Endurance Care Ltd

Coppice Lodge

Inspection report

66-68 Walter Nash Road East
Kidderminster
Worcestershire
DY11 7BY

Date of inspection visit:
10 April 2019

Date of publication:
22 May 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Coppice Lodge is a residential home registered to provide accommodation with personal care for up to eight people with a learning disability. There were six people living at the home at the time of our inspection visit.

The service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with a learning disabilities and autism using the service can live as ordinary a life as any citizen.

People's experience of using this service:
● Staff had not always detailed the full description of the food and drinks provided to safely meet people's needs.
● The management team were continuing to develop their quality checks, so they could be assured people with specific eating and drinking needs had these met effectively and safely.
● People were supported by staff who understood how to prepare and serve people their food and drinks so people could safely and comfortably enjoy these.
● People's care and risk plans guided staff in providing safe and consistent support to people when eating and, external professionals had been consulted.
● People received their medicine in a way which met their individual swallowing needs.
● The management of the home had changed since the last comprehensive inspection. The manager showed commitment and enthusiasm to implement the changes needed to improve staff practices so risks to people from choking were consistently managed and mitigated.

Rating at last inspection: At the last comprehensive inspection undertaken on 16 January 2019 the rating was Inadequate and the report was published on 5 March 2019. At this inspection the rating has not changed because our focus was on people who required care and support from staff to meet their swallowing needs and, mitigate the risks of choking.

Why we inspected: We undertook this focused inspection because we had received information of concern in relation to people who required staff to support them in reducing the risks of choking. As a result, the team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led, specifically linked to people with swallowing needs. This report only covers our findings in relation to this and therefore, the ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection. 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.

Enforcement: At the previous comprehensive inspection we identified five breaches of regulation of the

Health and Social Care Act (Regulated Activities) Regulations 2014. We issued an urgent Notice of Decision to impose conditions on registration and restriction on admissions into the home. We found the service was inadequate overall, and in the key questions safe, effective and well-led. The inspection identified five breaches of regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014. 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.

Follow up: We will continue to monitor the service through the information we receive until we return, as part of the inspection programme. If any concerning information is received, we may inspect sooner.

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.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Coppice Lodge

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of two inspectors.

Service and service type: Coppice Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager. 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.

Notice of inspection: This unannounced focused inspection visit took place on 10 April 2019 because we had received concerns about the management of people's choking risks.

What we did: We considered the information of concern we had received about the management of choking risks. We sought feedback from the local authority who worked with the provider. We used all this information to plan our inspection.

During the inspection visit: We sampled four people's care records, to ensure they were reflective of their swallowing needs and identified risks of choking, and other documents such as medicine records for four people. We looked at records relating to the management of people's choking risks such as quality checking systems and procedures.

Due to their needs, people could not provide us with any information about the care they received in relation to meeting their swallowing difficulties, or how the management team checked and assured

themselves risks to people were mitigated. Therefore, we used different methods to gather experiences of the care and support people were provided to mitigate the risks of choking. For example, we saw how staff assisted and supported people to eat their meals.

We spoke with three care staff, the manager, the regional operations manager and area operations manager.

After the inspection the area operations manager sent us additional documentation which included staff training.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management:

- At this focused inspection we reviewed this key question of 'Safe' because the Care Quality Commission [CQC] had received specific concerns about the management of choking risks. Therefore we specifically looked at how the provider managed identified risks to people from choking so the rating remains unchanged.
- At our last comprehensive inspection on 16 January 2019, we rated this key question as 'Inadequate'. The provider did not identify and address significant risks to people's safety and welfare. We found medicines were not managed safely, so people could be assured they would be provided with their medicines as prescribed. We also identified concerns regarding the environment people lived in and, infection risks as the provider did not have enough measures in place to reduce risks.
- A comprehensive inspection will be undertaken within six months of the last inspection report being published. This will be completed to look at the progress the provider has made regarding the required improvements identified at our last comprehensive inspection and to show they are meeting the law.
- At the time of this focused inspection visit there were four people who were at risk of choking due to their swallowing needs. Although the staff we spoke with understood people's individual swallowing needs the daily records were not always completed to accurately describe the meals provided. This meant it was not always possible to check the daily records to establish whether people's meals were safely prepared in line with their eating and drinking guidelines.
- One person required their drinks to be prepared in a specific way. This was so the person was able to safely enjoy their drinks and the risks of choking were mitigated. Although, staff were able to tell us about this person's needs the daily notes where staff documented how much the person drank did not include the specific way these were prepared.
- People's care plans contained risk assessments which reflected their swallowing needs. For example, where people were at increased risk by eating certain foods and or by how food items were prepared.
- Risk documentation also gave guidance for staff to follow in the preparation and management of people's eating and drinking needs. This included the provision of texture-modified food in line with the guidelines provided by speech and language professionals.
- The assistance provided by staff during their lunchtime meal reflected the guidelines in people's care documentation so risks to people from choking was mitigated. Staff sat with people at dining tables and care was taken to support each person with their meal, so their specific needs were met.
- Staff promoted people's safety in the way meals were prepared and served. For example, one person was provided with a sandwich which was cut into the sizes and texture they required. This was in line with the person's eating and drinking guidelines to mitigate the risks of choking. Another person had a hot meal which was of the consistency they required so they could comfortably and safely enjoy their meal.

● Staff used different techniques when assisting people so their safety while drinking was maintained. This included providing a person with small amounts to drink at a time to support their needs safely.
● Staff we spoke with told us they did refer to people's support plans and risk assessments for eating and drinking, and found the guidance was comprehensive. On this subject one staff member told us people's needs are detailed, "In the care plans and it says what they [person] needs and how to prepare it [meal] safely." Another staff member said, "We keep guidance in the kitchen and also in their [people's] care plans. We had a dysphasia course so if someone is choking we were shown two different movements to try and dislodge the food and then call the emergency services."

Using medicines safely:

● We did not look at all the provider's management of people's medicines at this focused inspection. However, we did sample the medicine of people who had swallowing needs.
● Where people required their medicine in liquid forms this was made available to them, so their needs and safety was maintained.
● We did identify a person who was prescribed a short course of antibiotics had these in tablet form. On checking this arrangement with staff, we were advised the tablets were crushed and put into food substances such as, yoghurts for the person's ease of swallowing. The management team advised us they had done this in the person's best interests in conjunction with the GP and speech and language therapist. We saw discussions with the GP and speech and language therapist had been recorded in the person's health action plan. However, this specific decision this was not followed through using the principles of the Mental Capacity Act. The management team told us they would act to ensure they are fully meeting this legislation.

Systems and processes to safeguard people from the risk of abuse:

● The management and staff understood their responsibility to safeguard people from abuse. Staff were confident the management team would act to protect people if they raised any concerns for people's safety. A staff member told us, "I have no concerns about anyone, I think we all know how the food has to be and if I saw a staff member doing things incorrectly I would stop the staff member and advise them then speak to the manager."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- At this focused inspection we reviewed this key question of 'Well-Led'' to specifically look at the concerns which had been raised with the Care Quality Commission about the management of choking risks so the rating remains unchanged until we undertake our next comprehensive inspection.
- At our last comprehensive inspection on 16 January 2019, we rated this key question as 'Inadequate' and we issued an urgent Notice of Decision to restrict admissions to the home. We found the provider did not have effective quality checking systems in place, so they were able to monitor and review all aspects of the service. Without effective governance systems the provider was unable to identify areas for improvement so people benefitted from effective monitoring to ensure they received quality care with their safety in mind. There were no reliable procedures in place to enable people to share their views and experiences to help shape and influence their care. Additionally, record keeping, and communication was poor and ineffective which impacted upon the quality of the service provided.
- A comprehensive inspection will be undertaken within six months of the last inspection report being published. This will be completed to look at the progress the provider has made regarding the required improvements identified at our last inspection and to show they are meeting the law.
- Since our last comprehensive inspection, a new manager has been appointed and they were working with the provider's senior management team to drive through improvements. The senior management team were aware the provider was required to have a manager registered with the Care Quality Commission. They advised us action would be taken to ensure the provider met the conditions of their registration.
- The management team had developed quality checking systems. We specifically looked at the management teams' oversight and governance arrangements in place to provide assurance people were provided with care and support to safely manage choking risks. For example, quality checks were completed by the manager to check staff competencies such as, with meal preparation, serving of meals and support for people during meals. This practice supported staff to maintain good practice and identifying staff practices which required improving. However, more time was required to ensure the improvements in staff practices in relation to managing people's choking risks were embedded and sustained in the longer term.
- The management team spoke about a weekly management report which monitors amongst other things, safeguarding incidents and maintenance. In addition, the management team had devised a dignity observation and supervision tool to provide another quality check. This included checking daily notes and meals, so the management team had another method of maintaining an oversight of the safety and quality of care people received to meet their eating and drinking needs.
- The manager was visible in the home and took a 'hands-on' approach as they supported staff and people

who lived at the home during the inspection. This included assistance at meal times. On this subject a staff member said, "[The manager] is firm but fair and is hands on, she helps on the floor and is very supportive. Staff morale has been very low due to all the changes, but [manager] is very encouraging and offers security. She has a lot of respect from the staff already."

● Staff told us they found the training provided was effective in supporting the knowledge they required to meet people's eating and drinking needs while maintaining their safety.

● Staff also said they felt supported in their roles and would not hesitate to report any unsafe care practices. A staff member told us, "Things are slowly changing for the better, there is more organisation and paperwork is a lot more detailed now."

● As reported in the key question of 'Safe' the daily records completed by staff were not always accurately describing the food and drinks provided to people with identified swallowing needs. However, the management team were developing quality checks on care documentation and assured us action would be taken to drive through continual improvements in record keeping.

Continuous learning and improving care:

●The management team showed they were responsive to the feedback provided at this focused inspection and were keen to continue to drive through improvements, so the provider could be assured people were receiving safe and effective care.