Care Quality Commission

Caring Homes Healthcare Group Limited

Coppice Lea

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 August 2018 and was unannounced. At our previous inspection in August 2016 we rated the service as Good.

Coppice Lea is a 'care' home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can accommodate up to 53 older people. Care is provided across two floors in a converted Victorian house near the village of Bletchingley. At the time of our inspection there were 44 people using the service the majority of whom were living with dementia.

There was a registered manager in post. 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.

A number of key staff had left the home since our last inspection. This had an impact on the registered manager, the staff team and their ability to consistently provide a good standard of care and support to people. We found areas that required improvement across all five of the key questions that we ask during an inspection (Is the service safe, effective, caring responsive and well led?). We have identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the full report.

The provider had identified that the service was struggling to provide a good level of care in June 2018. They had begun to act to make improvements, such as supplying additional management support.

People were not always supported to stay safe at Coppice Lea. Risks to people's health and safety had not always been identified or appropriately managed by staff. Staffing levels and their deployment around the building meant that there were times when there were not enough of them to give a safe level of care.

People received their medicines when they needed them, however we identified improvements were needed in how 'as required' medicines (such as pain relief medicines) are managed.

Staff recruitment processes ensured appropriate checks were carried out on prospective staff to ensure they were safe to work at the home. Staff understood their responsibilities around protecting people from abuse.

People's rights under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were not always met. Issues identified included assessments of people's capacity; if the person could not make a decision for themselves who had legal authority to make decisions for them; and updating Deprivation of Liberty Safeguard (DoLS) authorisations when restrictions were no longer required.

Staff did not always have the knowledge and skills to ensure ensuring people received a good standard of care. Examples were seen where staff did not follow written guidance, or where they did not follow best practice, such as when using wheelchairs to move people. This also impacted the support people received with eating and drinking, and where health care professionals had given guidance and advice. For example, people at risk of pressure sores were seen to be in the same position throughout the inspection, when guidance stated they should be turned at regular intervals.

The provider had not ensured that the home environment had kept up to date with best practice around supporting people living with dementia. The provider had a dementia specialist, however they had not been effectively utilised to review the home and implement changes to meet people's needs.

People were overall positive about the staff that supported them, however we identified a number of areas where improvements were needed. Staff did not always show respect to people, for example going into rooms without knocking. Many staff were 'task focussed' having little interaction with people while they supported them. Staff were also unaware of people's preferences with regards to some of the protected characteristics of the Equalities Act. A person told us they did not feel comfortable identifying their preferences to staff, as they were uncertain how this would be received and if they would be supported.

Peoples care and support plans were found to contain out of date information, or information was missing. There were a number of agency staff used so there was a risk that people's current needs and preferences would not be known.

Complaints were not always fully resolved to the satisfaction of the people who made them. Actions proposed by management to address the concerns were not always followed by staff.

People had access to a range of activities, which included clubs and trips out. However, those people that stayed in bed had less access to them, and told us they often felt bored and lonely.

People received care and support at the end of their lives that met their needs and preferences.

The providers quality assurance process had been slow to identify that the staff team were failing to provide care and support that met people's needs. However, the provider had now begun to make improvements around the home.

Although we identified a number of areas where the staff and provider needed to make improvements, we did also see some good care and support being given. People were positive about the staff, and felt safe living at the home. They liked the food, even though they had to wait a long time for it sometimes.

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

People were not always cared for in a safe way.

Risks to people were identified but not always acted upon to help keep people safe.

There were not always enough staff employed to safely meet people's needs.

Improvements were needed in how 'as required medicines were managed. Other medicines were stored and given in a safe way.

Staff recruitment process ensured only suitable staff were employed at the home.

Is the service effective?

Requires Improvement

The service was not always effective

Staff training and supervision had not been effective at ensuring staff were able to give a good standard for care and support to people.

People were not always supported to ensure they had enough to eat and drink. People's preferences and specialist diets were known by the care staff.

People had access to health care professionals for routine check-ups, or if they felt unwell. However, conditions that should have prompted a referral to a specialist were not always identified by staff. Staff did not always ensure professionals guidance was followed, such as for people at risk of pressure wounds.

Adaptations were needed around the home to make it more dementia friendly.

People's rights under the Mental Capacity Act were not fully met. Assessments of people's capacity to understand important decisions had not always been recorded in line with the Act. Where people's liberty may be being restricted, applications for DoLS authorisations had been completed. However, these had not been withdrawn when no longer required.

Peoples needs had been assessed prior to coming to the home, to ensure those needs could be met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always caring and were tasked focussed. However, we did see some good interactions by staff that showed respect and care.

Staff did not always know the people they cared for as individuals, or their preferences and how they wanted to live their lives.

People could have visits from friends and family whenever they wanted.

People's right to practice their faith was respected and supported by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were often out of date or had missing information. People were involved in their care plans and their reviews. However, these did not always result in the care plan being updated to give staff correct or current information.

There was a complaints procedure in place. The registered manager had not ensured that actions taken to resolve complaints had been followed by staff.

Staff offered activities that matched people's interests. People who spent their time in bed had less access to activities.

People were supported at the end of their lives to ensure their needs and preferences were met.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance checks had not been effective at ensuring the staff were following best practice, or that people had received a good standard of care and support. The provider had recently identified the issues themselves. They had given additional support to the registered manager to address these (and our)

concerns.

Records management needed to improve to ensure management oversight of the home was effective.
Feedback was sought from people via meetings and annual surveys.

Staff felt supported and able to discuss any issues with the registered manager.

The registered manager understood their responsibilities with regards to the regulations, such as when to notify CQC of events.

Care Quality Commission

Coppice Lea

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.

The inspection was prompted in part by concerns raised about the standard of care people received. The information we received indicated there were potential concerns about how risks to people were managed, whether there were enough staff to meet people's needs and if complaints were responded to appropriately. This inspection examined those areas.

This inspection took place on 15 August 2018 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist nurse advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held including notifications we received from the service of significant events. We had not asked the provider to send us an updated Provider Information Return as we were responding to concerns. The PIR 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. We review this information to see if we would need to focus on any particular areas at the service. We also contacted the local authority to seek their views on the care being provided.

We spoke with 12 people on a one-to-one or in small groups . We spoke with five relatives or visitors to the home. We also spoke with eight staff which included the registered manager who was present on the day. We observed how staff cared for people, and worked together. We also reviewed care and other records within the home. These included eight care plans and associated records, four medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

We also contacted commissioners of the service to see if they had any information to share about the home. After the inspection the provider sent us further information to show that they had responded to the concerns we had raised

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and safety were not appropriately managed. Where people were at risk of malnutrition or dehydration food and fluid charts were in place. These recorded their food and fluid intake to ensure they maintained good health. However, fluid charts did not have a target amount set and there was no analysis of the charts to identify when people had not had enough to drink. As a result, staff would not be able to see whether people were receiving enough fluid throughout the day. On two occasions two people had less than 1000ml of fluid recorded in a day. The actual amount recommended by the Association of UK Dieticians is 2000ml for men and 1800ml for women (including the elderly). The nurse in charge told us it was the responsibility of night staff to total the amounts people drank and to raise any concerns with day staff at handover. Without a recommended target staff would not know if the amount totalled was inadequate or not.

Known risks to people were not always acted upon to keep them safe. One person was nursed in bed and at risk of developing pressure sores. They had an air mattress in place, however, the incorrect setting for their weight was used. We asked staff to address this straight away which they did. Another two people at risk of pressure sores also had the incorrect setting recorded on the check sheet that staff used. This meant staff would not be able ensure the correct weight setting was used. Some people needed regular turning. We found this was not happening with one person who remained in the same position for an extended period of time. Where staff had turned people, they did not always accurately record this.

Staff did not always follow documented guidance to ensure risks to people were managed in a safe way. One person was at risk of choking. There were clear instructions (in the care plan and displayed in the persons room) on how staff should support them to have food and fluids. However, we observed staff using an incorrectly sized spoon when giving food to the person. The staff member also made them take another sip of fluid before they had swallowed the first. Both could have resulted in the person choking. We immediately raised these concerns with the registered manager. They told us that only a select few staff who understood the persons needs was in place. None of these staff were on shift on the day of the inspection. The staff member supporting the person to eat and drink when we raised our concerns was also not on the 'approved staff' list. The identified hazard of choking had not been managed to ensure the person was not put at risk of harm.

Failure to assess and mitigate risks to people is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider supplied us with information on how they had implemented new guidance for staff to address the issues we had raised.

There were not always enough staff deployed to safely meet people's needs. People gave us mixed views about staffing levels which echoed our concerns in this area. One person told us that, "Staff are a little short on the ground" and there was, "Sometimes a delay" with staff responding to them. Another person needed reassurance told us staff didn't have time to talk to them. One person told us there, "Were often delays" and

staff took, "Too long to do simple things". This was observed during lunch. Some people had to wait almost 40 minutes siting at the dining table before their food arrived. One person told us that the meal-times often took this long, and that sometimes they, "Ran in to teatime." "The next round of food is being offered up before lunch had gone down," and, "Supper is upon you before lunch is over."

The registered manager told us staffing levels were determined using a dependency tool which took into account people's needs. The registered manager told us safe staffing levels were set as two nurses working during the day with eight care staff in the morning which reduced to seven care staff in the afternoon. At night there should be one nurse and four care staff. This contradicted the calculation according to the dependency tool. Whilst we found that staffing levels were met on the day of the inspection there had been 12 occasions in the preceding three weeks where minimum staffing levels had not been met. Additionally, we found that due to the layout of the building there were times that people were left without appropriate support. One person who had used their call bell waited 10 minutes for staff to attend to them. Another person, nursed in bed, was not checked on at the frequency recorded in their care plan to ensure they were safe and in good health. In the lounge, one person kept leaving their chair to leave the room. There was only one member of the staff in the room so the person could leave each time. We found this person walking about the dining room collecting the knives and forks from the tables that had been prepared for lunch. This could have placed them at harm of injury, or place other people at risk of infection as the cutlery may no longer be clean.

Staff deployment around the building meant that people's call bells were not always responded to quickly. During the afternoon, we heard a call bell ringing. Having checked that is was not an emergency with the person we waited to monitor the response. After four to five minutes one of our inspection team responded to the alarm, to check the person was alright. It was a further five minutes before a member of staff responded. In total the person had waited 10 minutes for a member of staff to attend to them. We were concerned because the lack of staff response could place people at risk of harm for example if they had a stroke or heart attack.

Failure to maintain staffing levels and deploy them effectively is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider supplied us with information on how they would address these concerns, to ensure staff had been deployed in a safe manner.

The management of 'as required' medicines (PRN) had some areas where it could be improved. An 'as required' medicine is something that is only given on occasions when needed, rather than being given at specific prescribed times. An example would be pain medicines for when people have headaches. There were PRN protocols in place but they lacked detail, for example 'Paracetamol for pain or fever.' Where pain relief was given there was information that it was given for pain in the stomach or pain in ankle or for fever. However, they did not always include information such as, how much medicine should be given, signs to look out for and when to offer the medicine, including verbal and non-verbal cues and if there are any alternatives to PRN. Without this information staff may offer PRN inappropriately or fail to give PRN when people needed it. but no details of temperature of the person or if they were in pain. There were no pain charts in place for many people, or those that were in place were not detailed enough. These can be vital for identifying when someone who may not be able to verbally communicate is in pain. In one case the pain chart stated that there was a need to monitor a person's body language, but there was no detail in the care plan of how pain was displayed by that individual.

We recommend that the provider review their policies and practices for 'as required' medicines to ensure

these are robust.

People's other prescribed medicines were managed and given safely. People were involved as much as possible. Where people or their relatives had questions about medicines the nursing staff were heard to answer these questions to help people understand. Medication was stored appropriately in locked rooms and within locked cupboards, or trolleys which were secured to the wall. The temperature at which medicines were stored was checked daily. This ensured the medicines remained within the manufacturers guidelines so that its effectiveness would not be affected. Medicine storage areas were seen to be clean, with a clear schedule of cleaning in place. Medicine stock levels were recorded and routinely checked by qualified staff to ensure they were accurate.

People received their medicines when they needed them. Nursing staff administered medicines in accordance with the National Institute for Health and Care Excellence (NICE). NICE provide national guidance and advice to improve health and social care. The medicine administration records (MAR) charts were neat and tidy and had been signed appropriately. This ensured staff could easily check if people had received their medicines, and who required what medicine at what time.

Medicine that required specific equipment or techniques for it to be administered to people was done in a safe way. One person required their medicine to be given using a small battery-operated pump called a syringe driver. This gave medicine continuously under their skin over a period of time. Nursing staff were seen to prepare, check and label the syringe driver medicines correctly and then use the equipment in a safe way. The area where the medicine went into the person's body was clean without any redness or signs of oedema (this is where build-up of fluid in the body causes the affected tissue to become swollen.) This was a further indication that the medicine was given correctly. The person also looked comfortable throughout the process. Only staff trained in the use of the specialist equipment were authorised to administer medicines in this way.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that potential staff were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff understood their responsibilities around protecting people from abuse. They were able to identify the signs that someone may be being abused, and knew they had to report their concerns immediately.

People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the registered manager to look for patterns that may suggest a person's support needs had changed.

People were protected against the risk of infection because the home environment was kept clean. There was a cleaning schedule in place and staff ensured that the rooms and equipment were kept clean. Staff were observed to wear appropriate personal protective equipment such as gloves and aprons when needed, for example when serving food. There were no unpleasant odours in the home. This demonstrated that the people's needs with regards to continence management and support were met, and the risk of spread of infection was minimised.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (2004) (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.

Where people lacked capacity to make certain decisions, there was an inconsistent approach to ensure their rights under the MCA were met. Some assessments of people's capacity were decision specific. For example, where bed rails, or pressure sensing mats were in place to reduce the risk of falls. However, other assessments for people under the same restrictions were not in place. When people lacked capacity, we found their advanced decisions had not always been followed so treatment had been given without their consent. This meant people lacking capacity were at risk of being restricted of their liberties unlawfully. One person's care notes had an entry dated December 2015, saying that prior to loss of capacity the person had refused the flu vaccine and his GP was aware of this. However, later notes recorded that the person had been given a flu injection in October 2017. There was no record of a best interest decision process taking place, which is a requirement of the MCA.

Staffs understanding of when relatives should make decisions for people's health and welfare were also inconsistent. One relative had power of attorney over a person's finances, however staff had sought the relatives consent for decisions around healthcare, such as the use of bedrails. For another person there was an undated and unsigned document saying that the person's wife and daughter held a power of attorney, however, it did not say whether this was for property and finance or welfare. On another document "enabling care" it recorded there was no power of attorney. Elsewhere in the same file it recorded that the person's family member took care of their finances. These inconsistencies could mean that decisions were made for a person by those that may not have the legal authority to do so. Shortly after the inspection the provider supplied us with an updated list to demonstrate they had reviewed who held power of attorney and for what aspect of people's lives.

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 are called the Deprivation of Liberty Safeguards (DoLS). Where people's liberty was restricted to keep them safe, appropriate applications had been made to the DoLS team. People were not always supported in having these authorisations removed as their capacity to understand and agree a restriction improved. One person was being administered their medicines covertly. There had been a best interest meeting with appropriate healthcare professionals who had agreed this, however clinical staff told us that they always told the person they were putting the medicine in the yoghurt and the person took them knowing they were there. The staff member did not appreciate that this was not covert, and therefore a DoLS should not be in place.

Failure to provide care and treatment without determining the consent of the relevant person is a breach in Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People told us that staff asked their permission and gave them information to understand decisions that may need to be made. One person said staff, "Advised" her rather than, "Told" her what they could or should do in order to keep her safe and well.

Staff training and supervision did not ensure that people received effective care and support to meet their needs. Staff had a variable understanding of the Mental Capacity Act 2005, such as the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff supporting people to mobilise did not always use the equipment effectively. One person was moved with the use of a wheelchair, however the staff had not put the foot plates in position. This left the person at risk of injury as their feet were not correctly supported. We immediately brought this to the attention of the staff, and the foot plates were then put into place. Another staff member had not followed instructions on how to support a person to eat and drink. Staff understanding of dignity and respect also demonstrated that training and supervision were not effective. Multiple times during the day of the inspection staff were seen to enter people's rooms without knocking.

Staff who had regular supervision (approximately monthly) told us they felt that it was not very useful. It was generally used to discuss problems and things that went wrong. It was not used to discuss residents and how they could better be cared for or to reflect on individual practice unless it had gone wrong. The staff member also provided supervision to other staff and used a similar approach. They had not received any training on how to do supervision so had learned by their own experiences.

Failure to provide suitably competent and experienced staff was a breach in Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nursing staff told us they received the training they needed to meet the clinical needs of the people. They said that this was ongoing and they were able to ask for courses if they felt they lacked competence in an area. The clinical lead was very knowledgeable about people and their needs and could answer any questions we had to demonstrate this.

The home environment and decoration had not been adapted to meet the needs of people living with dementia. One person told us that due to the size and layout of the building that they were unsure where things were in the home. They went on to say that it took them a long time to find their way around. The environment could be confusing with all corridors and doors looking the same. There was a lack of signage and what there was, was not ideal for older people, the visually impaired or those who mobilised using wheelchairs. Signs were not in strong contrasting colours and were quite high up and not very large. There was no dementia friendly signage i.e. with pictures. There was nothing distinguishing one room from another, e.g. by use of colour or pictures. There were no memory boxes or similar objects outside rooms to help people recognise their own space by individualising it. The corridors had little in the way of interesting objects, such as tactile surfaces, for people to interact with. There were no toilet seats in contrasting colours which could help people with dementia to use toilets more appropriately and retain their dignity.

The home environment did not meet the needs of people living with dementia. This was a breach in Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider assured us that they would have their dementia specialist visit the home and review the environment with regards to meeting peoples needs.

People did not always have effective support to protect from malnutrition and dehydration. Food and fluid care plans were not always completed, or did not give adequate information to staff to ensure people had enough to eat and drink. A food and fluid care plan stated, "make sure that fluid intake is adequate" but did not state a target so it was unclear what was meant by adequate. Nor were there any instructions on what should be done if the intake was inadequate. Staff told us that if they felt the fluid intake was "inadequate" they would tell the manager, possibly the GP after exploring other reasons for low intake and maybe refer to Speech and Language Therapist (SaLT). They were unaware of simple actions they could take such as ensuring records were completed, supervising carers to ensure enough drinks were being offered and if they offered the favoured drinks of the individual. During the morning we observed a person's food and drink were placed out of their reach on a side table by their chair. There was only one staff member in the room and 11 people eating. The member of staff supported one of the other people to eat. They had their back to the room so were unable to see the person struggle to reach their food.

The provider had identified the issues in their internal audit and had begun to introduce a new system (called GULP) for assessing people's needs around hydration. This had not been fully implemented at the time of our inspection.

The dining experience for people was very quiet on the day of the inspection. There was little conversation taking place between people and no music. We raised this with the registered manager, who stated that this was not the usual way mealtimes were carried out. She explained that staff may have forgotten to turn on the music and encourage conversation due to our presence.

It is recommended that the provider implement their new system for assessing people's hydration needs and review how care staff support people with regards to food and fluid intake.

People had inconsistent access to health care professionals and effective support to keep them healthy. Staff had not always taken action to involve other healthcare services, or follow professional guidance that had been given. Shortly after the inspection we were notified of a concern raised around a person's foot care. This person received support from staff to bath and dress. Staff had not identified an issue with the person's feet that had affected their ability to walk. Action had only been taken to address the issue after the change in mobility had been identified by the persons family.

Some people were at risk of pressure sores. A key requirement in the care plans for these people was that they should be turned by staff at specific times during the day. This stops the person staying in one position and applying pressure to one area of skin for a long time. One person at risk of developing a pressure sore had no turning regime in place and they remained on their back for at least five hours while we at the home. Other people were observed to be in the same position throughout the day, although their turning charts recorded they had been turned. One person had developed a pressure sore some time ago and there had been effective action taken by staff to monitor this. However, the records that were kept were contradictory and did not detail the improvements made because of the medical treatment they had received. There was no one with a pressure sore at the time of our inspection.

Other people had a more positive experience. A relative talked about how in the 12 months leading up to their family member coming into the home they had been in and out of hospital many times. This had been very stressful on the family. In the time the person had been at Coppice Lea, the staff had stabilised the person's condition and they had not needed to be readmitted to hospital. This had gone a long way to reduce the stress on the family. They felt, "Very confident" in the staff. One person talked to us about the physiotherapy they received. They explained how the therapist came in regularly and was working with him to help him raise his arms up to shoulder height and has given him exercises for his legs. He then went on to

say that the staff were also helping him to do these daily. Another person told us about how if they felt unwell they could ask to see the doctor and an appointment would be made. Health care professionals did come to the home to see people. These included the GP, dentist, dietician, podiatrist, physiotherapist, Speech and Language Therapist (SaLT), optician, Tissue Viability N urse (TVN), and the older adult's mental health team.

People's needs had been assessed before they moved into the service to ensure that their needs could be met. This involved meeting with people and those important to them. Assessments contained detailed information about people's care and support needs. The assessments also reviewed people's psychiatric requirements or use of specialist medicines that may be required to see if there were any specific legislation or standards that needed to be met.

Requires Improvement

Is the service caring?

Our findings

We had mixed feedback about how caring the staff were. One person said, "There are often delays - it takes them too long to do simple things. While I am not trying to be unrealistic and I do understand they need to take care of all of us and some of them [indicating the other people who used the service] need help more than my friend and myself." We asked if the delays meant that they felt the service was poor and they replied that the care was, "Very good . . . just sometimes it was delayed." Another person said, "I can see that the staff are taking care of the other people here."

Further to these mixed comments we found some staff were uncaring at times and focused on tasks instead of people. Staff communication with people did not always show a caring attitude during their conversations. A member of staff supported a person in their room (with the door open). We overheard the conversation. The staff members tone of voice and what they said was 'instructive' such, "You need to go to the lounge", "Put your jumper on." The person was not given a choice. The member of staff left the room and saw that we were in the corridor. When they returned to the person, the way the spoke changed. For example, "Would you like me to put the battery into your hearing aid?" and, "Shall I walk you down to the lounge?" Choice was given from this point on. Another observation was made during lunch. The staff that sat at a table assisting people to eat spoke amongst themselves with little or no conversation with the individual they were supporting.

Staff did not always treated people with dignity and respect. During the inspection staff were observed to enter people's rooms without knocking and waiting for an answer. This happened throughout the day by different staff. This meant people had no privacy in their rooms as staff entered without warning. People who stayed in their room, by choice or due to their support needs had little access to organised activity, or interactions with staff on the day of the inspection . This left them vulnerable to feeling isolated.

People's had an inconsistent experience with staff being caring and attentive to their needs. Those that stayed in their rooms, for example due to having to stay in bed had a less positive experience, than those in the communal areas. One person told us about their anxiety. We asked what staff had done to support them with this and they said, "Nothing. The staff don't have time to talk to me about it." Another person said they felt, "Quite lonely." We talked to them about joining in with the activities and they were unclear or unaware of the activities on offer. A third person told us they were very grateful for a visitor as they felt lonely. A fourth person had a different experience and said, "I think the staff are very caring and they take time to help me. I know all the staff names and where they come from." Over the course of the inspection some staff were seen to have positive interactions with people, being cheerful and happy in their job. Other staff did not look to be particularly happy doing their job nor did they engage with people.

Staff told us they were knowledgeable about people and their past histories. However numerous signs were seen in people's bedrooms from family members giving instructions to staff. An example such as, 'Carers please do not put jumpers or cardigans in the wash' was seen stuck to a person's wardrobe. Another person had a sign on their door asking for it to be kept shut as they found it 'drafty.' This door was left open. If staff understood people's needs and preferences, and families were confident, these signs would not be

required.

People's rights under the Equalities Act 2010 were not always identified or supported. During our conversations one person identified with one of the protected characteristics of the act. They told us that they felt having 'special friends' and 'private time with them' was, "Most definitely not allowed." They explained that their understanding was that only your spouse or relatives were allowed to visit you in your room. Other residents either of the same sex or opposite sex where not allowed in their room. Throughout the day staff did not knock before entering people's rooms and doors were left open, even if a notice on the door instructed them to keep it shut. Therefore, if a couple wanted to have a private moment, the actions of the staff were prohibiting this. We spoke with the registered manager and area manager about this. At the start of the inspection they had told us that there was no one living at Coppice Lea who came from the lesbian, gay, bisexual, transgender (LGBT+) community. They took immediate action to review their equality and diversity provision to begin to address these issues.

People were not always treated with dignity and respect by staff. The provider's systems around equality and diversity did not ensure that people's needs had been met. This is a breach in Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Aside from the examples above we also saw some good care and positive interactions between staff and people during the day. Permanent staff were seen to sit with people and take the time to talk with them. They laughed and joked with people in the main lounge. During the resident meeting with the registered manager the views of people were gathered. One person wanted to make the same point repeatedly. This was effectively managed by the registered manger in a respectful way. The registered manager acknowledged the person's remarks and reminding them politely that it was somebody else's turn to speak. One of the offices had a stair gate across the doorway with the door open. People felt free to stop by and talk to the staff and not cross over the threshold into the office (as there may be confidential information present). Staff members came to them to hold the conversation, so the people did not have to raise their voices to be heard, and could see the staff clearly. One person had a dedicated table in the lounge. Cleaning staff showed respect as they took care to not move things from their given place on the table.

People were not always given information about their care and support in a manner they could understand. An information board in the hall showed the correct date, weather, house announcements and any birthdays. This was not well positioned for people to see as it was in a corner in the stair well and a hoist was in front of it. Information boards are key in letting people know what is happening in the home, as well as for orientating people to the date and time of year. Other important information such as evacuation signs in people's rooms were in small print so may be difficult for people to read. Staff had also not considered positioning of information and items in some people's rooms. One person who had to stay in bed had photographs on the wall. We asked if this was their family and they said they thought it might be, but as they were so far away they could not see them.

It is recommended that the provider review how information is given to people to ensure it is in a format they can access and understand.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. At the beginning of the inspection the registered manager informed us that they had identified a problem with care plans, as they were not up to date. This had an impact because staff, especially agency staff that were present, may not have the correct information to support a person. Care plans were large files with conflicting or out of date information. One care plan on how to help a person mobilise stated that the person needed two care staff to assist them. It also detailed the type of hoist and sling that was required. However, in another section of the care plan it recorded the person had a hip replacement, and that staff needed to take care when moving the person to minimise pain. This was not contained in the care plan for how to mobilise them. There was a notice in this person's room which stated "Do not pull on [person's name] knees to roll them over as you will damage his hips. This information was not in the care plan. The same person had a care plan which addressed the risk of pressure ulceration. It stated that they should be repositioned every two to four hours. This was being done and recorded correctly. However, the plan stated that they should have the, 'right positioning' but did not state what this position was. It did not address the risk of moving to their hips or how to avoid or minimise causing the person pain.

Another person had a sight and hearing care plan. This recorded that the person had hearing aids but did not use them. It recorded that this came from, 'the previous placement.' It stated that the person's hearing was fair but there was nothing in the notes regarding their reasons for not wearing the hearing aids or why this was or whether this had been discussed with family or any action taken.

Where care instructions had been correct and up to date, staff did not always follow them to ensure people received the correct support. One person had a nutritional assessment and regular Speech and Language Therapist (SaLT) and dietician assessments. This resulted in very specific instructions on how the person needed to be supported to eat and drink in a safe way. The most recent dietician assessment stated that the person should be assisted to eat with a teaspoon and staff should interact with them while assisting them to eat. The SaLT assessment instructed that the person was slow-swallowing and needed to be given time when eating and drinking. We saw the person being assisted to both eat and drink. Staff used a large spoon which was the opposite of the guidance instructions. When we pointed this out to the staff member they said, "Oh yes" but continued with the large spoon. The person was given thickened tea with a teaspoon, as per the guidance. However, the staff member did not wait for each mouthful to be fully swallowed prior to the next spoonful being given. This meant there was a risk of aspiration. (This is the accidental sucking in of food particles or fluids into the lungs.)

Some care plans were out of date. For example, one care plan stated the person liked to spend time with other people and was on a normal diet. The person was now bed-bound and was no longer able to swallow. Some care plans had been written nearly three years ago. Although some changes were made and additional information was recorded in people's care review notes this information had not always been used to update the care plan. There was a risk that information on care and support would be missed by staff as it was not easy to find.

People had an inconsistent experience with regards to helping make and review their care plans. There were care plans of people who had been admitted with minimum verbal communication. These had been written by staff in the first person, such as 'I like' or "I prefer". It was evident that the words used were not the person's own. On some care plans there were crossing outs, changes made and some of the hand writing was hard to read. Changes to care records were not always signed and dated. One person's activity care plan stated, "I like my own company." This was crossed out and then stated, "Likes socialising, likes to be in communication." There was no record how this turn around came about, or if the person had been involved in the process. Other people could tell us about their care plans and told us they felt staff had consulted them.

Failure to provide care and treatment to people that was appropriate, met their needs and reflect their preferences was a breach in Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to some activities to keep them entertained and stimulate their minds. People who could access the communal areas told us they enjoyed activities on offer. Activities were more prevalent in the morning and quieter in the afternoon. People told us about seaside trips, a candle light evening, and a BBQ held in the grounds last weekend. There were also a 'Gentleman's Club' and 'Ladies Club' which ran on alternate week. Other clubs included reading, movies, art, gardening and knitting. These were spread over the course of the week, including the weekends so there was always a coordinated event for people to take part in if they wished.

People were not always supported by staff that listened to or respond to complaints. Prior to the inspection we had been contacted by a relative concerned with the care of their family member. They told us they felt staff were not listening to them or acting to address their concerns. We discussed this with them during the inspection, and with the registered manager and area manager. The staff felt they had done everything they could to support the person and address their complaint. However, the action taken by the management had not been followed by the care staff. The registered manager said that they had dedicated specific staff to support the individual due to their support needs and to support the family member with their concerns. None of these staff were on shift at the time of the inspection. The relative's complaint had therefore not been addressed to ensure their concerns had been responded to.

The provider had not taken effective action to ensure complaints had been resolved. This is a breach in Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of complaints had improved between July and August 2018 with the support provided to the registered manager by the provider. The three complaints received during this time had been reviewed and the registered manager had contact with the people involved. They had discussed people's concerns and acted to address the issues raised.

There was a complaints policy in place that was clearly displayed around the home. The policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman.

People were supported at the end of their life to have, as far as possible a dignified and pain free death. Relatives told us they felt staff had responded well to support their family members at the end of their lives. A relative said, "The staff have been very helpful, very supportive and are taking great care of my family member." One person who was being supported through this process said, "The care I receive is second to

none, it starts at the top, there is good leadership. They have a good team".

End of life plans had detail and had been kept up to date. One end of life plan stated that it was the person's wish to not be admitted to hospital and "not to prolong the inevitable". It also stated that they would like the curate {name} to be present. The persons family were present during the inspection and were happy to talk with us. They told us they were kept informed and were fully aware of the situation. The palliative care team had been involved and their family member appeared very peaceful and comfortable. The staff at the home had achieved a gold award in the National Gold Standards Framework (GSF). This is a model of good practice that enables a 'gold standard' of care for all people who are nearing the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

Records of people's care and support needs needed to improve. Throughout the inspection we identified many concerns with the quality of information in care records and their completeness. We have demonstrated the impact this has had on people and the standard of care throughout this report. The home had a number of agency staff in place and accurate record keeping is a key requirement to ensure they and regular staff have up to date knowledge on people's daily carer and support needs.

Quality assurance processes and management oversight had not been effective at ensuring people received a good standard of care. A number of key staff had left the home during the year since our last inspection. As a result, the registered manager's focus had been on 'firefighting' day to day issues, rather than coordinating and managing the home. Audits to assure quality had been completed but many of these had ceased in February 2018. This had been identified by the provider, and action to re-implement them began in July 2018. However, this gap had meant shortfalls in staff practice across all five of the areas we looked at (Safe, Effective, Caring, Responsive, and well Led). As such the home was not able to maintain a good level of care and support to people at the time of the inspection.
The Caring Homes provider audit had identified issues with fluid charts, wound care documents, weights and turning charts, MCA assessments, and risk assessments for bed rails. Evidence action has been taken from last visit was seen during this inspection. However, they had not identified the issues with regards to staffing and how staff were not always meeting people's needs.

As the provider had failed to maintain complete and contemporaneous records in respect to people's care, decision taken in relation to their care, and the treatment provided there was a breach in Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Additional management support from the provider was in place at the time of the inspection. This included registered managers and registered nursing staff from the providers other care homes. The regional manager was also overseeing to assist in the improvement process. During and after the inspection we received regular updates from the area manager detailing how our concerns were in the process of being addressed. For example, 'dementia friendly' signs had been ordered, staff were retrained in dignity and reissued 'dignity cards' to give guidance on acceptable behaviour.

The registered manager and the staff team worked in partnership with other agencies to help improve the service people received. The local pharmacy had completed a medicines audit in July 2018 and both actions that had been raised had been resolved by the staff team. The provider was in the process of working with the local NHS Continuing Healthcare (CHC) team on the Commissioning for Quality and Innovation scheme. This is a framework that supports improvements in the quality of services and the creation of new, improved patterns of care.

People and their relatives could attend regular 'Residents Meetings' to talk about the home and if they had suggestions to improve it. We sat in on the one held on the day of the inspection. There was a robust discussion of activities and events. An issue was raised around the type of music being played in the home. A

suggestion for more variety was made. The registered manager listened to that suggestion and noted it in the meeting minutes. The action that arose from this was that the music being played in the communal areas should be more varied. In addition, a further action came about as people had shown an interest in music. This was to ensure that one of the upcoming outings should be to a classical musical event. The registered manager asked the activities coordinator to look in to this. Other actions that had been completed included the purchase and use of hot plates to keep food warm while it was served.

Staff were also encouraged to give ideas and suggestions on how to improve the service. Staff team meetings gave an opportunity to discuss people and issues related to their care. It also gave the opportunity to share ideas that they thought would be useful.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The home environment did not meet the needs of people living with dementia. People were not always treated with dignity and respect by staff. The provider's systems around equality and diversity did not ensure that people's needs had been met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to provide care and treatment without determining the consent of the relevant person .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to assess and mitigate risks to people. Failure to provide care and treatment to people that was appropriate, met their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not taken effective action to ensure complaints had been resolved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain complete and contemporaneous records in respect to peoples care, decision taken in relation to their care, and the treatment provided .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to maintain staffing levels and had not deployed staff effectively. The provider had failed to provide suitably competent and experienced staff