Ideal Carehomes (Number One) Limited

Coppice Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 28 April 2016, it was an unannounced inspection. When we last inspected the service on 26 and 27 November 2015, we found a breach of the legal requirement related to staffing levels. We took action against the provider to ensure that they took action in this area. We also received additional information of concern following our previous inspection.

We undertook this focused inspection to check whether or not the service now met legal requirements and to address the information of concern we had received. This report only covers our findings in relation to this requirement and what we found in relation to the concerns raised. 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.

Coppice Lodge is run by Ideal Care Homes (Number One) Ltd. The service is registered to provide accommodation for 64 older people who require personal care. There were 22 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 13 people living upstairs and nine people living downstairs.

There was no registered manager for the service. A representative of the provider informed us that they had appointed a manager who they planned to put forward for registration as manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements had been made to staffing levels at Coppice Lodge and further improvements were planned. We saw that most shifts were fully staffed to the level determined by the acting manager. However, we found that staff were not always effectively deployed and people told us that there were still not enough staff at times.

Medicines were not consistently stored and administered safely. Risks relating to the management of infection control were not always appropriately managed. There was no one responsible for ensuring infection control processes were adhered to.

Risks to people's health were not always assessed or planned for to ensure people received safe and appropriate care. There was no system for analysing and learning from incidents and accidents such as falls. This put people at risk of receiving unsafe care.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to safe care and treatment at the service. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were still not always receiving care and support in a timely way, due to ineffective deployment of staff.

Risks in relation to people's care and support were not always assessed or planned for appropriately. Accidents and incidents were not routinely analysed by the service.

Risks relating to the management of infection control were not always appropriately managed and medication was not always administered or managed safely.

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was done to check that improvements to meet the legal requirement planned by the provider after our 26 and 27 November 2015 inspection had been made and to look at concerns we have received since the last inspection.

We inspected Coppice Lodge on 28 April 2016. This was an unannounced focussed inspection. The inspection team consisted of two inspectors.

The team inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting a legal requirement in this area in 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 the visit we spoke with seven people who used the service, four relatives, four members of care staff, the cook, the laundry assistant and the quality support manager who was the acting manager. We also spoke with two visiting health professionals. We observed care and support in communal areas. We looked at the care records of four people who used the service, the medicine administration for seven people and staff training records relating to medication, as well as a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Risks relating to people's care and support were not properly assessed or planned for. People told us that staff supported them to reduce any risks to their health and welfare. One person said, "My legs are bad and I can't stand up on my own. The staff come by regularly to try and get me standing and moving around." However we found that care plans did not consistently contain clear information relating to risk and we saw that staff did not always provide people with the support they required to reduce risks.

One person's care plan identified that they required support to change their position every one to two hours during the day. We observed that this person had sat in the same position for two hours and 50 minutes and staff had not repositioned them. We asked a member of staff why this was the case and they told us the person normally, "asks to go to the toilet every hour or so but they haven't so far today." Staff had not encouraged the person to visit the toilet or change their position which increased the risk of them sustaining a pressure ulcer. We also checked the person's position change records which confirmed that staff did not always reposition the person within the suggested timescales.

We observed another care plan for someone who had a current pressure ulcer. The care plan did not detail the pressure relief equipment that was in place to reduce the risk to the person. We observed that this person had a pressure relief mattress; however it was not clear from the care plan which setting the mattress should be on. Although staff we spoke with were aware of the correct setting, a visiting health professional told us that the mattress had been on an incorrect setting on two occasions when they had visited. This put the person at risk of further deterioration of existing pressure ulcers or development of new pressure areas.

One person's care plan contained a section relating to food and nutrition as well as a nutritional risk assessment. The risk assessment identified they were at 'medium risk' of malnutrition. The care plan guided staff to weigh the person on a weekly basis and report any loss or gain to a senior or deputy manager who would contact the person's GP. We saw that the person had lost a significant amount of weight over a period of two and a half months; however this had not been reported to their GP. This placed the person at risk of malnutrition and further weight loss.

We looked at two care plans for people with diabetes. These care plans did not have adequate detail relating to this health condition to ensure that care and treatment was provided safely. Neither of the plans had any information relating to foot care or diabetic eye screening. One care plan identified that the person needed encouragement to limit their sugar intake to prevent their blood sugar becoming too high. However the care plan did not provide any guidance to staff on how to recognise the person's blood sugar may be too high or low and how to respond to this. We spoke with one member of staff who, despite reading the person's care plan, did not have an adequate understanding of how to support the person with all aspects of this condition. This presented a risk that people may not be supported with this health condition in a safe way.

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

Incidents and accidents were not routinely analysed. This meant that there was no method of identifying patterns of events such as falls and consequently no clear way of taking action to mitigate such risks. This was confirmed by the acting manager. Therefore steps were not taken to minimise the risk of further falls and placed people at risk of preventable harm.

During our previous inspection of this service in November 2015 we found that improvements were needed in respect of staffing levels in order to ensure people received care and support when they needed it. We told the provider they must make improvements in this area. During this inspection we found that some improvements had been made but that there were still further improvements needed.

People provided mixed feedback about staffing levels in the home. Four people living on the upstairs floor told us there were not enough staff, one person said, "No there are not enough staff, yes sometimes I have to wait." However another person told us, "I think there are enough staff, they always come quickly when I call for them." Two relatives also confirmed they felt that staffing levels were sufficient. During our inspection we activated the call bells in bedrooms and these were responded to in a timely manner.

Since our last inspection the provider had closed one area of the service where people who lived with a dementia related illness had resided. This was due to maintenance works. The staff we spoke with felt that current staffing levels were adequate to meet people's needs due to the low occupancy levels.

However staff were not always effectively deployed which meant that people did not always receive the support they needed in a timely manner. For example, we observed two people who were not supported to change their position within the recommended timescales. However, staff were present and available to provide this support. This put people at risk of developing pressure ulcers. We spoke with one person who had an appointment with a visiting health professional and was waiting for support from staff prior to the appointment. This person waited for two hours and was then supported five minutes before the time of their appointment. This meant that the person was unavailable when the health professional arrived and the health professional then had to come back later in the day.

Staff rotas showed that most shifts were fully staffed to the level determined by the acting manager. The provider had a system for calculating how many staff were required based on people's support needs. However this was not currently in use at Coppice Lodge as decisions about staffing levels were being made by the local management team. The acting manager explained that the reason for this was due to recent changes in the management team and the impact of ongoing maintenance works at the service. We saw that plans were in place to recruit a management team and additional staff.

Medication was not consistently stored and administered safely. When we arrived at the home we saw one partially dissolved tablet had been placed on a coffee table and not disposed of. This meant that the person may not have received their medicines as prescribed and placed other people at risk of taking medicine that was not prescribed for their use. We made the acting manager aware of this who took action to dispose of the tablet.

The service used blister packs to support the safe administration of medication. A blister pack is a special method of packing medicines, where each dose of medication is sealed in a small plastic bubble and organised by day. We observed two blister packs that had medication missing from the end of the pack. There was no record of why these medications were missing.

Each person had a medication profile which detailed medication taken, details of allergies and instructions on how the person preferred to take their medication. We saw examples of medication administration

records (MAR) that had been completed by staff with details of medications taken by people. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We saw that some MAR charts did not have details of how many tablets were left over from the previous months' sheet; in addition to this medication stock balance checks were not completed. This meant that the service did not always have a clear record of how much medication was held for each person. The above issues also made it difficult for the provider to check and audit medications.

Liquid medicines were not always signed upon opening. We saw one bottle of liquid medication that had been opened and kept for significantly longer than directed on the bottle. This put people at risk of being given out of date medicine which could potentially reduce the effectiveness of the medication.

Despite the above the people we spoke with told us that they received their medicines as prescribed and in a timely manner. One person said, "I get all of my tablets every day, no problem." We observed a member of staff following appropriate procedures in administering people's medicines. We saw training records which showed that staff had been trained to safely handle, administer and dispose of medicines. All staff who gave medicines to people had their competency checked yearly.

Infection control practices were not always followed. We observed that clinical waste bins were not secured and could be accessed easily from the road by the public. We saw that mattress protectors were damaged in four bedrooms which meant that mattresses would not be protected from spillages of body fluids and may put people at risk of infection. We were informed by the acting manager that new covers had been ordered. There was not a designated person with overall responsibility for infection control practice in the home. This meant that there was no one responsible for ensuring infection control processes were adhered to. We were told during our inspection that this was being addressed.

We checked the records relating to measures taken to reduce the risk of legionella developing in the water supply. The records showed that no flushing of water outlets had been carried out since 14 March 2016. At the time of our inspection, over half of the bedrooms and bathrooms were not in use. This meant that not all steps had been taken to reduce the risk of legionella developing in the water supply and this could pose a risk to people's health. The acting manager assured us that this would be acted upon.

The people we spoke with commented positively about the cleanliness of the home. One person said, "The cleaner does my room every day and it is spotless". Another person told us "they [staff] always wear gloves". A relative praised the organisation of the laundry staff and told us that they took pride in their work. We observed that the communal areas of the home were clean and hygienic and any spillages of food and drink were quickly cleaned. People's bedrooms and bathrooms were also cleaned on a daily basis. Bathrooms and toilets were free of clutter to ensure that areas could be more effectively cleaned.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks associated with their care and support. Regulation 12 (1) (2) (a)