by the manager, area manager and service commissioner.

Requires improvement

Is the service safe?

Our findings

At a previous inspection in June 2014 we found there were not sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there were not enough staff on duty at key times of the day and the provider had not made the improvements required. This resulted in people not always receiving the support they required and their need not being met in a timely way. One person told us they did not feel safe due to the lack of staff. They said, "No I don't feel safe. I don't feel threatened or anything, but there's not enough staff in an emergency." A staff member told us, "We definitely need more staff, particularly on nights." Another staff member said, "It's hard when there's just two of you to cover [the unit they worked on]."

We saw periods of time where there were no staff present in one of the lounges where a number of people were, including some who were at risk of falls and needed to be carefully supervised. We also saw during a mealtime on one of the units for people living with dementia one member of staff was left on their own to serve food, provide support and ensure people's safety. During this time we saw one person poured hot soup over themselves and onto the floor and threw food at other people in the room. We had to intervene to stop another person putting their head into a bowl of hot soup as the only available staff member was supporting up to eleven other people and was unable to help this person.

In addition to this we found people were not always given the care and support they required in response to their needs. We observed several periods of time throughout our visit were staff were unable to assist people as they were too busy. For example one person waited over an hour and twenty minutes after asking to be taken to the toilet before they received help from staff. A second person was at risk of falls and had a sensor mat in their room to alert staff if they got out of bed or chair. We activated the nurse call system in that room and recorded a period of ten minutes without response before we switched off the call. This delay in assistance from staff would expose people to risk of injury or harm.

On a unit on the residential side of the home, we were approached by a chiropodist who wanted to know which was the correct walking frame for a service user as no staff were present on the unit at that time. A staff member returned to the unit and informed us they and a second member of staff allocated to the unit had been working on a different unit. This left the one unit without any staff cover, exposing residents to risk of harm and delaying delivery of treatment from visiting health professionals.

People may receive care and support from staff who were unsuitable to work with vulnerable people. We found missing information in four out of five staff files including Disclosure Barring Service checks and references. The DBS provide information to providers to help them make safe recruitment decisions. We also found some staff had not had references taken up from their previous employers. Although the manager had recognised this during their review, there were no risk assessments in place to ensure people were protected.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's safety could not be assured because the equipment to support them was not properly managed. A staff member told us, "The beepers should be louder as I can't hear them." We also found that call bells could not be heard in some parts of the building due to the bells ringing only at the main control board. In addition to this we also saw that some call bell cords were disconnected. We raised this issue with care staff. However those we spoke with did not demonstrate awareness that this was a cause of concern and that people would not be able to call for assistance if needed.

Additionally we identified multiple ligature / strangulation points throughout the home in the form of pull emergency cords, light cords and telephone lines. The service did not have a Ligature / Strangulation Risk Assessment in place nor access to a ligature cutter. This could expose people who use the service to risk of harm. We informed the manager of our findings during the visit and received assurances the call bell cords would be replaced and they would discuss the ligature concerns with the provider.

Requires improvement

Is the service safe?

People did not have access to their walking aids when they needed them. We saw people's walking aids were left out of their reach so they were at risk of falling if they tried to get up independently. One person had a falls risk assessment which stated the person should have their frame near them. We saw that the person's frame was not within their reach. We also found a chiropodist trying to determine the correct walking frame for one person because the person's was not readily available and there were no staff present to advise them which one should be used. Therefore potentially leaving the person at risk should the incorrect walking frame being used or in fact at the risk of falls if the person attempted to walk without this.

The building was purpose built which ensured ease of access and movement throughout the units including wider doorways and corridors for wheelchairs and level access on all floors. The upper floor was accessed by a lift which was regularly maintained.

Although staff had not received up to date safeguarding training and three staff members we spoke with could not remember when they had last received this training, they were able to identify the signs and types of abuse. In addition this this they were also able to describe their role in raising a concern both internally and externally should abuse happen.

We saw the provider had systems in place to record and act upon concerns identified and that they made referrals to the appropriate agencies when required. Where recommendations where made the provider acted on these.

We found medicines were not always stored safely and the effectiveness of medicines could be compromised. The monitoring of the fridge temperature had been missed over 28 times since August 2015. In addition to this staff were not able to lock the fridge as the key had broken in the lock.

On checking controlled medicines we found that these were stored, checked and administered appropriately.

We observed the lunch time medicine round in one of the units and found the member of staff administering the medicine followed safe practice and ensured that people took their medicine before signing for this as administered on the medication records (MAR).

We observed one person to be slumped over in their chair so we spoke with a member of staff about this. They were able to provide an explanation of their medicines, the effects and the GP intervention thus demonstrating a good knowledge of the person they were caring for and their medicines.

Requires improvement

Is the service effective?

Our findings

People may receive the care and support they required from staff who had not been suitably trained to provide this. A recently employed member of staff told us they had been, "Thrown in at the deep end" when they started to work at the home. New staff were expected to complete the care certificate within the first 12 weeks of their employment, but none had done so. The care certificate is a nationally recognised qualification is designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. Additionally we found that not all staff had completed the provider's induction training programme.

In addition to the above, staff training records showed that every member of staff was overdue some training they were expected to have completed and two staff were not up to date on any aspect of their training. Furthermore we also saw that some staff did not receive regular supervision where they had the opportunity to discuss their work and if they had any difficulties or additional training needs. The manager told us they were aware that some staff had not had the support and supervision they should have been provided with and they had put a plan into place to rectify this.

We saw that the lack of training and supervision had a negative impact on care delivery. For example we observed two members of staff did not follow good practice when supporting a person to stand. This showed that not all staff were using correct lifting techniques and observations of their performance had either not been carried out or observations had not identified this.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured that all staff followed the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards to ensure their rights were protected. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found staff did not have a good understanding of the MCA. One staff member told us, "The ones higher than me [managers] deal with that." Another staff member said they were not aware of any decisions that had been taken in a person's best interest. We saw decisions had been made on behalf of people without first determining if the person had the capacity to make the decision for themselves.

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). Applications made where people had restrictions placed on their freedom although decisions for these were not always available due to delays at the authorising authority.

People did not always have the support they needed to maintain adequate nutrition and hydration and their food was not presented in the most suitable way to aid their nutritional intake. One person attempted to eat their food with their fingers as their food was not cut up. We saw a staff member go to assist the person for a while but they did not stay with them to ensure they ate as much as they wanted. We saw that the person did not eat any more of their meal and put their fork down saying "I can't find it," another person then took some food from their plate.

Another person was sat in an armchair in a position that was not suitable to eat their meal. A staff member placed the person's meal in front of them but made no attempt to reposition them which made it difficult for the person to get the food to their mouth without spilling it.

We also saw that a staff member took a cup away from a person without asking. When the person called out, "I still wanted that" the staff member continued to walk away and said, "Well I thought you were done with it."

We saw one person had been referred to the GP when they had lost weight. However there was no further information about advice given or action taken by the GP so that staff could ensure they were supporting the person appropriately. Although the person had a malnutrition risk assessment which showed they were assessed as high risk, this had not been updated for two months to ensure staff were supporting the person as needed. Where people's nutritional and fluid intake was monitored we saw forms were not correctly completed so it was not known what people's food and fluid intake had been.

Requires improvement

Is the service effective?

Most people made positive comments about the food. One person said, “The food is very good.” A relative told us their relation “Gets more than enough to eat. The food looks hot and smells nice. There are snacks if they want them. They offer [relation] a sandwich if they’ve not eaten much dinner.” Another person told us they did not think the food was very good and said, “What I think I’m ordering doesn’t always turn up.”

People were supported to maintain their healthcare needs. There was evidence of people seeing different multidisciplinary professionals such as the dentist, optician and chiropodist on a regular basis. In addition to the home also has a Care Home Team who visit from the GP and that this team will triage resident’s medical needs before a doctor attends. This ensured that people received the level of support and assistance they required.

Requires improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. We observed a number of incidents where staff spoke with people abruptly and did not treat them with dignity and respect. For example we saw that people were not covered to protect their dignity when receiving care and support. One person was left sat on the toilet with the door open which allowed anyone passing to see them. Another person asked if a staff member could help them to get up and was told, "Well no, not really, you can get yourself up". A third person said, "You never see staff talking with residents." A visiting health worker told us there were occasions when people had not been spoken with respectfully by some staff. We raised our concerns with the manager who took immediate action.

People's dignity was not always protected whilst they were eating. We observed staff cutting up people's food without asking if it was required. One person became agitated and told staff twice not to cut up their food but they continued to do so. Another staff member assisted people to eat while standing up with their elbows on the table, even though there was space and chairs where there so they could have sat down next to the person so they could support them in a more dignified manner.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with also told us there were other staff who were kind and treated them with dignity and respect. One person told us, "The staff are lovely, they are always very nice, they ask if they can do things for you". A second person said, "I think this place is brilliant, the staff are polite and friendly, you do what you want, when you want, it's fabulous. We saw examples of kindness and compassion during our visit. For example one person became upset when talking about their past, staff showed empathy and compassion when comforting them. The maintenance worker stopped and listened to every person who spoke with them and made sure people's requests were listened to and passed on.

People were not supported to have involvement with the design and delivery of their care. None of the people we spoke with had been involved in planning their or their relatives care although one person's relative told us, "I think I've seen the care plans once or twice, once because I asked to see them. We've had a chat about them. They're pretty straight forward". Staff told us they were not involved in care planning. However one staff member told us 'We know what people like from the care plans and they tell you anyway.'

We looked at four people's care plans which did not evidence the involvement of people or their relatives in the design or review of these. This would mean care was delivered in a way contrary to people's wishes and they had not agreed to. The manager informed us they were undertaking audits of care plans and had put procedures in place to ensure greater involvement of people and their relatives in future.

Some people told us they had a positive relationship with staff at Coppice Lodge. One person said I think this place is brilliant, the staff are polite and friendly, you do what you want, when you want, it's fabulous." A second person told us I have banter with the staff and feel welcome here."

The majority of staff we spoke with and people talked to us about, understood the needs of people they supported and had positive relationships with them. We observed people being supported to eat their meals in a calm and unhurried way, some staff joined in with people who were singing and dancing.

People's relatives told us they found staff to be generally friendly and approachable and felt they understood their relative's needs. One person told us, "We do see some of the same staff faces. That's what's important. They get to know their little habits.'

A staff member said, "I most enjoy the residents. They are so caring. Some days it can be hard. We lost two and you don't realise how close you get to them in only a few months. Everyone's got stories to tell you."

Requires improvement

Is the service responsive?

Our findings

At a previous inspection on 10 September 2014 we found people's care and support was not always planned and delivered in a way that was intended to ensure people's safety and welfare. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection although care plans were in place detailing how to support people with needs such as pressure ulcer management and continence care, these were not always updated as the person's condition or needs changed. Additionally they did not always contain information that would help staff understand the person for example life histories, food preferences or interests. A further example being, a health assessment in one person care plan indicated they had suffered stroke, had glaucoma and breathing difficulties and there were no care plans or risk assessments were available for any of these conditions. Additionally, staff told us one person's behaviour had become increasingly challenging including being violent towards staff. This was not recorded in their care plan and therefore staff did not have sufficient information to guide them in regard to how to support this person and manage their behaviour effectively, nor did it ensure that they, staff and other people using the service were protected as there was a risk that staff would not be aware of their complex needs and the support they needed.

The personal safety care plan for one person stated that staff should check on them in their room every hour. Additionally, the care plan stated that 30 minutes observations should be recorded, but there were no records in place and staff were not aware of this.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not routinely involved in the design, planning or review of their care. The new manager had identified this and showed us how they planned to increase involvement for all future reviews.

We found there was differing views on the activities on offer for people using the service. A visiting health professional felt that there was a lack of activities and meaningful occupation and that they struggled to get these set up and maintained. They also felt that although the home did run groups they didn't have the staffing levels to maintain them. Whereas a staff member told us they tried to provide activities when they were able. They said 'We have singers, card making, Halloween pictures, we used to have karaoke. They like a good singalong. They only go out with their families".

We spoke with the deputy who told us that the provider had recently appointed a regional activity coordinator who would advise on activities. They said there was lots of equipment for staff to use such as a parachute, skittles, paints and colours. They told us there was chair based exercise and reminiscence once a month too. During our inspection we saw in one of the units that staff were able to sit and colour with people and in a second some people were having their nails painted.

For those people wishing to continue to practice their faith we were told that a visiting celebrant came to the home every three weeks.

People we spoke with told us they felt able to speak to staff or the manager if they had concerns and were happy these were dealt with well. Staff spoken with were able to explain what they would do if a complaint was raised with them. A relative told us that they would feel comfortable to raise any concerns. They told us dates for family meetings were on notice boards and that they had been to about two of these. They thought they were very good and that the service was very open about everything.

The provider's complaints policy was comprehensive and well publicised. We saw that complaints were investigated thoroughly and the complainants kept informed at all times. All complaints we reviewed were resolved satisfactorily. Staff told us that they had not received any complaints but if they did they would tell the manager.

Requires improvement

Is the service well-led?

Our findings

At a previous inspection in June 2014 we found people were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the registered person did not effectively operate systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

At this inspection we found that some records contained contradictory and out of date information. Additionally information was difficult to find, which could have a negative impact on the care people received. For example one person's care plan about hygiene and personal appearance, stated they preferred to shave themselves with prompts from staff. However staff told us that they shaved the person now. One staff member said, 'If I do it [the person] gets agitated.' Two staff told us that the person had a preference of female carers which was not noted in the care plan. It also said that the person would require one carer. Three staff told us that this person had become more agitated recently when they need support with their continence needs. They told us that they step back or try again later and this usually works. Techniques for assisting the person were not recorded in the care plan and there were no capacity assessments or best interest's decisions relating to this. We saw an accident report where the person had been very agitated during personal care and had banged their elbow on the wheelchair causing a skin tear.

We found there was not an effective system to ensure staff recruitment files were monitored to ensure the required information was collected prior to new staff starting work. We looked at the employment files for five of the 31 staff. Four of the five files had information missing which could not be found by the manager. Although the manager had identified this via their own review and had requested the information from staff they had not put any risk assessments in place in the interim.

Systems were in place to allow people who used the service, their relatives and staff to give feedback regarding their experiences of the service, but these had not been well used. Meetings for people who used the service and their relatives had been held infrequently changes or action plans had not been developed from these. The new manager had instigated a programme for these meetings and staff meetings to be held for the year ahead.

People told us they felt the new manager was approachable and that they were confident they would deal with any issues raised. A relative told us they would feel comfortable to talk to the manager, "It's improved since [the manager] started she listens." A second person told us, "They listen to me, issues get addressed"

Staff we spoke with were not involved in or aware of any auditing processes. However we saw records of monthly audits completed by the provider's area manager. These identified areas for improvement including daily checks of medicine records, residents' monthly meetings to be reinstated and for floor records to be reviewed daily. We saw that the new manager had begun to instigate these changes.

Audits of medicines were carried out and their findings acted on. Processes were in place to ensure equipment and facilities were regularly reviewed and maintained.

Reviews of staffing levels had failed to identify that sufficient numbers of staff were not always available in all units. We had previously identified this as a concern and have taken enforcement action telling the provider to make improvements.

At the time of our visit the service did not have a registered manager as the manager had only recently been appointed. The provider has a number of services in the area and support was offered form existing registered managers at other homes. For example we saw a visiting manager had completed a review of accidents and incidents. As the service had been without a manager for a number of months we had not received statutory notifications from Coppice Lodge for all incidents.

Staff told us that the manager, deputy manager and senior staff were approachable and good leaders. They were aware of the whistleblowing policy and knew how to report internally and externally. They told us if managers were not

Requires improvement

Is the service well-led?

in the building the seniors always were. Staff told us they would feel comfortable to raise any concerns with the manager and felt that they would listen and act on what was said.

Staff told us that the manager would take action if care was not up to scratch and would give the person supervision. A plan of monthly supervisions had been established.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Care Plans were not person centred and did not show evidence of involvement form people or their relatives. MCA/DoLS applications were in place but not updated. Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) (d) (e) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with dignity and respect. Staff were abrupt to people and did not ensure they were covered or their privacy protected at all times. Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Notification of incidents that affect the health, safety and welfare of people who use services. Were not submitted to the Care Quality Commission. Regulation 18 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of people who used the service. Regulation 18 (1).

The enforcement action we took:
We have issued the provider and registered manager with a Warning Notice instructing them to address the concerns identified and breach of regulation.