Ideal Carehomes (Number One) Limited

Coppice Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6, 7 and 12 October 2016 and was unannounced. Coppice Lodge is run by Ideal Care Homes (Number One) Ltd. The service is registered to provide accommodation for up to 64 older people who require personal care. There were 33 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 17 people living upstairs and 16 people living downstairs.

We carried out an unannounced comprehensive inspection of this service on 15 June 2016. Breaches of legal requirements were found in relation to the safe care and treatment of people, safeguarding, consent to care and in relation to staff training and supervision. 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 which we received on 29 July 2016.

During the inspection on 15 June 2016 we also found a breach of legal requirements relating to good governance. We issued a warning notice against the provider and told them they must make improvements.

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

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coppice Lodge on our website at www.cqc.org.uk.

Although people felt safe in the service, people were still 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 still not planned for appropriately to ensure people received safe care and people's care records did not contain sufficient guidance for staff to minimise risks to people.

People did not always receive their medicines as prescribed and medicines were not always managed safely. Staff were not appropriately deployed in the service to provide effective care and support and this resulted in people receiving unsafe care.

We found that improvements had been made to recruitment procedures and safe practices were now followed. Although some improvements had been made to staff supervision we found that staff still did not always receive suitable training to help them carry out their duties effectively and meet people's varying

needs.

People who lacked the capacity to make certain decisions were still not always protected under the Mental Capacity Act 2005. People received support which was not assessed and planned for to ensure it was delivered in the least restrictive way. However when people had capacity they were supported to make decisions relating to their care and support.

People did not receive effective support with health conditions and were not consistently enabled to access healthcare services. In addition to this we found that people did not receive adequate support to eat and drink.

There was a continued lack of appropriate governance and leadership and this resulted in us finding ongoing breaches in regulation and negative outcomes for people who used the service. Improvements to the care planning systems planned by the provider had still not been made and this had a continued negative impact on the quality of care.

People who used the service and staff were offered opportunities to get involved in the running of the service and staff and people who used the service found the management team open and approachable.

We found multiple ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, safeguarding services users against abuse and improper treatment, staffing, consent and good governance.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Action was not taken to protect people from the risk of harm.

Risks in relation to people's care and support were still not assessed or planned for appropriately. People's care records did not contain sufficient guidance for staff to minimise risks to people.

Staff were not appropriately deployed in the service to provide care and support to people when they needed it.

People did not always receive their medicines as prescribed and medicines were not managed safely.

Is the service effective?

Requires Improvement

The service was not effective.

Staff still did not always receive suitable training or support to help them carry out their duties effectively and meet people's varying needs.

People who lacked the capacity to make certain decisions were still not always protected under the Mental Capacity Act 2005. People received support which was not assessed and planned for to ensure it was delivered in the least restrictive way.

People did not receive adequate support to eat and drink.

People did not receive effective support with health conditions and were not consistently enabled to access healthcare services.

Is the service well-led?

Inadequate

The service was not well-led.

There was a continued lack of appropriate governance and leadership and this resulted in us finding ongoing breaches in regulation and negative outcomes for people who used the service.

Improvements to the care planning systems imposed by the provider had still not been made and this had a continued negative impact on the quality of care.

People who used the service and staff were offered opportunities to get involved in the running of the service.

Coppice Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 15 June 2016 inspection had been made and to look at the overall quality of the service.

We inspected Coppice Lodge on 6, 7 and 12 October 2016. This was an unannounced focused inspection. The inspection team consisted of three inspectors.

The team inspected the service against three of the five questions we ask about services: is the service safe, effective and well led. This is because the service was not meeting legal requirements in these areas at our previous inspection.

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 our visit we spoke with six people who used the service and the relatives of four people. We also spoke with eight members of care staff, a senior carer, the deputy manager, the manager and the regional director. We looked at the care records of seven people who used the service, medicine administration records, staff training records and four staff files, as well as a range of records relating to the running of the service.

We observed care and support in communal areas. 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.

Inadequate

Is the service safe?

Our findings

During our previous inspection we found that people were put at risk as the systems and processes in place to safeguard people from harm were not always followed. During this inspection we found improvements had not been made in this area.

Although people we spoke with told us they felt safe living at Coppice Lodge, the systems in place to protect them from harm were still not being adhered to. One person said, "I feel safe, especially at night." Another person commented, "Safe, oh yeah, I didn't at first but I do now." The relatives we spoke with also confirmed that they felt their relations were safe at the home.

People were not protected from the use of avoidable restraint. We were informed by the deputy manager that no form of physical restraint was used at Coppice Lodge. However during our inspection we found that this was not the case. We observed one person who intentionally put themselves at risk of falling. A member of staff intervened and lifted the person back into their wheelchair and placed their arms around their torso, applying gentle pressure, until they stopped resisting. There was no care plan in place detailing this as an authorised type of restraint and so there was a risk the person was not being supported in the least restrictive way. This did not respect the person's rights and put both the person at risk of harm.

Although the staff we spoke with told us that they understood how to report safeguarding concerns and felt able to speak with the management team about this we found that in practice the correct processes were not always followed and this put people at risk of harm. For example, we spoke with a member of staff who told us that a person who used the service had recently thrown a hard object at them. The member of staff told us, "I didn't report it or anything, I'm not like that." We reviewed the person's care records and saw that there was no record of this incident. This absence of reporting and recording meant that this information could not be used to try and prevent future occurrences and placed other people who used the service at risk of harm.

We reviewed a safeguarding file which contained details of incidents that the management team had deemed to be of a safeguarding nature. We found that this was incomplete and did not contain details of all safeguarding incidents within the service. In addition to this it was not always clear whether or not the incidents had been referred to the local authority safeguarding team as required. Care records showed that one person missed two consecutive doses of medicine; the record stated that this was due to the pharmacy not delivering the medicine. Records showed that this omission had an impact on their physical wellbeing. The service manager, informed us that in their absence the incident was not referred to the local authority safeguarding team, we saw that there was no record of it in the safeguarding file and the incident was not investigated by the management team until we intervened. This failure to investigate safeguarding concerns and refer to the local authority placed people at risk of harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our June 2016 inspection we found that people were not always protected from risks associated with their care and support. We asked the provider to make improvements in this area. During this inspection we found that the required improvements had not been made and consequently people were placed at continued risk of harm.

People we spoke with told us they felt safe when staff supported them. One person said, "Oh yes, they (staff) always like to know that I have got this (walking frame) with me." Another person said, "I feel very safe, they are very organised here." Despite this positive feedback, we saw that risks to people's health and safety were still not properly assessed or well managed.

People were not protected from the risk of developing pressure ulcers. Pressure ulcer risk assessments had not always been completed correctly which meant that the support put in place for people may not have been sufficient. For example, one person's appetite had been assessed as being both 'Poor' and 'Good/average' in the two different assessments which were completed on the same day. A member of staff we spoke with confirmed that the person's appetite was poor meaning that the pressure ulcer risk assessment was incorrect. This may have resulted in inappropriate or ineffective control measures being put in place to mitigate the risk and put the person at an increased risk of developing a pressure ulcer.

We found that pressure ulcer risk assessments did not provide adequate detail on the measures put in place to reduce risks. One person who used the service required a specialist air mattress to reduce the risk of skin damage. Their care plan did not specify the required settings for the mattress. During our visit we found that the mattress was not set at an appropriate level for the person's weight which increased the risk of skin damage. Staff we spoke with were not aware of the correct settings for the mattress. We spoke with the deputy manager about this who was aware of the issue said it was something they were "trying to improve."

Care records were still not completed in a timely manner and this put people at risk of receiving inconsistent care. Staff were aware of who needed to be supported to change position, to reduce the risk of them developing a pressure ulcer, and we observed people being offered support to change position, however records of this were not always completed. This made it unclear how often people had their position changed and may have resulted in people not being assisted to do this as frequently as required. This put people at risk of further deterioration of existing pressure ulcers or development of new pressure areas.

People were still not protected from the risk of falls. The rationale for decisions made about equipment put in place to reduce the risk of falls was unclear and this placed people at risk of harm. For example, one person's care plan stated that they previously had a motion sensor in their room to alert staff to the potential risk of falls. We observed that this was no longer in place and the person's care plan stated that it had been removed as there was 'no use for it'. The risk of this person falling from their bed had not been formally assessed so it was unclear how or why this decision had been made. This person also had a health condition which potentially increased the risk of them falling from their bed. During our visit we observed that the person spent the afternoon in bed, although they had their call bell to hand there were no other measures in place to reduce the risk of them falling from their bed or lessen the impact of any fall. Regular checks were not in place and two staff members informed us that they just checked on the person as needed when they used their call bell. This placed the person at risk of falling and potential injury.

Staff still did not always have an understanding of individual risk factors and consequently did not respond appropriately to reduce the risk of people falling. For example, records showed one person had been assessed as being at high risk of falls. Their care plan stated that they walked with a stick but could forget to use it and that staff must prompt them in its use. We observed the person walking without their stick on three occasions in communal areas, staff were present but did not intervene to ensure the person's safety.

People were not always supported to move and transfer in a safe way. Care plans contained contradictory information relating to people's mobility which increased the likelihood of error. Whilst we observed that some people were supported with their mobility safely this was not always the case. For example, we saw a member of staff lift a person by pulling them up from under their arms, this is an unsafe method of assisting someone to move and put the person at risk of injury.

We found that care plans did not provide sufficient information about people's current needs or provide staff with guidance on how these should be met. For example, the information contained in one person's care plan did not accurately reflect how their needs had changed due to deterioration in their health and well-being. We observed that the person was supported by staff to transfer from a wheelchair to chair because they were no longer able to do so independently. However, their care plan stated that they were able to walk short distances with support from one member of staff. During our visit a significant number of staff were within their first two months of employment at Coppice Lodge and consequently this lack of accurate information in care plans placed the person at risk of receiving inconsistent and unsafe support.

Risks associated with people's health conditions were still not managed safely. For example, one person had a condition which caused them to have seizures and there was a lack of assessment for this risk. Their care plan did not contain any information about the type or frequency of seizures, any rescue medicines prescribed or detail when emergency services should be contacted in the event of seizure. We saw that the person spent the afternoon in their bedroom and regular checks were not in place to ensure their safety. Furthermore staff did not all have a good understanding of how to support the person. One member of staff told us, "We cover it (health condition) in the two weeks (induction) it gives you enough knowledge to support [person]." However they were unable to describe how they would support the person in practice or when to call the emergency services. We asked another member of staff about care plans relating to this health condition and they told us, "Is there guidance? I honestly couldn't tell you. We don't get time to see the care plan or see if it's updated. We sometimes get told, but not always." This placed people at risk of receiving unsafe support.

Some people communicated with behaviour which may challenge staff. We found this was not being assessed or planned for appropriately and the information in people's care plans about how to safely support them was limited. Some care plans did not contain any reference to behaviour or specify how staff should respond. For example we saw incident records for one person which showed that their behaviour had put staff and others at risk of harm. The person's care plan did not provide staff with guidance about how to support them if they became physically aggressive. A member of staff told us they felt that they were unable to meet the person's needs safely. This placed the person and other people who used the service at risk of harm.

People could not be assured that they would be given their medicines as prescribed. One person had not received a pain relieving patch in line with the prescriber's instructions. The prescription label indicated the patch should be changed every 72 hours. However, on four occasions in the two months prior to our inspection the patch was not changed as frequently as directed. This meant that the person was not receiving effective pain relief during these periods. Records for another person using the service showed that they became unwell after missing their medicine for two consecutive days. The record stated that this was due to the pharmacy not delivering the medicine, however there were no records to show what the staff team had done to chase up this medication.

We checked the medication administration records (MAR) and saw that in most cases 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. However one person's MAR was confusing. Due to an

anomaly with the start date of the person's medicines some errors had occurred. Medicines had been signed for but not administered on one occasion and on another day no records had been made at all. This meant it was not possible to check that the person had been given their medicine as prescribed. We also found that when people were prescribed creams for topical application there were not always clear details of how, where and why these creams should be applied and staff did not always record the application of these creams.

During our June 2016 inspection we found that people could not always be assured that their medication would be administered by competent staff. During this inspection we found that although some improvements had been made further improvements were still required. We saw records to show that senior staff had their competency to deliver medication assessed within the past six months. However where concerns had been identified about a staff member's competency there were no clear records of action taken to remedy this.

Medicines audits were completed monthly; however these were not effective in identifying issues as the most recent audit did not identify the issues we found during our inspection.

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

Following our inspection the provider informed us that action was underway to review all care plans and risk assessments and that action had been taken to implement more effective measures to ensure the safe handling and administration of medicines.

Most people we spoke with felt that they were supported to take their medicines safely, one person told us, "They (staff) always make sure I have my medication, they give it me every morning at breakfast." However on the morning of our inspection we heard several people complain that they had not received their medicines on time. We observed that the morning medicines round did not finish until shortly before lunch time. The staff member acknowledged that it had taken longer than normal because they were working alone due to an unplanned sickness. Despite this the staff member ensured that any time specific medicines were administered at the correct time and supported people in a safe and patient manner to take their medicines.

Medicines were stored safely in a locked trolley which was kept in a locked room. Staff regularly checked the temperature that medicines were stored at and we saw that the temperatures were within an acceptable range. Controlled drugs were safely stored in a locked cabinet.

The people we spoke with told us they felt there were enough staff. One person said, "Yes I think so, they pop in to say hello." The relatives we spoke with also felt there were enough staff to meet people's needs. One relative said, "There is always a carer in the lounge when I visit."

The staff we spoke with provided mixed feedback about staffing levels. One member of staff told us that staffing levels were normally sufficient, but acknowledged they had struggled on one day of our inspection due unplanned sickness. Another member of staff told us, "If everyone is in it works brilliantly. But if we are supporting our other service and staff ring in sick it leaves us short and puts pressure on the staff." A third member of staff told us that staffing levels sometimes meant it was difficult to meet people's needs in a timely manner. Three staff we spoke with talked about having 'floating' staff between both floors and how this helped. They also said that deputy managers were good at supporting when needed.

The deputy manager described staffing levels on the day of our inspection as "good" but stated that this was not always the case. They explained that staff from Coppice Lodge were frequently transferred to support another local Ideal Carehomes (Number One) Limited service and this impacted on staffing levels at Coppice Lodge. We reviewed staffing rotas which showed unplanned sickness, and the transfer of staff to the other service meant that shifts were not always staffed to the level determined by the provider.

During our inspection we observed times when staff were stretched and struggled to meet people's needs in a timely way. During the morning staff were very busy supporting people to wash and change and then making their breakfast. We saw that some people were still eating breakfast shortly before staff laid the tables ready for lunch. Staff had not completed paperwork for the care provided during the morning until lunchtime because they had not had time to do so. The morning medicines round did not finish until shortly before lunch time because there was only one senior member of staff instead of the planned two. Action was not taken to rectify this until we intervened and informed the deputy manager.

The deployment of staff on the day of our inspection placed people at risk of harm and we observed occasion's where staff were not able to respond to mitigate risks. For example a member of staff was left alone in the upstairs lounge with 12 residents. Two people who were present in the lounge were both at risk of falls and we saw that both people simultaneously put themselves in a risky situation. The member of staff was not able to respond to both people's needs which meant that one of these people was left to mobilise unaided. This placed them at risk of harm.

During our visit we observed that there were occasions when people were adversely affected by the behaviour of others. Sometimes staff were able to intervene and distract people in order to prevent an incident occurring. However, there were occasions when staff were busy elsewhere and could not intervene in a timely way. For example, one person frequently behaved in a way which could upset other people. This reduced when staff sat with the person, however this was not always possible as staff were often called away to assist other people. We spoke with one person who used the service who made it clear that this person's behaviour had an impact on their wellbeing. One member of staff told us that they could not always support people to stay safe because some people required more intensive support which meant they were not able to safely monitor other people.

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

Following our inspection the management team informed us that they had taken action to implement a new system for allocating staff dependent upon the needs of people using the service.

People could be assured that safe recruitment practices were always followed. 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.

During our last inspection we found that people were not adequately protected from risks associated with the environment. During this inspection we found that improvements had been made in this area. People lived in an environment that was well maintained and free from preventable risks and hazards. Regular safety checks were carried out, such as testing of the fire alarm, and measures followed to prevent the risk of legionella developing in the water supply. Staff reported any maintenance requirements and these were

resolved in a timely manner.

Requires Improvement

Is the service effective?

Our findings

In our June 2016 inspection we found 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. We asked the provider to make improvement in this area. During this inspection we saw that although some developments had been made further improvements were still required.

People received care and support from staff who still did not have the skills and knowledge to support them safely. During our inspection we observed that staff were not always effectively utilising the training they had received. For example although records showed that many staff had up to date moving and handling training we observed one person being supported to mobilise in an unsafe manner which demonstrated that staff were not applying their learning. We also found that although some staff had MCA training staff knowledge in this area was variable.

The staff we spoke with told us they had received training which they felt was of good quality but identified that they would like more training. One member of staff told us, "I've enough (training) but I've not had any training refreshed. They need to make sure they get everyone refreshed." Another member of staff told us, "I'd like more training on how the care plans work. What goes where and how to build them up." Training records showed that staff had not been provided with any training in this area and we found significant issues with the quality of care plans during our inspection.

We also found that not all staff had an understanding of health conditions people lived with. The staff we spoke with could not always demonstrate how they would respond should a person present symptoms relating to their healthcare conditions and records showed that staff had not had training in relation to specific health conditions. We asked one member of staff about training they had in relation to a particular health condition experienced by someone at Coppice Lodge and they told us, "I've not had training here (about health condition) that I can remember".

Since our last inspection training records had been updated and this showed that more staff now had training in relation to specific areas of safe working practice; however there were still gaps in important training such as safeguarding and the MCA. We spoke with the deputy manager who explained that they had experienced some issues with releasing staff to complete training but that they were hoping to rectify this.

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

When we inspected the service in June 2016 we found that people's rights under the Mental Capacity Act (2005) (MCA) were not protected. 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 MCA were not always protected. 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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not protected as the principles of the act were still not correctly applied. Whilst staff had completed capacity assessments for some people, this was not always the case. 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.

One person's care plan stated the person's capacity 'fluctuated', but the person's care plan did not contain any further detail about how to support the person with decision making to maximise their capacity. Another person was not able to consent to the content of their care plan and other aspects of their care and treatment, but there were no MCA assessments relating to this. A consent form had been signed by the person's relative 'on behalf' of the person but there was no indication that this relative had any legal powers, such as a Health and Welfare Power of Attorney, to provide consent on behalf of the person.

Staff knowledge of the MCA was variable. Although some staff demonstrated an understanding of the MCA, for example one member of staff told us, "Just because someone has dementia doesn't mean they don't know what drinks they like", not all staff were able to adequately describe how the act applied in their role. Another member of staff we spoke with explained that they were relatively new to the role and had been given basic information about the MCA in their induction. When asked about the capacity of the people they supported they described people the in upstairs dementia unit as, "Able minded". Our observations and other discussions confirmed that a significant number of these people lacked the capacity to make complex decisions. This put people at risk of not being properly involved in decisions relating to their care and support and did not protect their rights under the MCA.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although the management team had an understanding of DoLS, we found that some people were being deprived of their liberty without the necessary application to the local authority having been made. For example, one person was being seated in a recliner chair because they had repeatedly fallen out of an armchair. This restricted their freedom because they needed assistance from staff to raise the armchair and get out of it. They did not have the capacity to consent to this arrangement and no application had been made to authorise this restriction on the person.

In addition to this there were other people who used the service whose care and support may be considered a deprivation of their liberty, however the appropriate authorisations were not in place. For example, a number of people lacked the capacity to consent to their care, had their freedom restricted by locked doors and were either under the continuous supervision of staff or had equipment in place that continuously monitored their movements.

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

Following our inspection the provider informed us that action had been taken to put decision specific MCA assessments in place and make referrals for DoLS where appropriate.

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 they felt in control of their care and that staff always asked for their consent before providing any support. One person told us, "I'm more or less in charge of what I do, unless I need advice and then I ask for help." Another person said, "They don't tell me what to do here." A relative of a person who had recently stayed at the service told us, "[Name] was always involved in decisions and given choice."

During our visit we observed that people did not always receive the support they required to eat a good diet. We saw that staff were busy assisting people to get washed and dressed and were not always available to provide the support people needed to eat well. For example one person was given a hot drink in a plastic beaker with a spout. They were not provided with support or prompting to drink and they then removed the lid from the beaker and spilt the drink on themselves. Their care plan stated they could eat and drink independently with some prompting. However, we observed this was not the case during our visit. Another person chose to remain in their room at lunchtime and was served a hot dinner. However, they were not supported or prompted to eat their meal and they did not eat any. They were then provided with a pudding which they only ate a small amount of. Additionally, meal times were not well spaced, for example, during the morning some people did not receive their breakfast until just before lunchtime. This did not facilitate effective nutritional intake. This meant people were not being supported with nutrition and hydration.

The risk of people losing weight was not managed effectively. For example, one person had lost over five kilograms in a six week period since moving into the home. Whilst staff had noted this weight loss, no clear action had been recorded to prevent future weight loss. This placed the person at risk of further weight loss.

We also found that food and fluid records were not always completed fully and there was a risk that they may be completed inaccurately. Food and fluid charts were being completed for people who had been identified as being at risk, however we saw that these were not completed in a timely manner which increased the risk of error and inaccuracies. We observed staff completing records up to four hours after mealtimes and heard staff discussing estimates of how much people had eaten for the previous meal. Although fluid charts were kept for people who had been identified as being at risk of dehydration these were not effective as they had not been fully completed and there was no evidence that the records were analysed to identify if people had consumed enough fluid.

The people we spoke with told us that they generally enjoyed the food and found it to be of good quality, one person told us, "The food is really good here and you can get snacks if you want. They (staff) always bring drinks and I can make drinks for myself if I want to." The relatives we spoke with were also complimentary about the food provided at the home.

Although some people told us they felt they had access to health care services when they needed it and we saw visiting health professionals on the day we visited, this was not consistent. Whilst we saw records to show that at times staff responded appropriately when people became unwell, and called their GP or district nurse, this was not always that case. For example, one person had lost a significant amount of weight however there were no records that attempts had been made to seek advice from a dietician or their GP. Another person's care records stated that the person's GP had recommended that they needed to be referred to a specialist health professional for a medication review. There were no further records related to specialist health professional input and we found no evidence that this referral had been made.

People could not always be assured that they would receive effective support with health conditions. People's care plans did not consistently provide an adequate level of information to enable staff to provide effective support nor did they contain guidance for staff on how to recognise that a person's health condition may be worsening. For example a member of staff informed us that one person had a serious health condition, however this was not recorded anywhere in their care plan which meant there was no information for staff about the condition and how it affected the person. Another person's assessment documentation recorded that they had a health condition and again there was no further information related to this in their care plan. This lack of information meant staff may not realise if people's health conditions deteriorated and posed a risk that people may not be enabled to access support from external health professionals if needed.

Following our inspection the provider informed us that the training plan had been updated and staff had been booked onto a programme of face to face and eLearning which included MCA, care plans and specific training related to health conditions experienced by people who lived at Coppice Lodge.

During our previous inspection we found that staff did not always have regular supervision and support. During this inspection we found that improvements had been made in this area and staff now received regular supervision with their line manager. We saw records which confirmed this to be the case and staff told us they felt well supported.

Inadequate

Is the service well-led?

Our findings

During our previous inspection we found that the registered provider had failed to implement an appropriate governance and risk management framework which resulted in us finding risks to the health and safety of people who used the service. We took action against the provider and issued a warning notice to ensure that improvements were made in this area. In this inspection we found that the improvements necessary to meet the warning notice had not been made.

The ongoing lack of effective leadership and governance at Coppice Lodge resulted in negative outcomes for people who used the service. Despite action taken by CQC, adequate steps had not been taken to alleviate risk and ensure service users health and wellbeing was maintained.

Despite the seriousness of the ongoing issues at Coppice Lodge the provider was not aware that the required improvements had not been made and we found there was no clear process for tracking progress made following our June 2016 inspection.

Audits completed by the provider were ineffective and had not picked up on issues identified in our inspection or indeed the failure to comply with the action plan submitted to CQC. We saw records of an audit visit undertaken seven days prior to our inspection, by the provider's compliance manager. This visit looked the quality of the service in areas such as accidents and incidents, audits, medication, occupancy, the business and staffing. This did not identify significant issues found during our inspection such as the failure to ensure the safety of people using the service or to respect their rights under the MCA and as a result action was not taken to resolve these issues. We discussed this with the regional director who informed us that the last visit by your compliance manager was not intended as a full 'compliance audit' more of a "pop in to see how things are going." This was not an adequate level of monitoring given the issues found at our June 2016 inspection.

We found a continued failure to implement robust systems for monitoring the quality of the service, in particular, for periods where there was no manager in place. At the time of our inspection there was a significant reduction in management staff due to a combination of planned and unplanned leave. No action had been taken to implement any interim management support despite the known issues with service and the planned leave of management staff. There was also no evidence that the frequency of visits from the provider had increased during this period to account for this. During our visit we observed that there was limited management presence in the communal areas of the home and this meant that the staffing issues we identified earlier in the report had not been noticed until we intervened.

Although there was some evidence of improvements to auditing and quality assurance processes the quality and quantity of audits had not been sustained in the absence of the manager. An analysis of accidents and incidents had been completed monthly and we saw that this had previously been effective in identifying patterns and ensuring action was taken. However we found that this had not been fully completed for the previous month. Other management audits had also been missed in September including a weight loss audit and we saw evidence that this resulted in action not been taken to reduce risks. For example one

person lost a significant amount of weight since moving into Coppice Lodge however records showed that no action had been taken to address this and a lapse of audits meant this had not been identified and this placed the person at risk of further weight loss.

Care plan audits were not effective in identifying issues and this put people at risk of receiving unsafe care. One person's care plan had recently been audited by a member of the management team and no issues had been noted. Consequently there were no actions for improvement recorded. We reviewed this care plan and found significant errors, omissions and contradictory information including a missing risk assessment. This meant that the risks associated with the person's care had not been properly considered and put the person at risk of harm. Had the audit have been completed effectively this would have been identified.

We found no evidence of any action taken by the provider improve the quality of care planning and risk assessment systems despite clear detail of deficiencies being provided in the warning notice issued in June 2016. As a result of this we found people were being placed at risk of harm due to a lack of effective care planning and risk assessment and this also contributed to continued failings in ensuring that people's rights under the Mental Capacity Act 2005 were protected.

There were insufficient processes in place to ensure that adequate assessments were undertaken when people moved into Coppice Lodge and this put people at risk of harm. One person had moved into Coppice Lodge at the end of August 2016. We reviewed their care plan and found it to be incomplete. Numerous important parts of the care planning paper work were blank including the 'health and welfare' care plan, pressure ulcer risk assessment and corresponding skin and pressure area care plan and the 'personal safety and security section' of the care plan. In addition to this we saw behaviour charts which showed that this person often behaved in a way that put other people who used the service at risk. There was no detail of this in their care plan. This put the person at risk of receiving inconsistent and unsafe support which may have led to harm to the person, staff and others.

In addition to the above we also found concerns about other areas of governance during our inspection. Sensitive personal information was not stored securely. We saw that over ten files for newly recruited staff were stored on the reception desk and were accessible to other staff, people who used the service and visitors. This was a breach of security under the Data Protection Act 1998. We also found that cupboards containing care plans were left unlocked throughout the duration of our inspection. This meant that information relating to people's health and support needs could be accessed by people who used the service and visitors. This was a breach of confidentiality and did not respect people's right to privacy or promote their dignity.

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

Coppice Lodge is 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 manager has now applied to register with CQC and we will monitor this. The provider also informed us that they have recently developed a new role of 'care manager' to strengthen the management team at Coppice Lodge.

During our previous inspection in June 2016 we found that the provider had failed to notify CQC of significant events. Providers have a legal obligation to notify us of such incidents. During this inspection we found that there had been a continued failing in this area. For example we found that we had not been notified of all safeguarding incidents within the service. We spoke with the manager about this who told us

that they had not fully understood their responsibilities to notify CQC and assured us that appropriate notifications would now be made.

At our previous inspection we found that the provider did not have systems in place for involving people, families or staff in the design and development of the home. During this inspection we saw improvements had been made in this area. We saw records of staff meetings for July and August. These were well attended by staff and were used to provide feedback, discuss issues and concerns and come up with new ideas and suggestions. Since our previous inspection a social committee for people living at Coppice Lodge had been established by the management team. Records of meetings held in June and July showed that these meetings were primarily used to discuss activities and food.

People were happy living at Coppice Lodge. People who used the service and their relatives told us that they felt the culture and atmosphere at Coppice Lodge was positive and welcoming. One person told us, "I couldn't have found a better place." Another person said, "I'm very happy here for the moment." A relative told us, "We had high expectations for care and those have been met. [Relation] said they were happy here."

People and their relatives felt comfortable raising any issues they had. We spoke with a person who lived at Coppice Lodge and they told us, "I would talk to one of the staff or seniors if I had a problem. It's well organised and I don't have a problem." One relative said, "I have raised problems and everything is sorted now."

Staff told us that they were happy working at Coppice Lodge and felt supported by the management team. They were aware of their duty to whistleblow on poor practice and felt confident in raising any concerns with the management team. Staff were positive about the manager. One staff member commented, "Things are a lot better now under (the manager)." Another person said, "You couldn't ask for a stronger person (than the manager)."

Throughout our time at Coppice Lodge the management team were open, honest and receptive to feedback. Following our inspection the management team took swift action to develop an action plan based upon the feedback we shared. The regional director also informed us about improvements which were being made to a number of organisational systems and processes such as the analysis of accidents and incidents and the introduction of a 'root cause analysis' tool to better understand the reasons for incidents. However, it is of concern to us that this action was not taken following our last inspection when we identified concerns and took action against the provider.