Copper Beeches Limited

Copper Beeches

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We conducted an unannounced inspection at Copper Beeches on 7 June 2018. Copper Beeches is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Copper Beeches accommodates up to 20 people in one building. On the day of our inspection, 19 people were living at the home; all of these were older people, some of whom were living with dementia.

At the last comprehensive inspection in June 2017, we asked the provider to take action to make improvements across a number of areas including; risk management, safeguarding, recruitment, person centred care, consent and leadership and governance. We conducted a focused inspection of Copper Beeches in September 2017. That inspection only looked at whether the service was safe and well led. We found ongoing concerns in relation to the safety and leadership of the home.

During this inspection, we found continued concerns about the safety and quality of the service provided at Copper Beeches . We found eight breaches of the Health and Social Care Act 2008 regulations. We also found a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was no registered manager in post at the time of our inspection. The previous registered manager had left the home in September 2017. 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. There was a manager in post who told us they were planning to register. We will monitor this.

During our inspection we found the service was not safe. People were not always protected from risks associated with their care and support. People were placed at risk of choking as risks were not assessed and staff did not have adequate guidance to inform their care and support. People were not protected from the risk of pressure ulcers. Incidents were not analysed or investigated; this meant action had not been taken to reduce the risk of reoccurrence. Risks associated with the environment, specifically fire, were not safely managed and this exposed people to the risk of harm. Medicines were not stored or managed safely, poor record keeping meant people may not receive their medicines as prescribed.

People were not protected from abuse and improper treatment. We found evidence of an allegation of abuse that had not been referred to the local authority safeguarding adults team for investigation. The cause of unexplained marks to people's skin were not investigated. Infection control and prevention measures were not effective, this exposed people to the risk of infection spreading. People could not be

assured that good hygiene practices were followed, effective cleaning procedures were not in place for some items of equipment and some areas of the home.

Staff levels were not based upon an assessment of people's need and consequently, there were not enough staff to meet people's needs and ensure their safety. Staff were not always deployed effectively and this placed people at risk of harm. Safe recruitment practices were in place to reduce the risk of people being supported by unsuitable staff.

People were supported by staff who did not always have appropriate training or support. Staff lacked training in key areas, such as people's health conditions and we found this had a negative impact on people living at the home. Furthermore, when staff did have training this did not always ensure their competency. Staff did not receive regular supervision which meant opportunities to monitor staff performance and development may have been missed.

People were not supported to have maximum choice and control over their lives; the policies and systems in the service did not support this practice. Where people lacked capacity to consent to their care and treatment their rights were not always upheld. There was a risk people may not receive person centred support when they moved between services and systems to gather and share information were not always effective. The design and decoration of the building accommodated people's diverse needs; however, some areas of the building and grounds had not been adequately maintained.

Risks associated with people's health were not managed safely. Staff had a poor knowledge of people's health conditions and did not always identify deteriorations in people's health. Advice from specialist health professionals was not always followed. We received mixed feedback about the food, but found that overall people were provided with enough to eat and drink.

People did not consistently receive caring support. People were not always treated with dignity and respect and staff did not always communicate effectively with people when providing care and support. The language used by staff to describe people did not always promote their dignity.
People were supported to be as independent as possible. People were involved in day-to-day choices and decisions, but feedback about involvement in care planning was mixed. People had access to advocacy services if they required this to help them express their views. People's right to privacy was respected.

People were at risk of receiving inconsistent support as care plans did not contain accurate, up to date information. People did not receive support that met their preferences. The quality of care for people who were coming towards the end of their life was poor. People were offered some opportunities for social activity, however, these were not always based upon their individual needs or preferences. Consequently, some people told us they had little to do or were bored. There were systems to investigate and respond to concerns and complaints; there had not been any complaints recorded since our last inspection. We were aware of a complaint regarding the quality and safety of care which had been upheld by the Local Government Ombudsman.

Copper Beeches was not well led. A lack of effective governance systems meant areas of concern had not been identified or addressed. This placed people at risk of harm. The approach to quality assurance was reactive and was limited in scope. Care was not always based upon specialist advice or best practice. Systems to monitor and improve quality and safety were not comprehensive and when systems were in place they were not consistently effective in identifying and addressing areas for improvement. Sensitive personal information was not stored securely. Staff and people living at the home only had limited opportunities to express their views in relation to how the service was run.

The overall rating for this service is 'Inadequate' and the service therefore remains 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.

People were not always protected from risks associated with their care and support. Accidents and incidents were not adequately investigated.

Effective processes were not in place to protect people from abuse and improper treatment.

People were not adequately protected from the risk of infectious disease. The home was not clean and hygienic in all areas.

Medicines were not always stored and managed safely.

There were not enough staff to meet people's needs and ensure their safety. Safe recruitment practices were followed.

Is the service effective?

Inadequate

The service was not effective.

People were supported by staff who did not always have appropriate training to enable them to carry out their jobs safely and effectively.

People were not supported to have maximum choice and control of their lives; the policies and systems in the service did not support this practice.

People did not always have timely access to healthcare and there was a risk their health needs may not be met as care plans did not contain adequate information.

We received mixed feedback about the quality of the food, but found people were provided with enough to eat and drink.

The environment was adapted to meet people's needs, however some parts of the premises had not been adequately maintained.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people in a respectful and dignified manner.

They were involved in choices and decisions about their support and had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person centred care that was responsive to their needs and preferences.

People could not be assured they would receive the support they required, as care plans did not all contain accurate, up to date information about the support people needed.

People were not provided with caring and compassionate support when they were coming towards the end of their lives.

People were provided with some opportunity for meaningful activity. However, this was not based upon individual needs and preferences.

There were systems in place to manage complaints.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective systems to monitor and improve the safety and quality of the service. Where systems were in place these were not consistently effective. Action was not taken in response to known issues.

Policies were not based upon current legislation and guidance.

Sensitive personal information was not stored securely.

Staff and people living at the home had limited opportunities to express their views about 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 and to provide a rating for the service under the Care Act 2014.

Before 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, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Two inspectors undertook the inspection. During our inspection visit, we spoke with eight people who lived at the home and four relatives. We also spoke with four members of care staff, a member of the catering team, the deputy manager and the manager. In addition, during the course of our inspection we spoke with three external health and social care professionals.

To help us assess how people's care needs were being met we reviewed all, or part of, five people's care records and other information, for example their risk assessments. We also looked at the medicines records of five people, four staff recruitment files, training records and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

Inadequate

Is the service safe?

Our findings

At our June and September 2017 inspections, we found concerns about the management of risks associated with people's care and support. This was a breach of the legal regulations. At this inspection we identified a number of ongoing concerns about the failure to identify and address serious risks to people's health and well-being.

People were not protected from the risk of pressure ulcers. Tissue viability care plans were not always in place for people who were at high risk of pressure ulcers. One person had a pressure ulcer and required specialist equipment and regular repositioning. Despite this, there was no care plan in place related to this and consequently staff did not have access to information about how best to support them. Consequently, the person was not receiving the required support. For example, specialist footwear designed to relieve pressure was not used as advised. In addition, they were not repositioned in line with guidance from specialist professionals. Records showed they were not turned as frequently as required and they were routinely positioned on a part of their body which had been advised against. This failure to follow professional guidance increased the risk of further deterioration of the person's pressure ulcers placing them at risk of harm.

In addition to the above, people were at increased risk of skin damage as equipment was not used as intended. Throughout our inspection we observed people were routinely left sitting on their slings (used for transferring people in a hoist) for long periods of time. As these slings were not designed to be left in place they could increase the risk of pressure ulcer development.

People were not protected from the risk of choking. Risks associated with choking were not always identified, assessed or managed. Staff told us that they suspected one person was eating materials from their bedding, this posed a risk of choking. However, this behaviour was not referred to in the person's care plan, there was no risk assessment and no effective measures were in place to reduce risk. Staff told us the person spent less time in their bedroom alone to reduce the risk of choking. However, on the day of our inspection the person was left unsupervised in their room for most of the afternoon. This placed them at risk of choking.

There had been a failure to follow professional advice in relation to people's diets. The above person's care plan stated they required a specific texture diet to reduce the risk of choking. Their care plan contained guidance of foods to be avoided. However food records showed they had recently been provided with foods which were not of the required texture. We also observed they were served food of an incorrect texture during our inspection. The failure to follow professional guidance placed them at risk of choking.

There was no effective system to review and learn from accidents and incidents. When people had sustained falls there was little evidence of any action having been taken to reduce the risk of repeat events. For example, one person had recently sustained a fracture resulting from a fall, their care plan had not been updated to take account of this incident and consequently there was no up to date guidance for staff about how to prevent the same from happening again. Furthermore, patterns and trends of falls were not

analysed. For example, one person sustained three falls within a three week period, these all occurred at approximately the same time of day. However, as no overall analysis of falls had been completed, the pattern of falls had not been identified. This meant opportunities to reduce the risk of future falls may have been missed.

People were not always adequately protected from the risk of infectious disease. One person who used the service was suspected to have an infectious disease. There was no person specific protocol for preventing the spread of the infection. Staff did not have adequate access to personal protective equipment. There was also no infectious waste bin in use for disposal of this person's continence wear. This placed people at increased risk of contracting an infectious disease. The provider had not followed good practice and reported the suspected infection to the local infection control and prevention team. This meant opportunities to obtain specialist advice and support may have been missed.

We also found adequate infection control practices were not followed in other areas. Staff were using flannels, rather than single use wipes, to attend to people's personal care needs. There was no system, such as colour coding, to ensure that flannels used for personal care were then not used on other people's faces between washes. This was not dignified and did not promote good infection control and prevention practices. A member of the Clinical Commissioning Group infection control team conducted an audit on the same day as our inspection. They identified a significant number concerns related to the control and prevention of infection, such as staff failing to change gloves between care tasks.

Medicines were not stored safely. During our inspection, we found the medicine trolley was left unlocked and unattended for a period. We had sufficient time to able to open the trolley and access the medicines unobserved without it being noticed by any member of staff. This posed a risk that people may access medicines not prescribed for them and a further risk they make take them.

Medicines were not managed safely. Errors made on medicines records had led to discrepancies in the recording of medicine administration and possible errors. Medicines records had been completed in a way that was misleading to staff and consequently staff had signed for medicines at times when they were not prescribed. For example, one person was prescribed a medicine to be given once a day. However, due to the misleading medicines records this had been signed as given twice daily for seven consecutive days. This meant staff were not completing the necessary checks when administering medicines and mistakes could have been occurring without them being identified. Furthermore, we were not able to identify if these were actual errors due to a failure to consistently record when medicines were checked in or carried over from previous records. This placed people at risk of harm as they may be given too much medicine.

Staff did not all have training in the safe administration of medicines. Records showed one member of staff, who had responsibility for administering medicines did not have up to date training in medicines management. Furthermore, we found this member of staff had made recent medicines errors. This failure to adequately train staff to administer medicines increases the risk of further error and subsequent harm to people living at the home.

Risks associated with the environment, specifically fire, were not safely managed and this exposed people to the risk of harm. There was no fire safety risk assessment for the home, which meant the provider was not able to assure us they had taken action to protect people from the risk of fire. This also meant the home was not compliant with The Regulatory Reform (Fire Safety) Order 2005. There had not been any recent routine fire safety checks. Automatic door releases, fire alarm checks, fire doors, means of escape and emergency lighting checks had not been completed since October 2017. Furthermore, a number of fire doors were propped open during our inspection and we observed that two automatic door closers on people's

bedroom doors were not functioning effectively. This failure to assess and mitigate the risk of fire placed people at risk of serious harm. We informed the fire service who conducted an inspection of the home and issued a notice of deficiency.

After our inspection visit we wrote to the provider and asked them to take action to address the above urgent risks to people's health and safety. In their response they advised they had taken immediate action to reduce some of the risks posed to people. However, we remained concerned that the provider had not given assurances that a comprehensive review of all risks associated with people's care and support would be undertaken. Consequently, people remained at risk of harm.

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

People were not protected from abuse and improper treatment. The provider had not ensured effective systems were in place to investigate unexplained bruising or injuries to people living at the home. We reviewed incident records and found multiple records of unexplained injuries that gave us cause for concern, as there was no evidence of investigation or reporting to the local authority safeguarding adults team. We found records of nine unexplained injuries to one person between January and June 2018. For example, one record documented bruising around their eye area and another recorded skin tears on the person's legs. A body map completed for another person recorded they had a large bruise on their elbow. Again, this was an unexplained injury which had not been investigated or referred to the safeguarding adults team. The failure to investigate unexplained injuries meant action was not taken to safeguard people from harm.

Allegations of abuse had not been referred to the safeguarding adults team. Prior to our inspection, the local authority informed us about an allegation of abuse which they had become aware of during a recent audit of the home. The provider told us they were not able to conduct an investigation as the alleged perpetrator no longer worked for them. This had not been referred to the local authority safeguarding adults team to enable further investigation and consideration had not been given to whether this person still posed a risk to others.

Following our inspection visit we wrote to the provider and asked them to take urgent action to address our concerns. The provider advised us that safeguarding procedures, practices and training would be refreshed. However, they did not provide assurances that action would be taken to investigate unexplained injuries for all people living at Copper Beeches. Furthermore, we were not given assurances about how the process for identifying and investigating unexplained injuries would be improved in the future to avoid the same from happening again.
Consequently, we remained concerned that people may be exposed to abuse or improper treatment.

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

There were not enough staff available to meet people's needs and ensure their safety. Feedback about staffing was mixed. Although some people told us there were enough staff others commented staffing levels were not sufficient. One person told us, "Care is good, it's just that there aren't enough staff … After tea is the worst time because everyone is waiting to go to bed," another person said, "We have to wait as they have lots of other people to see to, but not too long." A third person commented, "Sometimes when I press my buzzer they are a while coming." During our inspection we identified concerns about the deployment of staff. Staffing levels were not based upon the needs of people living at the home, consequently three staff

were deployed on shift at all times, regardless of level of need. Some people had very complex needs, there were at least twelve people who required two staff to support them with some aspect of their care. Three staff was not sufficient to ensure people's needs were met and their safety was maintained. This had resulted in people being left unattended in communal areas for prolonged periods of time.

A member of staff told us late afternoons and evenings were particularly short staffed, this was confirmed by our conversations with other staff, staffing rotas and observations. Additional staff, such as domestic and catering staff, activities staff and management were available to assist care staff during early shifts. However, these additional staff were not available on late shifts, this meant there were only three staff to provide routine care, respond to people's requests for support, prepare and serve evening meals and fulfil other tasks, such as assisting people to bed.

At approximately 7:00pm on the day of our inspection we observed nine people were in the communal lounge and dining areas. There were no staff around as they were all busy assisting people to get ready for bed. There were no staff available to ensure people's safety, to respond to their requests for support or to mitigate the risk of accidents such as falls. In addition, due to the geography of the building it was unlikely staff would be able to hear people should they call for help and people did not all have access to call bells. This failure to deploy staff effectively placed people at risk of harm.

Following our inspection visit we wrote to the provider and asked them to take urgent action to address our concerns. The provider advised us that they would ensure there were four care staff on evening shifts. However, we were not provided with any assurances about what action would be taken to ensure the care staff were organised effectively to ensure people's safety. This meant we remained concerned that staff may not be effectively deployed to meet people's needs and maintain their safety.

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

The home was not sufficiently clean. We found areas of the service were not cleaned to an adequate standard. People's bedrooms were not sufficiently clean, some bedrooms were dusty and we saw furniture and equipment in two bedrooms, such as mattresses and pressure mats were sticky and heavily soiled with debris. Bathrooms were also not clean, we observed shower seats and toilet frames were not effectively cleaned resulting in rust and staining. We also observed other unhygienic practices, for example, liners were not used in communal toilet bins and bathroom bins. Some of these bins had been used to dispose of continence waste. This was not a hygienic practice and it also did not promote the control and prevention of infection.

Furthermore, some areas of the home were not properly maintained. Some carpets were stained and worn and some bathrooms were also poorly maintained, we observed cracked tiles and damaged, unsealed flooring. The poorly maintained environment did not promote good hygiene practices and increased the risk of the spread of infections.

Systems to ensure the cleanliness of the home and to monitor this were not effective. There was a member of domestic staff employed at the home, they only worked part time and there were no domestic staff on at weekends. Several members of staff commented there were insufficient hours allocated to the domestic team to ensure the effective cleaning of the home.

The above information was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal records checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Inadequate

Is the service effective?

Our findings

Risks associated with people's health were not managed safely. Staff had a poor knowledge of people's health conditions. One person had diabetes, their care plan did not contain information about the condition or guidance on how to recognise a deterioration in health. Furthermore, staff had not received training in the management of diabetes. Consequently, staff were not aware of signs that their condition may be deteriorating. The person told us they had recently felt unwell in the mornings. Staff had not considered that the cause may be related to the person's condition and consequently they had not sought specialist advice. Another person had a condition which meant they had seizures and they had been admitted to hospital on four occasions due to this since February 2018. There was a basic care plan in place but this did not provide adequate detail to inform staff support and there was no risk assessment detailing how to reduce risks in the event of a seizure. Staff had not had any training in seizure management and consequently they told us they lacked knowledge and confidence in managing seizures. This had resulted in unnecessary hospital admissions. This lack of knowledge meant there was a risk people may not receive appropriate or safe support.

Timely action was not always taken to enable people to access support from external health professionals. During our inspection we observed one person had a wound which needed to be redressed due to a build-up of fluid under the dressing. Staff had not taken action to seek medical advice about this until we raised it with them. This posed a risk of the person's health deteriorating.

Staff did not always follow guidance from specialist health professionals. Records showed a specialist health professional had advised a person should be positioned in a certain way to reduce pressure and maintain good posture. They had had also advised that the person should use a specific piece of equipment and have regular nail care to prevent damage to their skin. During our inspection we observed this guidance had not been incorporated in to their care plan and not had been followed. The person was positioned incorrectly, had not had nail care and was not using the recommended equipment. This failure to follow professional guidance placed them at risk of harm.

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

People were not always supported by staff who had the skills and knowledge to provide safe and effective care and support. Only three of the 17 staff employed at Copper Beeches had training in end of life care and, during our inspection, we found end of life care was poor. Only seven of the 17 staff had training to enable them to safely support people whose behaviour could put others at risk. Consequently, staff told us they felt they lacked confidence and training in this area. Staff had not been provided with training in relation to people's health conditions and consequently we found their knowledge of these conditions was poor. Staff told us they had requested additional training, such as caring for people living with diabetes and epilepsy, but this had not been provided. Some staff told us they were expected to pay for their own training if it was not part of the homes usual training programme, for example staff told us they had been asked to pay for epilepsy training.

When staff did have training this was not always effective in ensuring their competency. For example, although 15 of the 17 staff employed had recent safeguarding training and were able to describe steps they would take in theory, this was not applied in practice. All staff had training in infection control; however, during our inspection we found that effective infection control and prevention measures were not in place.

Staff did not always receive regular supervision of their work. Records showed staff had had a recent appraisal, but there were no records of any other meetings with staff to discuss their performance prior to April 2018. The manager was aware of this and told us it was an area for development. This meant that staff were not given regular, formal opportunities to access support, reflect on their practice and share any concerns. This was of concern given the gaps in staff training.

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

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

People's rights under the MCA were not upheld. Where people's capacity to consent to decisions was in doubt, assessments of their capacity had not always been conducted. For example, one person was subject to a number of restrictions, such as bed rails. It was highly unlikely they would be able to consent to these restrictions; however, their capacity to consent had not been assessed, which meant the provider could not assure us that decisions made were in their best interests. Where capacity assessments were in place they were not always decision specific and they lacked details about how people's capacity had been assessed.

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. Although DoLS applications had been made conditions imposed upon DoLS were not complied with. One person had conditions imposed on their DoLS which stated the managing authority (the staff team at Copper Beeches) must make referrals to specified health professionals, however, this had not been undertaken.

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

Systems were in place to ensure information was shared across services when people moved between them, however these were not always effective. The manager told us an assessment of people's needs was conducted prior to them moving in to the home. This was then used to develop their care plan. However, we saw this had not always been completed, which had resulted in staff not having access to detailed and personalised information about the people they supported. There was no assessment of need for one person who had recently moved into the home, consequently we found their care plan lacked detail. The manager told us that key documents such as medicines records and care plan overview documents were shared when people went into hospital. However, we found these care plan overviews did not always reflect people's current needs and did not contain person centred information about what was important to people. This meant there was a risk people may not receive effective, person centred support when they

moved between services.

The home was adapted to meet people's needs, however it was not well maintained in some areas. Copper Beeches is situated in a large converted residential premises. Consideration had been given to people's needs in the design and decoration of the building. For example, aids and equipment had been installed in some areas to enable people with mobility needs to navigate around the building and the provider had installed a call bell system to ensure people could request staff as required. There was a communal lounge and dining area on the ground floor and a separate 'library' room, which meant people, had ample space to spend time socialising with friends and family. People's needs associated with dementia had been taken into account in the design and decoration of the environment. Dementia friendly signage was in use throughout the building. There was a large garden; however, this had not been maintained and was overgrown and uneven. It would not have been safe for someone with mobility issues to access this area. There was a small veranda from the sun lounge but this was being used to store old furniture and so was not a pleasant area for people to spend time outside.

People gave mixed feedback about the food served at Copper Beeches. One person told us, "The food is not bad. We have enough and have choices." Another person said, "The food is okay, there are two choices." A third person said, "Some of the food is very nice others not. You can't always eat the meat you are chewing it for ages and it is so hard to chew… We sometimes get a choice."

During our inspection, we observed a mealtime and saw people were offered an adequately sized portion of home cooked food. People were provided with assistance when needed; however, at times this was task focused with little communication between staff and the person. People were provided with cold and hot drinks throughout the day. The manager told us told people were involved in making suggestions for the menu, this information was then used to improve and update the menus. When people were at risk of losing weight they had been referred to health professionals for advice and this advice was acted upon. For example, a member of staff explained how they fortified one person's diet to help promote a healthy weight.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. We found that some people's bedding was in a poor state of repair. One person's bedding was dirty, very torn and worn, as were their bed rail bumpers. Another person's sheet was old and worn and had started to develop holes. No action had been taken to replace the worn bedding. This was not dignified. In addition, we observed that continence products were routinely left on display in people's bedrooms. This would be visible to their family, friends and other visitors. This did not promote people's dignity or respect their right to privacy.

The language used by staff was not always dignified. During our inspection we observed a staff member hoisting a person, although they intended to be encouraging the language used was that which would be used with a young child, for example they said "Good girl," on a number of occasions. This use of language was not dignified or respectful.

Staff did not always communicate with people to explain the support they were providing. During our inspection, there were some instances where staff didn't explain to people what was happening during transfers with hoists. Two staff were moving someone using a hoist, they did not speak to the person and as the person was lowered they made vocalisations indicating alarm or distress. Staff did not offer the person reassurance and one member staff of commented, "[Name] doesn't like it do they." Although they did not intend to be unkind, this was not compassionate or caring support.

On other occasions we heard staff talking about people without involving them in the conversation. For instance, we observed a member of staff say to another member of staff, "We can't leave [name] here." The other staff member said, "I know but I can't put [name] at the table until everyone is in." and the first member of staff responded, "Let's put [name] there then." They did not involve the person in the conversation. This failure to acknowledge and communicate with people was undignified and disrespectful.

The above information was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, people and their relatives said staff were kind and caring. One person told us, "Oh yes, they look after us very well. They are kind, if they weren't I would give them what for." Another person said, "I like it here because it has a homely feel. The staff are lovely, you can't fault any of them." This view was also shared by people's relatives. One relative told us, "Staff are kind, they are very good with [relation]."

People told us they were involved in day to day decisions about their care and support. One person told us, "I can choose what I do and I can stay in bed if I want to." In contrast, people could not recall being involved in their care plan. One person told us, "I don't think anyone has talked to me about my care plan." Another person said, "No, no one has said anything about a care plan. I don't think there is a plan." Some people's relatives told us they had been involved in developing care plans when their relation had moved into the home.

People had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. Three people were using Independent Mental Capacity Advocates (IMCA) at the time of our inspection. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions.

People told us staff respected their privacy. One person told us, "Staff knock on my door and give me privacy if I want it." Another person said, "You can have your privacy if you want it. You can go to your room if you want to be on your own." Staff said they always knocked on people's doors and when providing care they closed the door and kept people covered as much as possible.

People were supported to maintain relationships with friends and family, and people's friends and relatives were welcome to visit Copper Beeches. There were no restrictions upon visitors to the home.

People told us they were supported to maintain their independence. However, we found people's care plans did not clearly reflect what support people needed or areas where they were independent. This posed a risk that people may get inconsistent support.

Requires Improvement

Is the service responsive?

Our findings

There was a risk people may not consistently receive care and support that met their needs as staff did not have access to clear, detailed, up to date information about the support they required.

The quality of information in care plans was variable. Care plans did not always contain adequate detail to enable staff to provide person centred support. One person's care plan stated they were independent with eating and drinking. However, a care plan update, dated 30 April 2018, documented 'due to further deterioration [name] needs assistance with eating and drinking. Staff to assist in best interests.' There was no further information to guide staff on exactly what assistance the person needed. Furthermore, the manager told us the person did not always need assistance with eating and could sometimes eat independently. This posed a risk that the person may receive inconsistent support.

Information in care plans was confusing and contradictory. Another person's oral health care plan documented they were able to manage their own oral care. This had not been reviewed since September 2017. In contrast, a mental capacity assessment had been completed in 2015 stating that the person did not have the mental capacity in relation to oral health care. This resulted in lack of clarity about the person's support needs and posed a risk of them receiving inconsistent support that did not meet their needs.

Staff told us information about people's care and support was not always shared effectively. One member of staff told us, "Communication could be improved … Information about residents isn't always passed on." They said they received a handover, but it was mainly about how the shift had gone and didn't provide any information for further back than that, this meant there was a risk they may miss key information if they had been off work for more than one day. Another member of staff said communication was not always very good. For example, they didn't know why a person's GP had been called on one occasion. This further increased the risk of people receiving inconsistent support that did not meet their needs.

The quality of care for people who were in their last few months of life was poor. The manager told us one person was coming towards the end of their life. During our inspection we found they were in a poor state. Staff had not attended to some aspects of personal care and they were left in room all day with very minimal interaction. Although their care plan stated a love of music, staff had not put any music on for them. Although the person had an 'end of life care plan' this focused solely on their families wishes for their treatment after their death and did not include any information about how they should be cared for as they came towards the end of their life.

Other care planning had stopped at the point at which Copper Beeches had been informed that the person was coming towards the end of their life. For example, their social care plan was reviewed regularly until February 2018, subsequent entries just stated that the person 'is end of life care' with no evidence of their social needs being considered. The person had not been weighed since September 2017 due to their 'end of life' diagnosis and the were no alternative arrangements in place for monitoring weight loss. Furthermore, we found the Chiropodist had stopped providing care in December 2017 but there was no explanation of why chiropody care was unsuitable for them. This meant the provider was not able to demonstrate people

were provided with caring and compassionate care as they approached the end of their lives.

People were not provided with support in line with their preferences. One person's care plan documented they wished to have a shower three times a week. However, their care records showed they had only been offered a shower twice in the 19 days prior to our inspection. This did not demonstrate their preferences were being catered for. Furthermore, the same person's care plan documented they had been offered the choice of a bath or shower and had expressed a preference for a bath. However, during our inspection we found there was no working bath at Copper Beeches. The manager told us the bath had been out of service since at least September 2017 when they commenced employment at the home. Another person told us their needs in this area were not always met and said, "There isn't a bath here, that's the problem." This meant the person's preferences were not being met.

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 some opportunities for social activity; however, these did not always cater for people's individual needs. Although some people were positive about opportunities for activity others told us there was a lack of activity. One person told us, "We don't do anything, it is so boring … One day is like another … I had always been so active. I feel so useless." Another person said, "I'm getting fed up of sitting all the time." A third person commented, "The thing is I am bored and lonely."

The provider employed an activities coordinator who worked part time, 10am until 4pm, Monday to Friday. The activities coordinator told us they did a mix of group activities and also spent time with people on a one to one basis. During our inspection we observed them facilitating a chair exercise session with a small group of people. They also offered people the opportunity to get involved with traditional games such as hoopla. The activities coordinator also told us they sometimes had external entertainers and occasional social events that were open to the local community. However, people's individual needs had not been considered when planning activities. The activities coordinator had limited knowledge about activities which may be appropriate for people with dementia and told us those people were offered the same opportunities as others. One person who lived at the home had a visual impairment and was unable to take part in many of the activities. We asked the activity coordinator how they catered for this person's needs and they told us they did plan any specific activities to accommodate their needs. The activities coordinator had not had any specialist training or support in their role and told us that although they had previously requested further training this had not been provided. This meant people were not always provided with accessible or appropriate opportunities for meaningful activity.

People's diverse needs in relation to their culture or religion were recognised and accommodated. The manager told us that people's individual needs, in relation to areas such as culture and religion, were discussed before people moved in to the service and as part of care planning. The manager told us they were not supporting anyone with diverse needs at the time of our inspection, but added that they would identify and accommodate people's needs as and when required. The manager also told us that local religious leaders visited the home on a regular basis to ensure people's religious needs were met.

The provider was not aware of their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. The manager told us they had not needed to make any adjustments to meet people's needs and added they would do so if needed in the future. This did not assure us that proper consideration had been given to meeting people's information access needs and posed a risk they may not have equal access to information.

There were systems and processes in place for people to provide feedback and to deal with, and address complaints. People told us they would feel comfortable telling the staff if they had any complaints or concerns. One person said, "I am quite satisfied. If I wasn't I would speak up. I think they would listen and do something about it." Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. Staff told us they were confident the manager would act upon complaints appropriately. There was a complaints procedure available to people which detailed how they could make a complaint.

Records showed that no formal complaints had been made since our last inspection. However, prior to our inspection, we were notified of a complaint regarding the quality and safety of care which had been upheld by the Local Government and Social Care Ombudsman (LGO). The LGO are the final stage for complaints about adult social care providers (including care homes and home care agencies). They investigate complaints in a fair and independent way. The LGO had ruled that a person had been treated unfairly and stated the compliant had not been adequately handled. The LGO recommended Copper Beeches should apologise and provide financial remedy.

Inadequate

Is the service well-led?

Our findings

It is of significant concern that a number of serious breaches of the legal regulations at Copper Beeches had not been identified or addressed prior to our June 2018 inspection. This is of particular concern given the history of non-compliance with the legal regulations. There has been a continued lack of effective governance by the provider which has meant areas of concern have not been identified or addressed.

There had been a failure to implement systems to monitor the quality and safety of the service. At our inspection, we requested copies of audits and quality assurance systems in place to ensure the safe and effective running of the service. We were not provided with any audits during our inspection but were subsequently provided with care plan audits following our visit. The manager, told us there were no other audits in place at Copper Beeches. This had resulted in a failure to identify risks to the safety and wellbeing of people living at the home and staff. There was no health and safety or fire audit; this had resulted in a failure to identify serious failings in fire safety. There was no infection control audit and, again, during our inspection we found multiple concerns related to the control and prevention of infection. It is of significant concern that the provider was not aware of these risks prior to our inspection. This lack of governance placed people living at the home and staff at risk of harm.

Care plan audits were not robust. Although some care plans had been audited these audits were not effective in identifying issues and bringing about change. During our inspection, we identified serious concerns in the care plans and records of all five of the plans reviewed. For example, despite a recent audit of one person's care plan it still did not clearly reflect their needs. We found this had had a negative impact on the person's care. Staff had not attended to some aspects of the person's personal care need and their social needs were neglected. This failure to identify and address poor quality care plans placed people at risk of receiving inconsistent and unsafe support placing.

Other systems intended to ensure the safety of the home were not effective. The manager completed a monthly falls matrix in order to monitor falls. During our inspection, we found this had not consistently been completed, for example it was not completed in March or May 2018. The provider advised us this was because there were no falls in these periods. However, we found evidence that one person sustained a fall on 31 March 2018. This had not been recorded on the falls matrix which meant opportunities for learning may have been missed.

The approach to quality assurance was reactive rather than proactive and reliant on third parties identifying issues of concern. The improvements made at Copper Beeches were limited in scope. Issues raised by CQC had been responded to, but improvements made were limited to individuals, rather than taking a service wide approach to improvement. For example, following our June 2018 inspection, the provider told us improvements were made to the care of individuals referred to in our urgent letter, but no consideration had been given to safeguarding others. This failure to proactively monitor and manage risk placed people at risk of harm.

We were not assured that decisions made were based upon specialist advice or best practice. For example,

after our inspection visit we wrote to the provider with concerns that one person was not routinely using a hand protector provided by a specialist health professional. The provider told us they had purchased a new piece of equipment. However, they had purchased a generic piece of sports equipment. There was no evidence that this equipment would be suitable for the purpose of protecting the person's hands and we were not provided with evidence that advice had been sought from specialist health professionals prior to purchase. This may have increased the risk of the person sustaining skin damage. This reactive response to concerns posed a further risk to the health and wellbeing of people living at Copper Beeches.

There had been a failure to act upon advice from external bodies. On 9 April 2018, the local authority advised us of an allegation of abuse at Copper Beeches. The local authority had told the manager to make a safeguarding referral. However, during our June 2018 inspection we found this had not been acted upon. This demonstrated a failure to take action on advice from external bodies.

Policies were not based upon current legislation and guidance. For example, the safeguarding policy listed outdated guidance such as 'No Secrets.' There was no reference to the Care Act 2014 which sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. It also did not list all recognised forms of abuse, for example, institutional abuse and self-neglect were omitted. Nor did it detail the role of the Local Authority in investigating allegations of abuse. Consequently we found people were not protected from the risk of abuse.

Sensitive personal information was not stored securely. Care plans and records were stored in the office which was left unlocked and unattended at periods throughout our inspection. Furthermore, we observed the office was left open and accessible in the early evening, during this period there were no staff in communal areas which meant the records could be easily accessed unobserved by people living at the home or others.

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

There had been a failure to notify CQC of some events within the service, which the provider is required to by law. We found the provider had failed to notify us of three serious injuries to people living at the home. In addition, we had not been notified of DoLS authorisations as required. We had not received any DoLS notifications from Copper Beeches since it's registration in November 2016. However, during our inspection we found evidence that DoLS authorisations were in place for a number of people at the home. We had not been notified of any of these authorisations. A failure to notify CQC of such incidents has an impact on the ability of the CQC to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating on their website. However, this was not displayed in the home during our inspection.

There were limited opportunities for people living at the home and staff to influence the running and development of the home. There were not any meetings for people who lived at the home or their relatives. A satisfaction survey had recently been completed by eight people, who lived at the home. Whilst the results were largely positive, we saw most of the surveys had been completed on by a staff member on people's behalf. This lack of independent and impartial support may have had an impact upon people's answers.

There was a staff meeting held on the day of our inspection visit; however, prior to that there had not been any staff meetings since our last inspection. Despite this, staff told us they felt supported by the manager, but also commented that the manager required further support from the provider. People who used the service were also positive about the approach of the manager.

Before and during our inspection, we received concerns from health and social professionals that they sometimes found it difficult to access the home and had been asked to give notice prior to their visits. This did not promote effective working relationships between Copper Beeches and allied professionals.

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 protected from risks associated with their support. Infection control and prevention measures were not in place as required. Regulation 12 (1) (2)

The enforcement action we took:

We restricted admissions to the home and imposed conditions with required the provider to take action to improve the safety of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Regulation 13 (1) (2)

The enforcement action we took:

We restricted admissions to the home and imposed conditions with required the provider to take action to improve the safety of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to ensure people's safety. Staff were not provided with sufficient training to ensure their competency. Regulation 18 (1) (2)

The enforcement action we took:

We restricted admissions to the home and imposed conditions with required the provider to take action to improve the safety of the home.