Copper Beeches Limited

Copper Beeches

Inspection report

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Date of inspection visit:
02 October 2018
03 October 2018

Date of publication:
16 November 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We conducted an unannounced inspection at Copper Beeches on 2 and 3 October 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, 16 people were living at the home; all of these were older people, some of whom were living with dementia.

We carried out an unannounced comprehensive inspection of this service in June 2018. Breaches of legal requirements were found in relation to; risk management, safeguarding, cleanliness and infection control, person centred care, dignity, consent and leadership and governance.

Since our June 2018 inspection we received concerns in relation to the safety, management and leadership of Copper Beeches. As a result, we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Copper Beeches on our website at www.cqc.org.uk.

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.

During our inspection we found the service was not safe. People were subject to improper treatment that did not respect their rights. Restrictive practices were used to manage people's behaviour. People were not always protected from risks associated with their care and support. People were placed at risk of falls as assistive technology was not used effectively. Risks associated with people's health conditions were also not managed safely. This placed people at risk of harm. Risks associated with the environment, specifically legionella, were not safely managed. Furthermore, some areas of the home were unsafe, placing people at risk of harm. People were at risk of not receiving their medicines as prescribed, as there were not always medicines trained staff on shift. Medicines practices were not always hygienic. Infection control and prevention measures were not effective, this exposed people to the risk of infection. Staff were not always deployed effectively to meet people's needs in a timely way. Safe recruitment practices were not always followed.

Copper Beeches was not well led. Quality assurance processes were not effective, this had led to a failure to identify and address areas of concern. Serious incidents were not investigated; this meant action had not been taken to reduce the risk of reoccurrence. The provider had not kept up to date with current guidance and legislation. Decisions about people's care and support were not always based upon specialist advice or

best practice. The culture of the home was not respectful or person centred. There were limited opportunities for people living at Copper Beeches to influence the running and development of the home. The provider was not compliant with their own policies. We received mixed feedback from the staff team about the leadership and management of the home.

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 adequately protected from risks associated with their care and support.

Infection control procedures were not followed and the home was not clean and hygienic in all areas.

There was a risk people may not receive their medicines as prescribed.

Staff were not always deployed effectively to meet people's needs.

Safe recruitment practices were not always followed.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor and improve quality and safety were not comprehensive. When systems were in place, they were not consistently effective in identifying and addressing areas for improvement.

The provider was not compliant with their own policies. Concerns and incidents were not always investigated.

People living at the home had limited opportunities to express their views about how the service was run.

Feedback from staff about their involvement in the home and management was mixed.

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 consider concerns we received in relation to the safety, management and leadership of Copper Beeches.

The team inspected the service against two of the five questions we ask about services: 'is the service Safe' and 'is the service Well Led.' This is because we received concerns in these areas.
No further risks, concerns or significant improvements were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Before our inspection visit, 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.

Two inspectors and an assistant inspector undertook this unannounced inspection. During our inspection visit, we spoke with six people who lived at the home and three relatives. We also spoke with the deputy manager, the service manager and the provider. We made calls to nine staff on 3 and 4 October 2018.

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.

Inadequate

Is the service safe?

Our findings

At our past three inspections we have found concerns about the management of risks associated with people's care and support. This has been an ongoing a breach of the legal regulations. At this inspection, we found ongoing concerns about the management of serious risks to people's health and well-being.

People were not adequately protected from the risk of falls. One person was at high risk of falls and records showed they had sustained a serious injury in early 2018 as the result of an unwitnessed fall. During our inspection, we observed this person was in their bedroom alone. There was a pressure sensor mat in place to alert staff to their movements; however, this was not plugged in so was not working. The call bell was also not plugged in. This meant the person had no way of requesting assistance from staff and staff were unable to monitor their movement. We reported this, but found them to be in the same unsafe situation an hour and a half later. Furthermore, the pressure sensor mat was positioned next to the person's bed, but they were seated in their chair so would not have triggered the sensor mat were they to stand. This failure to ensure that measures in place to reduce the risk of falls are used effectively, placed the person at risk of harm as a result of falling.

Risks associated with people's health conditions were not always managed safely. One person had recently been diagnosed with epilepsy. There was a lack of information about how to manage their epilepsy in their care plan. For example, their care plan did not contain information about medicine to be given in the event of a seizure, which meant care staff did not have access to this information. There were no records of seizures, which meant there is no information about how long seizures have lasted, what time of day they took place at or possible triggers. Furthermore, risk assessments were not sufficient. A seizure risk assessment, stated the person should be checked on, two hourly at night, but there were no other measures in place to alert staff if the person should have a seizure. This meant the person may have a seizure and not be identified by staff for up to two hours. This placed the person at risk of harm. Following our inspection, we wrote to the provider asking them to address our urgent concerns. The provider informed us they took action to train staff and implement assistive technology to reduce risks. We will assess the impact of this at our next inspection.

People were at risk of not receiving their medicines as prescribed. Staffing rotas showed there were not always medicines trained staff on shift at night. The provider told us staff would call a senior care to come into the service if needed. This meant there was a risk people may not receive 'as required' medicines in a timely manner. This was of particular concern in relation to a person who was prescribed a medicine to be given after five minutes of a seizure starting. This was not a sufficient measure to ensure the person was given the medicine within the required timescale. Furthermore, training records showed that the senior carer had not attended training on how to administer the seizure medicine. This meant there was a risk of people not receiving their medicines as prescribed which could have a negative impact upon their health and wellbeing.

Topical creams were not always applied as directed. We looked at Topical Medicine Administration Records (TMAR) for four people all of which failed to evidence that creams had been applied as directed. This failure

to apply topical creams as directed may have had a negative impact on people's skin integrity.

Infection control and prevention measures were not adequate. During our inspection the provider told us the sluice (used to dispose of continence waste) had been out of service for "six to eight weeks." Despite this, no alternative, hygienic, measures to empty and clean commode pots had been put in place. Staff told us and we observed, that waste was tipped down toilet and commodes were rinsed in hand wash sinks. On one occasion we saw a member of staff rinse a commode in a hand wash sink which had a person's toothbrush on it. Furthermore, staff told us and we observed that commode pots were not sanitised between uses. This was not a hygienic practice and could lead to the spread of infection.

There had been a delay in seeking medical advice for a person who had an infectious disease. There had also been a delay in following up medical advice from a person's GP, consequently the person's course of medicine finished on the day of our inspection. The deputy manager told us they needed to chase this up but had not yet done do. This delay in seeking professional advice may have resulted in a delay in treatment.

Some areas of the home were unsafe. Since our last inspection a replacement bath had been installed. However, this was not suitably affixed to the floor. This meant the bath was unstable could tip on to a person or staff. This was a particular risk for people who were at risk of falls who may hold on to the bath to steady themselves. Given the size and weight of the bath this had the potential to cause serious injury.

People were not adequately protected from the risk of legionella. Legionella is a bacterium which can develop in stagnant water and lead to a fatal form of pneumonia. A legionella risk assessment advised that infrequently used water outlets should be run on a weekly basis to reduce the risk of bacteria developing in the water supply. The provider told us the cleaner did this on a weekly basis. However, there were no records to show that this was completed. Copper Beeches is an old building with several unused water outlets, this increased the risk of legionella developing in the water supply and placed people at risk of contracting Legionnaires Disease.

Hygienic medicines practices were not followed. The medicines trolleys were not clean and aero chambers (used to administer inhalers), were opaque due to a build-up of medicine. This was not hygienic and did not promote the control and prevention of infection.

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

At our June 2018 inspection we found people were not protected from abuse and improper treatment. At this inspection we found some improvements had been made and consequently most incidents were referred to the safeguarding adults team as required. However, we identified new concerns in relation to safeguarding.

People were subject to improper treatment that did not respect their rights. Restrictive practices were used to manage people's behaviour. During our inspection a member of staff told us one person had been, "Put upstairs because they are disturbing other residents and they can't eat their tea if they are there." We found the person alone in their bedroom. They were in an agitated state and had a cold cup of tea and a bowl of melted ice cream and fruit. This practice was not in line with their 'anxiety and aggression' care plan, which stated the person should be provided with one to one support should they become agitated. There was no evidence that the guidance in the care plan had been followed. This was a restrictive form of managing behaviour which may have a negative impact on the person's wellbeing. After our inspection we wrote to the provider and asked them to take urgent action to address the concerns identified about restrictive practices.

However, the provider did not provide any assurances about action taken to address poor practice and monitor staff practice. This placed the person at continued risk of harm.

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

At the time of our inspection, the local authority safeguarding team was investigating several safeguarding concerns, primarily into allegations of neglect of people's care needs. These investigations were not concluded at the time of writing this report.

At our June 2018 inspection we found there were not enough staff available to meet people's needs and ensure their safety. This was a breach of the legal regulations. Although we found staffing levels had been increased at this inspection, staff were still not effectively deployed to meet people's needs and this had a negative impact upon them.

People living at Copper Beeches told us staff did not always respond quickly to their requests for care and support. One person said they were left sitting on the commode for prolonged periods of time. Another person commented that evenings were hard as everyone wanted support. Sometimes they needed the toilet so badly it was "painful" and they said, "It becomes uncomfortable if you can't hold it and you are sat in wet clothes." Throughout our inspection, particularly early evening, we saw people were left unattended for periods of time as staff were busy providing support to people. The provider told us this was caused by last minute staff absence. Staff feedback was mixed, whilst some staff said there were enough staff, others said this was not always the case and there were times that they were "rushed" and did not have time to talk to people. We discussed our observations with the provider who told us they thought there were enough staff.

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

At our June 2018 inspection we found the home was not sufficiently clean. At this inspection this continued to be an issue. Although improvements had been made to some areas of the home to enable more effective cleaning, there were still areas which were not sufficiently clean. Pressure mats were very sticky and some bed bases showed evidence that they had been penetrated with fluids. We observed that one person had flies in their room, we noted this was likely due to apples rotting on a plate in their room. Staff had not acted to resolve this for the person. 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.

This was an ongoing breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them, as safe recruitment processes were not always followed. References obtained as part of the recruitment process were not always adequate. One staff member's references had been provided by the provider and manager of Copper Beeches. The provider told us this was because they knew the person from previous roles. There was no evidence they had tried to obtain references from the person's most recent employer as required. This meant there was a risk they may not have all the relevant information to make a decision about the suitability of staff members.

Inadequate

Is the service well-led?

Our findings

At our past three inspections we have found concerns in relation to the leadership and governance of Copper Beeches. This has been an ongoing a breach of the legal regulations. At this inspection we found continued concerns in this area.

The improvements made at Copper Beeches were limited in scope. Since our last inspection there had been some improvements. However, overall improvements were limited to issues raised by external agencies such as CQC and the local authority. Consequently, we found new concerns which had not been identified by the provider prior to our inspection.

Quality assurance processes were not effective. Following our June 2018 inspection, the provider had implemented a range of audits. However, these had not been effective in identifying areas for improvement or bringing about change. For example, an infection control audit in September 2018 had identified that the sluice was not in use. There was no information about planned timescales for repair and no alternative measures had been put in place to ensure hygienic disposal of waste and cleaning of commodes in the interim. Night checks had not identified there were no medicines trained staff on shift and the repair audit had not identified that the bath was not securely affixed to the floor. This failure to identify and address areas of concern exposed people to the risk of harm.

Serious incidents were not investigated; this meant action had not been taken to reduce the risk of reoccurrence. One person had developed a pressure ulcer while living at Copper Beeches. There had been no investigation into the circumstances leading to the injury, which meant opportunities to prevent this from happening again may have been missed. Another person's relative had raised a complaint about communication. They had been advised that an investigation would be carried out. However, there was no written investigation and the manager told us they had just told the family this to resolve the complaint. A third person had made an allegation of theft. Although the manager and provider told us they had searched the home and asked people about it, there was no written evidence to demonstrate that all reasonable lines of enquiry had been investigated. This meant we could not be assured all reasonable steps had been taken to ensure the quality and safety of the service.

The provider had not kept up to date with current guidance and legislation. At the time of our inspection the provider was overseeing the running of the home while there was no registered manager. However, the provider told us they did not have any relevant, up to date training. Consequently, the provider lacked knowledge of the current good practice and this had a negative impact on the quality and safety of the service provided at Copper Beeches. For example, after our inspection visit we wrote to the provider with concerns that one person was not protected from falls. The provider shared photographic evidence of changes made to the person's room. However, this had resulted in an electric wire trailing across the floor. This created an additional trip hazard and could have further increased their risk of falls. This reactive response to concerns posed a risk to people's health and wellbeing.

The culture of the home was not respectful or person centred. We received feedback that that the provider

did not always promote or respect people's rights to privacy. One person told us the provider had recently walked into their bedroom uninvited when they were in a state of undress. Several staff told us that they had been told by the management team to prioritise care for people who were able to ask for it over those who could not complain. People living at the home said that some staff did not acknowledge them or others. In addition, we received concerns that members of the management team had spoken to staff and people who used the service in a derogatory manner. These concerns were under investigation at the time of writing this report.

There were limited opportunities for people living at the home 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 several people, who lived at the home. Whilst the results were largely positive, the surveys had been completed by a staff member on people's behalf. This lack of independent and impartial support may have had an impact upon people's answers. We also found that feedback in the survey was at odds with feedback provided to us during our inspection, consequently the provider was not aware of people's concerns prior our inspection.

The provider was not compliant with their own policies. For example, the complaints policy stated that records of complaints would be held in a complaints file. Despite this, we found there was no coordinated system for recording, handling and responding to complaints.

The overall rating for this service is rated as Inadequate. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding.' Good care is the minimum that people receiving services should expect and deserve to receive. The service has been rated as 'Requires Improvement or Inadequate' on four consecutive inspections. This shows that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved.

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

We also found the provider was in breach of the conditions of their registration. For example, after our June 2018 inspection we imposed a condition that required the provider to ensure there was always a medicines trained member of staff on shift. However this had not been complied with.

We received mixed feedback from the staff team. Some staff told us there had been improvements over the past 12 months. They said they could raise concerns and were confident they would be listened to. In contrast, other staff told us they did not feel their suggestions were listened to. One member of staff told us they suggestions were not encouraged or welcomed by the management team, another member of staff said, they had complained about things and but nothing had been done. Records showed there had been some meetings for staff, these were used to share information with staff and to discuss issues.

We checked our records, which showed the provider, had notified us of events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service.

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.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected from risks associated with their care and support. Infection control procedures were not followed. There was a risk people may not receive their medicines as prescribed. Regulation 12(1)

The enforcement action we took:

We took urgent action to impose conditions on the registration of the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The home was not clean and hygienic in all areas. Regulation 15(1)

The enforcement action we took:

We took urgent action to impose conditions on the registration of the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve quality and safety were not comprehensive. When systems were in place, they were not consistently effective in identifying and addressing areas for improvement. The provider was not compliant with their own policies. Concerns and incidents were not always investigated.

People living at the home had limited opportunities to express their views about how the service was run.

Regulation 17(1)

The enforcement action we took:

We took urgent action to impose conditions on the registration of the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always deployed effectively to meet people's needs. Regulation 18(1)

The enforcement action we took:

We took urgent action to impose conditions on the registration of the provider