Ideal Carehomes (Number One) Limited

Coppice Lodge

Inspection report

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Date of inspection visit:
15 June 2016

Date of publication:
19 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 June 2016, it was an unannounced inspection. Coppice Lodge is run by Ideal Care Homes (Number One) Ltd. The service is registered to provide accommodation for 64 older people who require personal care. There were 20 people living at the service on the day of our inspection. The service is split across two floors each with communal living spaces, there were nine people living upstairs and 11 people living downstairs.

We carried out an unannounced comprehensive inspection of this service on 26 and 27 of November 2015. Breaches of legal requirements were found in relation to the care, treatment and safety of people, induction and training of staff, recruitment procedures, dignity and respect, person centred care. We also found breaches in the legal requirements relating to notifications a provider must make to CQC. We asked the provider to make improvements in these areas. We asked the provider to develop an action plan to address the issues raised from our inspection however we did not receive an action plan.

During the inspection on 26 and 27 of November 2015 also found a breach of legal requirements relating to staffing levels. We took enforcement action against the provider and told them they must make improvements. We inspected the service again on 28th April 2016, this was a focused inspection to follow up issues relating to staffing. In this inspection we found that the provider had made some of the required improvements to staffing levels.

There was no registered manager for the service and there had not been one in place since 10 September 2015. A new manager had recently been appointed and they informed us that they planned to register with CQC as manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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

Although people felt safe in the service, people were not always protected from the risk of abuse and information of concern was not always acted upon or shared with the local authority. Risks in relation to people's care were not always planned for appropriately to ensure people received safe care and support. Safe recruitment practices were not always followed.

Medicines were managed safely and there were enough staff to provide care and support. People were supported to eat and drink enough and had their healthcare needs met.

People were supported to make day to day decisions but there was a lack of understanding of supporting people who lacked the capacity to make specific decisions. People were supported by staff who had not

received training and supervision.

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

People's care plans did not provide a detailed description of people's individual needs and preferences and did not contain all the relevant information to enable staff to provide personalised support. People were not involved in the development of their care plans. The care plans developed by the provider did not enable the service to provide high quality care.

There was a lack of effective governance from the provider which put people at risk of receiving poor care. Quality assurance systems put in place by the provider were not always effective in identifying areas for development and action plans were not consistently developed or implemented. People and staff were not involved the development and running of the service.

The management team were approachable and proactive. People and staff felt able to share ideas or concerns with the management. People knew how to raise concerns and these were responded to appropriately.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, staff training, consent and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Risks in relation to people's care and support were still not assessed or planned for appropriately. Risks in relation to the environment were not always managed appropriately.

People were not always kept safe because the provider did not have robust systems in place to recognise and respond to allegations or incidents.

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

There were enough staff to provide care and support to people.

Is the service effective?

Requires Improvement

The service was not always effective.

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

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

People were supported to eat and drink enough.

People had access to healthcare and people's health needs were monitored and responded to.

Is the service caring?

Good

The service was caring.

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

People were involved making decisions relating to their care.

People were treated with dignity and had their right to privacy

respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that met their needs because records detailing their needs were not tailored around their individual need or accurate.

Activities were available but were not tailored to people's individual hobbies and interests.

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

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to monitor and improve the quality of the service were not always effective.

There was a lack of effective governance from the provider which put people at risk of receiving poor care.

People and staff were not involved in giving their views on how the service was run.

The care plans put in place by the provider did not enable the service to provide high quality care.

The management team were approachable and proactive. People and staff felt able to share ideas or concerns with the management.

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. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 26 and 27 November 2015 inspection had been made and to look at the overall quality of the service.

We inspected Coppice Lodge on 15 June 2016. This was an unannounced comprehensive inspection. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the visit we spoke with seven people who used the service, two relatives, five members of care staff, the cook, deputy manager and the manager. We also spoke with one visiting health professional. We observed care and support in communal areas. We looked at the care records of six people who used the service, the medicine administration records for six people, staff training records and three staff files, as well as a range of records relating to the running of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

During our inspections in November 2015 and April 2016 we found that improvements were needed to care plans to ensure that people were protected from risks associated with their care and support. During this inspection we saw improvements had not been made in this area.

People we spoke with told us they felt safe when staff supported them and that any risks to their health and safety were well managed. One person said, "They have to use the hoist and they are ever so gentle." Another person told us, "I can walk on my own with this frame, but staff make sure I am using it all the time."

Despite this positive feedback, we saw that risks to people's health and safety were not always properly assessed or well managed. Risk assessments related to falls and pressure area care were not always assessed correctly. For example, one person's care plan contained a risk assessment which should have been used to work out the risk of the person falling. This was completed incorrectly because staff had not taken into account the number of falls the person previously had. This meant that the final score was incorrect which may mean that the person would not be provided with the support required to minimise the risk of them falling again. In addition, staff had not taken the required steps to support the person following the falls they had experienced. The provider's own guidance for falls management directed staff to make a referral to the local falls prevention team following a fall. The staff we spoke with confirmed that this referral had not been made.

Another person had previously sustained a serious injury as the result of a fall. Whilst the service had implemented a movement sensor to make staff aware if this person moved around in their room there were no other controls in place to reduce the likelihood or impact of a further fall. There was no information in this person's care plan about whether or not any equipment had been considered to lessen the impact of possible future falls and staff we spoke with were unsure if more could be done to reduce this risk. This put the person at risk of sustaining further injuries as a result of a fall.

Although staff were routinely recording accidents and incidents these were not effectively analysed and investigated to identify any trends or patterns. Information about accidents and incidents had been collated but this had not been analysed and no action plan had been put in place to reduce risks to people using the service. For example one person had fallen four times in five months and no action had been taken. This meant steps were not taken to minimise the risk of further falls and placed people at risk of preventable harm.

Care records were not completed in a timely manner which put people at risk of receiving inconsistent care. For example, staff were aware of who needed to change position and were offering people this support as detailed in care plans, however records of this were not completed after each position change. This made it unclear how often people had their position changed and may result in people not being assisted to change position as frequently as required. This put people at risk of further deterioration of existing pressure ulcers or development of new pressure areas.

Steps had not always been taken to reduce risks to people associated with the environment and maintenance of the building. Many important safety checks and routine tasks had not been carried out for a period of three months. For example hot water temperatures, window restrictors and hoists had not been checked for a period of three months. Routine maintenance issues were not always resolved in a timely manner. For example, a member of staff had reported that an immersion heater was not working properly two weeks prior to our inspection. There was no record to show that this matter had been investigated or resolved which meant there was a risk of legionella developing in the water supply as water was stored below the required temperature. The lack of systems in place to monitor environmental risks may also may mean that if legionella did develop in the water system it would not be identified. The manager told us that a new maintenance person would be starting work shortly after our visit.

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

Prior to the inspection we had concerns based on information from previous visits that the risks associated with bed rails were not being fully assessed and managed. During this inspection we found that the systems and processes were in place to assess the safety of bedrails. For example one person had an assessment for the use of bed rails and it was deemed that they were safe to use. Bed rails were in place on their bed, and a crash mat was also in place should the person still fall out of bed to reduce the impact of a fall. We saw that another person who had recently moved into the service was provided with bedrails and the manager informed us that the bed rails risk assessment was due to be completed that week.

Although people we spoke with told us they felt safe living at Coppice Lodge, the systems in place to protect them from harm were not being adhered to. One person said, "It is safe here, I feel quite alright." Another person commented, "Yes I do feel safe." A relative told us "yes it's safe, there is always someone around, people are given their medications when they need it and the building is safe."

However, people could not always be assured that the systems and processes in place to protect them from potential harm and abuse were being used as intended. The correct safeguarding procedures had not always been followed. We received information from the coroner about one incident which was not shared with the local authority safeguarding team or investigated by the provider. The new manager was not aware of any recent safeguarding incidents and was unable to locate any records of previous safeguarding or what action had been taken. In addition to this, although staff had an understanding of how to protect people from the risk of abuse, records showed that 17 staff members of staff had not recently completed training in this area. The manager was aware of these shortfalls and had recently put processes in place to record and act upon any concerns raised and had planned training for staff.

Some people sometimes communicated through their behaviour. Clear plans were in place to support people whose behaviour may potentially cause harm or distress to others. Staff demonstrated that they were aware of how to support people with these behaviours to reduce the person's distress and minimise the impact on others.

In our November 2015 inspection we identified that improvements were needed to the way staff were recruited to ensure that people were supported by suitable staff. During this inspection we saw that some improvements had been made in this area however further improvements were needed.

People could not be assured that safe recruitment practices were always followed. We saw one staff file where the member of staff declared that they had been dismissed by a previous employer. There were no details relating to this in the staff file and it had not been investigated any further. This meant the provider

did not have all the relevant information about this person's employment history to make a decision about the suitability of this staff member. This put people at risk of being supported by unsuitable staff. Other staff files contained all the necessary information. References from previous employers had been sought to determine if staff were of good character and checks through the Disclosure and Barring Service were completed as part of the recruitment process. The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work vulnerable adults. This helps employers make safer recruitment decisions.

People provided mixed feedback about the staffing levels at Coppice Lodge. Three people said they felt there were enough staff with one person telling us, "Yes there seems to be enough staff, they come quickly when I buzz for them." However, two people told us there were not enough staff to meet everybody's needs. One person said, "They are short staffed, the staff seem to be rushed all the time." Another person said "Its fine for me as I am pretty independent, but I don't know what it is like for people who need more help that I do, I don't know if staff have time."

We saw that staff responded quickly when people required assistance both in the communal areas and in their bedrooms. The staff we spoke with told us that there were generally enough staff. One staff member said, "Normally the staffing levels are alright, we can get to people fairly quickly." We saw staff spending time talking with people and visiting people who chose to stay in their rooms throughout the day. Rotas showed that shifts were staffed to the levels determined by the manager.

Although we found there were enough staff, they were not always deployed effectively to ensure the safe running of the service. We were informed by the manager that there should always be a member of staff present in the upstairs lounge area to ensure people's safety, however we saw that people were left alone in this lounge area for short periods of time. We spoke to the manager about this and they assured us that they would take action to rectify this.

People could not always be assured that their medication would be administered by competent staff. Although staff had received training in the safe handling and administration of medicines there was not an effective systems in place for checking the competency of staff to administer medication. We saw that three members of staff had their competency to deliver medication assessed recently however the manager was unable to locate records for other members of staff. The new manager was aware of these issues and had put a plan in place to start formally assessing staff's ability to administer medicines.

Despite this, people told us that they had received their medicines as prescribed and at the right time. One person said, "No issues there, they seem to manage my tablets." Another person told us, "I've just had some pills and am happy for staff to do that for me." We observed staff following safe procedures when handling and administering people's medicines.

People's medicines were stored safely and people were receiving their medicines as prescribed. We checked the medication administration records (MAR) for six people and saw that staff were completing these records correctly. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We noticed two minor errors in medication recording, however this had already been identified by the systems put in place by the new manager. We also noticed a minor error in the recording of controlled drugs. However we discussed this with the manager who assured us that this would be discussed with staff.

No one was managing their own medicines on the day of our visit, however we saw evidence that this was discussed before people moved into the service and that people were given the opportunity to do so.

Requires Improvement

Is the service effective?

Our findings

In our November 2015 inspection we found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff were not receiving adequate training and support. During this inspection we saw that improvements had not yet been made in this area.

People received care and support from staff who did not all have the skills and qualifications to support them safely. The manager told us there were a number of staff whose training had expired. Training records showed that there were a number of staff who had not received any recent training in relation to areas such as safeguarding, equality and diversity, the mental capacity act and dementia awareness.

The staff we spoke with told us they had found their training to be effective, although felt they would benefit from more in depth training about the healthcare conditions people lived with. One staff member said, "I think the training has been good, but I would like some more training about dementia care." The staff we spoke with could not always demonstrate how they would respond should a person present symptoms relating to their healthcare conditions. For example, staff could not describe the symptoms a person with diabetes might present despite the fact that the service supported multiple people with diabetes. This meant staff may not realise if a person's blood sugar levels were not right and there was a risk that people may not be enabled to access support from external health professionals when needed. We discussed this with the new manager who confirmed that staff had not had any specialist training in diabetes.

People were supported by staff who did not always have regular supervision and support. Staff we spoke with confirmed this to be the case and told us they did not consistently receive effective supervision. One member of staff had been working at the service for over a year and told us they had not received a supervision in this period. Another member of staff told us, "I have had supervision but they have not really been useful." Records showed that many staff had not had supervision for a period of five months. This lack of supervision and support for staff meant that there was a risk that staff did not have the skills, knowledge or competency to provide safe and effective support. We spoke with the manager about this and they told us that there was a plan in place to train senior staff to take on staff supervision after which all staff would be given a supervision.

This was an ongoing breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above gaps in training people told us they felt that staff were well trained and competent. One person said, "They do seem to know what they are doing." Another person said, "They have to move me with the hoist and they know how to do it." During our visit we observed staff putting the training they had received into practice, for example when using a hoist in the correct way.

The new manager was aware of the shortfalls in training and was in the process of putting plans in place to ensure staff had the necessary skills and knowledge to support people. We saw that a computer had been set up specifically for e-learning and there were plans to update all out of date training as a matter of

urgency. The manager had made links with local organisations such as the care homes team to enable staff to access high quality training and support. However these plans had not yet been implemented.

Staff we spoke with gave us mixed feedback about the support they had received when starting work at the service. One recently recruited member of staff told us that they had a comprehensive induction period and felt confident and knowledgeable when they started work at the service. However another staff member who had been that the service longer told us they felt like they had "been thrown in at the deep end" and not had the appropriate training or support. We discussed this with the manager who showed us the induction plan for new staff and talked us through the training. We saw that new staff were provided with a two week classroom based induction period, followed by a period of shadowing more experienced staff. This gave us assurances that the correct training and support was now in place for new staff starting at Coppice Lodge.

When we inspected the service in November 2015 we found that decisions were made on people's behalf without first determining if they had the capacity to make the decision themselves. We asked the provider to make improvements in this area. During this inspection we found that the required improvements had not been made.

Where people lacked the capacity to make their own decisions their rights under the Mental Capacity Act (MCA) (2005) were not always respected. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Whilst staff had completed capacity assessments for some people, this was not always the case. One person had bed rails in place and staff had deemed that they lacked capacity to consent to this arrangement. An MCA assessment had been correctly completed in relation to this decision. However, staff had indicated that another person lacked the capacity to understand risks relating to not taking their medicines. There was no capacity assessment in relation to this decision. Another care plan we looked at stated that a piece of equipment had been implemented 'in the person's best interests' however there was no MCA assessment to show how staff had come to the judgement that the person lacked the capacity to be involved in this decision.

A number of the MCA assessments we saw were not decision specific and covered general capacity to make day to day decisions. In addition to this decisions made in the best interests of people were not always recorded. This meant that there was a risk that people's rights and choices may not always be respected or upheld.

Staff had a very basic knowledge of the MCA and told us they had not had training in this area for a long period of time, training records showed this to be the case. Three staff we spoke with were not aware if anyone lacked capacity and if any best interests decisions were made on people's behalf. Training records showed that MCA training was overdue for five staff and a further 10 care staff had not attended any training on the MCA.

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

Where people had capacity they were supported with decision making and we observed that staff spoke with people and gained their consent before providing support or assistance. The people we spoke with told

us that staff always asked for their consent before providing any care and support. One person confirmed this by saying, "Yes, always." We also observed that staff asked people for their consent. For example, at lunch time staff asked people if they wanted a protective cover for their clothing before putting one on.

The manager displayed an understanding of the Deprivation of Liberty Safeguards (DoLS). DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed. We saw evidence in people's care files that DoLS applications had been made for people who lacked capacity in relation to restrictions placed on freedom such as movement sensors and locked doors.

People were supported to eat and drink enough. People told us that they enjoyed the food and were given plenty to eat and drink. One person said, "The food is lovely and there is always a choice." Another person commented that their meal had been, "Really nice." A relative told us, "The food is lovely, the cakes are to die for!"

During our inspection we observed lunch in the two dining areas that were in use. Most people ate large portion sizes and appeared to enjoy their food. One person did not want what was on the menu and staff arranged an alternative meal for them. Another person said that they did not feel hungry and didn't want the main meal. Staff respected this and offered the person a snack. We saw that people were offered drinks and snacks throughout the day, including those people who chose to stay in their rooms.

Staff had knowledge of how to support people with specific dietary requirements. One person had a health condition which was controlled by their diet. The kitchen provided special meals for this person and we spoke with the person's relative who told us, "They always make sure that [relative] has the right meals." Another person who required a special diet told us that they were always provided with the correct meals and that staff frequently gave them 'reminders' about their diet, they told us, "They (staff) always point out what I should and shouldn't eat." One person was at risk of choking. This person had been seen by the speech and language therapy team who advised a soft/normal diet and thickened fluids. These were provided on the day of the inspection and this was clearly reflected in their care plan.

People were supported with their physical and mental health. People told us that they had good access to healthcare services. One person said, "They put me on to my doctor a week or two ago because I wasn't feeling well." A relative we spoke with told us, "They are really on the ball with [relative] being ill, they identified when [relative] was not well and got things done really quickly."
One person 'was not feeling themselves' on the day of our visit, staff frequently checked how this person was feeling and they had implemented a 'close observation record' to ensure they were checking this person's wellbeing on a regular basis.

We saw records of contact with health professionals in people's care plans. One person had a health condition which meant they had to have regular eye screening, there were records to show that the person had recently attended an appointment for this. Records showed that people were supported to access the GP as needed and other health professionals such as dentists, opticians and hospital appointments. Outcomes of appointments were clearly recorded in care plans.
One person had been referred to the Dementia Outreach Team (DOT) for support and other referrals were planned. We spoke with the dementia outreach professional who was visiting on the day of our inspection and they told us that their advice had been incorporated in to support plans and staff had acted upon this to provide effective support. Where people were at risk of developing a pressure ulcer or had developed an ulcer, staff had sought advice from the district nursing team and we saw that the district nursing team visited regularly.

Good

Is the service caring?

Our findings

In our November 2015 inspection we found there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not treated with dignity and respect. During this inspection we saw that significant improvements had been made in this area.

People were positive about the care and support they received and told us they were happy living at Coppice Lodge. People told us the staff were kind and caring and treated them with respect. One person said, "Yes we seem to get on very well together." A relative said, "Staff seem very caring, they know everyone's names.I'm really happy for [relative] to be here."

During our visit staff treated people with warmth and kindness, they were polite and friendly and there were many examples of positive interactions. Staff took the time to sit and chat with people and showed genuine interest in them. For example, staff took their own breaks within the communal areas of the home so that they could spend time with people and asked about things that were of interest to them.

We saw staff encouraging and supporting people, taking their time and working at people's own pace. We saw one person being supported to move using a hoist, the staff members were gentle and reassuring and the person appeared calm and relaxed throughout. Staff took time to get to know and reassure another person who had recently moved into the service. We saw staff talking with them to find out what was important to them and how they preferred to be supported. During meal times staff were attentive and responded to people's needs quickly and skilfully.

The atmosphere was generally calm and relaxed. Staff responded quickly when a person displayed behaviour which may have disturbed other people. They spent time sitting and talking with the person which appeared to help relax and distract them, this was consistent with the information recorded in the support plan.

People were involved in decisions about their support. During our visit we saw that staff routinely checked with people about their preferences for care and support. We saw staff supporting one person who had recently moved into to the service discussing what sort of cup the person preferred to use, how they preferred to be supported and we also saw staff talking to the same person about their care plan. Due to changes in the service people had recently been asked to move bedrooms and people and their relatives told us that they had been consulted about which room they would like. One person had tried out different rooms before settling on their favourite.

People told us that staff treated them with dignity and respect. One person said, "The staff do treat everybody properly." Another person said, "I don't like the fact that somebody has to do my personal care, but they do it in a respectful way." We saw that staff were polite and respectful and ensured they treated people in a dignified manner. When it was necessary to have a conversation about personal matters staff ensured they did so in a discreet way. People's privacy was respected and some people chose to spend their time in their bedroom. We saw that people had locks on their doors and that people could choose to lock

their door when not in their room. Staff knocked on bedroom doors before entering and described closing doors and curtains whilst providing intimate care to ensure privacy.

The staff we spoke with demonstrated they had a good understanding of the importance of treating people in a dignified manner. The manager had plans to develop a dignity champion role within the staff team and this was on the agenda for the next staff meeting.

People were supported to maintain relationships with friends and family. People's friends and relations were welcome to visit and we saw a number of visitors on the day of our inspection. We saw relatives spending time with their family members in communal areas and making use of the facilitates. One relative we spoke with said, "I've been made to feel very welcome. The manager explained that they had an informal policy to restrict the number of visitors around mealtimes so not to distract people from their meals and to maintain a homely and relaxed environment, the manager also explained that they tried to balance this with choice so that if people or their relatives wished to share a meal with family this could be arranged in advance.

No one using the service was using an advocate to enable them to speak up. We saw there was no information in the service informing people how they could access an advocate. This meant people may not know about advocacy services available to them. Advocates are trained professionals who support, enable and empower people to speak up. We discussed this with the manager who informed us that staff had a knowledge of advocacy and would support people to access the services if needed.

Requires Improvement

Is the service responsive?

Our findings

During our inspection in November 2015 we found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, people were not involved in the development of their care plans. During this inspection we found that there had been some improvements in this area but further improvements were still needed. The new manager had plans for further improvements in this area, however these plans had not yet been implemented.

People who used the service and their relatives were still not involved in developing their care plans. Care plans were written by staff on behalf of people and there was no evidence to show how people had been involved. One relative we spoke with described effective strategies for enabling their family member to make choices about their care. Although staff had been informed about this, the information was not reflected in their care plan, despite the plan having been updated recently. The manager told us that there were plans in place to involve people in the development of care plans and we saw a letter had been sent to family members to invite them to a meeting to discuss this. One relative we spoke to told us, "Actually I've just been asked to come in to discuss [relative's] care plan."

People's care and support plans were not centred on individual need and were not always used by staff to provide consistent care and support. Care plans were task focused and did not contain information about what was important to people or their interests and preferences. Some care plans contained in depth information about the person's life history, where as other care plans did not have information in this area. This meant that staff did not always have access to information in relation to what was important to people. Staff told us that care plans were hard to use and complicated, although they had been given time to read care plans they did not to rely on them to inform people's care and support. This put people at risk of receiving inconsistent support.

Care plans were signed by staff regularly to show that they had been reviewed, however information in people's plans was not always accurate. For example, one person's care plan noted that they had a poor appetite and that they often only ate small amounts of food. However, the staff we spoke with told us that they ate very well and we observed this was the case on the day of our inspection. This meant that the information in the person's care plan was not accurate and there was a risk they may not receive the appropriate care or support.

Although most staff we spoke with were able to describe people's support needs and told us they felt able to meet people's needs, there was a risk that people may not receive the care they required because their care plans did not always contain accurate or up to date information.

The new manager told us that some work had started on people's care plans to improve them. For example, we saw that a recently written care plan provided detailed guidance to staff in how to support a person who may become distressed. During our visit we observed staff supporting this person in the way described in their care plan.

People told us that they received the care they required. One person said, "They have to help me in and out of bed and onto the toilet. They always do this properly and come quickly when I need them."

People were supported to have control over food, drink and the staff were responsive to people's choices and requests. For example one person had requested to go on a diet. We saw that this person was offered healthy choices at meals times and staff we spoke with were aware that the person was on a diet. We saw that staff respected the person's choice when they chose not to have the healthy option.

People were enabled to take part in social activities. People told us that there were a variety of activities on offer and they had enough to do. One person said, "Oh yes there is always something to do." A relative we spoke with told us, "There always seems to be something happening, making cakes, getting outside, going to the pub."

The provider had employed a regional activities coordinator and we saw records of activities that had taken place and posters advertising planned activities such as movement to music, poetic therapy and visits to church. On the day of our inspection an entertainer was visiting the service and people were offered a choice about whether or not they wanted to watch the entertainer and staff respected their choices. We saw people enjoying the entertainment. We were told by the manager that people had started to use the facilities in the newly refurbished area of the service. People, their relatives and staff described how much people enjoyed using the new area which had been designed to look like a pub.

The manager told us that they were working on making activities more in line with people's individual hobbies and interests by finding out what was important to people and basing individualised activities around this. We spoke with one person who had a love of birds and this person told us how they had been supported to fill bird feeders and had enjoyed watching the birds.

People could be assured complaints would be taken seriously and acted on. People told us that they felt able to make a complaint and knew how to do so. One person said, "If there was ever a problem I would go to the manager with no hesitation." People and relatives told us they felt comfortable raising a concern or complaint and felt confident that it would be acted upon. We saw records of one complaint raised since our last inspection and this was being investigated and acted upon. There was a complaints procedure and feedback forms available in the reception area.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection in November 2015 we found that the provider had failed to notify CQC of significant events. During this inspection we found that there had been a continued failing in this area but that there had been a recent improvement since the new manager had been in post. Prior to our inspection we were made aware of an event that the provider had failed to notify the CQC of involving an injury sustained by someone who used the service. Providers have a legal obligation to notify us of such incidents. We spoke with the new manager about this and they were aware of their responsibilities to notify CQC. We checked our records which showed that since the new manager had been in post they had made the appropriate notifications.

In our November 2015 inspection we found multiple breaches of legal requirements in relation to the care, treatment and safety of people, induction and training of staff, recruitment procedures, dignity and respect and person centred care. We asked the provider to develop an action plan to address the issues raised from our inspection however we did not receive an action plan. During this inspection we found that although the new manager had implemented positive changes, there was a lack of oversight from the provider and action had not been taken by the provider to ensure that the required improvements were made. This has led to further breaches in legal requirement as detailed in this report.

The home was required to have a registered manager in post as a condition of their registration. There was no registered manager in post at the time of the inspection and the service had been without a registered manager since September 2015. The registered provider had employed one other manager during this time but the registration process had not been completed. The new manager had recently taken up employment at the service and they had not yet applied to register with us. We contacted the provider about this who assured us that an application would be put in place and we will monitor this.

The provider did not have robust systems in place for quality monitoring the service whilst there was no registered manager in place, this meant that during these periods there was a lack of overall governance across the service. For example there were no records of quality assurance visits conducted by the provider between August 2015 and May 2016. We saw audits that had been completed by the previous manager were not effective in identifying issues and that action plans had not been developed as a result of the audits, however, this had not been picked up by the provider. For example, although we saw records of care plan audits they had not been effective in picking up issues that we found during our inspection. Missing information in care plans and inaccuracies in risk assessments put people at risk of receiving inconsistent and unsafe care. We also found that maintenance and infection control audits were not effective as no action had been taken to make improvements following the audit, again this had not been addressed by the provider.

The provider had failed to ensure the CQC rating was displayed in the service. The rating was not displayed on the day of our inspection. We informed the manager of this and they took immediate action to display the rating in the reception area. We checked the provider's website and saw the rating was clearly displayed.

The care plan format developed by the provider did not enable the service to provide high quality, safe care. The provider had developed a care plan format which the service was required to use, this included a form for risk assessments. Whilst the risk assessment forms did prompt staff to identify risks they did not clearly detail what controls measures had been put in place to reduce risks or detail the level of risk after control measures had been put in place. For example we saw that many people who had been assessed as being at risk of falling had movement sensors in their rooms. It was not clear in people's care plans if this was effective in reducing the risk of falling or if it lowered the risk of someone sustaining an injury from a fall. It was also unclear what other controls measures had been considered. In addition to this risk assessments related to skin integrity and pressure area care did not clearly detail the controls that had been put in place to reduce risks. The providers systems and the failure to check the effectiveness of these put people at risk of harm.

We saw that the provider's falls and mobility risk assessment did not assess the risk of people falling from their bed. The risk of people falling from their bed was only addressed in the bed rail risk assessment, which was only used for people who already had or were considering bedrails, this meant that the service had no system for identifying the risk of people falling from their bed who did not use bedrails and consequently placed people at risk of harm. We saw records that people had fallen from their beds but the risks of this were not clearly identified, assessed or planned for due to inadequacies in the providers risk assessment and care planning system.

The providers Mental Capacity Act (MCA) assessment form did not comply with the principles of the MCA. The form issued by the provider was general and did not relate to specific decisions, it did not contain space to include details of how the person's capacity had been assessed and it did not have space to record decisions taken in the person's best interests. We saw one person's care plan which stated that the person had capacity to make decisions, we spoke to this person's relative who described a situation where it was clear that staff were making decisions in the person's best interests, there was no MCA assessment in place for this decision and no details of the best interest decision. We discussed this with the manager who told us that they were aware of the issues with the current documentation explaining that use of the paperwork was required by the provider. The manager also informed us that the provider was reviewing all of its care planning documentation.

The provider did not have adequate systems in place to ensure that staff had appropriate training and this put people at risk of being supported by staff who did not have the appropriate skills and knowledge to provide safe, effective care. Training records showed many gaps in key areas including safeguarding, the Mental Capacity Act and equality and diversity. Records showed that this was a longstanding issue, however the provider's quality assurance systems had failed to pick this up. The provider had not put a plan in place to address the shortfalls in staff training prior to the new manager coming into post.

People could not always be assured that changes were made to improve the service as a result of accidents and incidents. Accidents and incidents were not analysed and learnt from. There were a number of people who had sustained falls but no investigation had been conducted into this and no action had been taken as a result. The new manager had recently put a system in place for analysing and investigating accidents and incidents, however this was still not always effective in ensuring the appropriate action was taken. For example one person had multiple falls and although these incidents had been analysed they had not taken any action to try and reduce the risk of future falls.

The new manager had not been provided with an effective handover when starting at the service. For example the manager had not been made aware of an infection control action plan that had been developed by a previous acting manager as the result of an external audit. This meant that a number of

actions in the plan had not been completed within the specified timescale. The plan stated that an infection control link would be put in place by the end of May 2016. On the day of our visit there was still no infection control link person. The manager told us they had not been made aware of the infection control action plan, but that they had recently found it and assured us that they would be taking action on the points in the plan. The manager was unable to locate records of any recent safeguarding incidents or concerns and had not been provided with an overview of any recent safeguarding referrals as part of their induction. The provider had also failed to handover important information relating to DoLS applications, consequently the new manager did not have knowledge of any DoLS applications that had been made or granted which meant that there was a risk that people's rights under the MCA may not be respected.

The provider did not have systems in place for involving people or families in the design and development of the home which meant that people were not involved in decisions affecting their lives and support. There were no meetings for people using the service or their relatives and there were no formal systems in place for communicating with people or their families or for gaining their views. For example, although people had a choice about what they ate from a menu they were not involved in menu development. Activities were available in the home, however these were not clearly based upon what was important to people using the service and there was no system in place for involving people in decisions about activities or for gathering feedback about activities. This meant that people were not consistently provided with the opportunity to pursue their interests.

We also found that staff were not actively involved in developing the service. Whilst staff did feel they could make suggestions about the service this was on an ad hoc basis as there were no formal systems in place to support and enable staff involvement. Staff meetings were infrequent and staff told us they were not always informed of or able to attend these meetings.

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

People told us that they felt the culture and atmosphere at Coppice Lodge was relaxed and open. One person said, "Yes I find it to be easy going." A relative we spoke with told us "this is a lovely service, the staff have bent over backwards to accommodate my [relative]." The staff we spoke with also felt that there was an open and honest culture and felt this had improved since the new manager started. One member of staff said, "Definitely, it is relaxed now. There was a time when it wasn't but it has improved." Another person told us, "Things have changed for the better. The atmosphere has lifted, it's a pleasure to come to work again." Staff praised the manager's approach saying that the manager was happy, supportive and positive. Staff also talked positively about recent visits from a new regional manager who was representing the provider saying "[person] is really friendly… they don't look down on you."

The new manager had a clear vision for the service and was passionate about making improvements. There was evidence that in the short time the manager had been at the service that they had started to work towards this. The staff shared the managers vision and were eager to see Coppice lodge grow and succeed, one member of staff told us, "I feel excited about the future of Coppice Lodge." The manager was working to build relationships with external professionals. There were plans in place for training to be delivered by the local care homes team. The manager informed us that they were starting to build links with other external health professionals to help develop the service and support the staff. There were plans to welcome the community into the home to promote inclusion and reduce social isolation. The new manager had also implemented a number of new systems and processes to ensure the smooth running of the service including team meetings and staff handovers and further improvements were planned.

The manager told us that there were now plans in place for a regional manager to visit the service on a weekly basis and we saw that the new regional manager had conducted an audit in May 2016 which had been effective in identifying some issues within the service. We saw that an action plan had been developed as a result of this and the manager was working towards achieving the actions.

Staff told us they felt that people living at Coppice Lodge appeared happier since the new management team had been in place. They told us how they had been encouraged to spend time getting to know what people's interests and hobbies were. Staff also described how they had recently supported people to become more involved in aspects of the home. Staff told us that despite having a garden people living at Coppice Lodge had felt that they didn't have a garden as they didn't use it or get involved with maintaining it. They had recently enabled people to get involved with gardening and had allocated a patch that people were supported to maintain, this had encouraged people to get out into the garden more. One staff member told us "you see people going out there now who never used to go out." The manager also told us that they were trying to increase the involvement of people and their families. They had plans in place to start a social committee within the home and to develop a newsletter.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 11 HSCA RA Regulations 2014 Need for consent Peoples rights under the Mental Capacity Act 2015 were not respected. Regulation 11 (1) (2) (3)

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 the risks associated with their care and support. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with the appropriate training and support to enable them to carry our the duties they are employed to perform. Regulation 18 (1) (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance systems and processes were not in place to ensure the safe and effective running of the location. Regulation 17 (1) (2) (a) (b) (c) (e) (f) (3) (a) (b)

The enforcement action we took:

We have issued the provider with a Warning Notice instructing them to address the concerns identified and breaches of regulation