Coppice Care Burgess Hill LLP

Coppice Close

Inspection report

1-4 Coppice Close
Burgess Hill
West Sussex
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Tel: 01444247168

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12 January 2018

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 11 and 12 January 2018. The first day of the inspection was unannounced. On the second day of the inspection the management team, staff and people knew to expect us.

Coppice Close is located in Burgess Hill. The home provides support to people living with a learning or physical disability as well as people living with a condition on the autistic spectrum or an acquired brain injury. The care 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 learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy.

The home accommodated a maximum of sixteen people within four purpose-built bungalows. Each bungalow consisted of people's own rooms with en-suite facilities, a communal kitchen and lounge area, and there was a large garden that was shared between all four of the bungalows. On the day of our inspection there were seven people living at the home.

The home had a registered manager. A registered manager is a '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 home is run. The management team consisted of the provider, a registered manager, a quality assurance manager and senior support workers.

At the previous inspection on 1 December 2015 the home received a rating of 'Good' At this inspection, on 11 and 12 January 2018, we found that the home remained 'Good'.

People, relatives and healthcare professionals told us that people were safe. Comments from relatives included, "I would know if my relative was not happy or felt unsafe" and "My relative has not displayed any negative behaviour which tells me they must be safe and comfortable". The provider had ensured that staff were suitably trained to recognise when people were at risk of abuse and staff demonstrated a good knowledge with regards to the signs and symptoms to look for if they felt that people were at risk of harm. Staff had access to specific training to meet people's needs, such as positive behaviour support training and supporting people with learning disabilities and autistic spectrum conditions. Relatives told us that they felt that staff had the necessary skills to support their relatives.

People, relatives and healthcare professionals told us that staff were kind, caring and compassionate and our observations confirmed this. One person told us, "10 out of 10". Comments from relatives included, "The staff team are very good, my relative gets on with most", "Very good, my relative is very happy" and "My relative enjoys being there". Another relative described the staff as having "Endless patience". A healthcare professional told us, "Oh yes, they do their best".

There was a warm, homely, and friendly atmosphere. This was echoed in comments made by relatives who

told us that the home was a "Family environment" and had "A family-home atmosphere". People told us that they were happy, that they liked the staff and thought that they were fun. People smiled and laughed when telling us about the staff and it was clear that positive and warm relationships had developed and grown. People were supported when they became anxious or distressed and staff took time to support people in the community for drives or to local cafes to reduce their anxiety and escalating behaviours. People were treated with respect and were afforded privacy, their dignity promoted and maintained.

Independence was encouraged and people were supported to undertake daily living skills to encourage their independence. A relative told us, "The food is very good and they involve my relative in shopping and cooking".

People's needs were assessed and support was adapted to meet people's assessed level of need. Care plans were devised to capture people's abilities, needs and preferences and staff worked hard to ensure that these were incorporated into people's care. People's end of life care had been discussed and plans devised to ensure that people's wishes, at the end of their lives, could be respected and fulfilled.

People and their relatives were involved in discussions about people's care and were able to make their thoughts and suggestion knows. People were able to make a complaint and those that had been made had been dealt with according to the provider's policy. People and relatives told us that they would feel comfortable and able to raise concerns without the fear of repercussions. People and their relatives told us that people were asked their consent before staff supported them and our observations confirmed this. The management team and staff had an understanding about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and had worked in accordance with this.

The provider had a clear set of values which were embedded in the practice of staff. Quality assurance processes and audits monitored the practices of staff and the effectiveness of the systems and processes at the home. When shortfalls were identified and raised with the provider and registered manager they took immediate action to ensure that these were rectified.

People, relatives and healthcare professionals were complimentary about the management of the home. Comments from staff included, "The manager is very supportive, she does a great job of managing things, she works very hard and is very professional". Another member of staff told us, "It's miles better, really good now. They [the managers and provider] are awesome". A relative told us, "The home is well-managed and there has been a vast improvement over the last 12-18 months, it was more chaotic in the past but is much more structured now". There were links with other external healthcare professionals to ensure that staff learned from other sources of expertise and that people received a coordinated approach to their care.

People's healthcare needs were assessed and met. People had on-going contact with external healthcare professionals and records showed that staff had been responsive when people's health had deteriorated. Health action plans (HAP) enabled people's health to remain a priority and people had been supported to attend healthcare appointments to maintain good health. Staff had adapted their approach and had supported one person, who had a fear of healthcare professionals, to go to the café in the local hospital to enable them to become more familiar with the environment should they ever need to attend in the future. People had their medicines on time and were supported by staff that had received training and who had their competence regularly assessed.

People told us that they enjoyed the food and observations showed that people were provided with choice and could actively participate in shopping for and preparing food.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The home remains 'Good'.	**Good**
Is the service effective? The home remains 'Good'.	**Good**
Is the service caring? The home remains 'Good'.	**Good**
Is the service responsive? The home remains 'Good'.	**Good**
Is the service well-led? The home remains 'Good'.	**Good**

Coppice Close

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 11 and 12 January. The first day of the inspection was unannounced. On the second day of the inspection the management team, staff and people knew to expect us. The inspection team consisted of two inspectors. Prior to this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. We used all of this information to decide which areas to focus on during our inspection. We did not ask the provider to complete to a Provider Information Return (PIR) prior to this inspection, this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make.

During our inspection we spoke with four people, three relatives, three members of staff, the quality assurance manager and the registered manager. Prior to the inspection we contacted the local authority and subsequent to the inspection a physiotherapist, speech and language therapist, learning disability health facilitator and a GP were contacted for their feedback about the home. Two of these healthcare professionals responded. We reviewed a range of records about people's care and how the home was managed. These included the individual care records for four people, medicine administration records (MAR), four staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounges and in people's own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines. Some people were unable to verbally communicate with us; therefore 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.

The home was last inspected on 1 December 2015 and received a rating of 'Good'.

Good

Is the service safe?

Our findings

People and relatives told us that the home was safe and our observations confirmed this. When asked why people were safe, comments from relatives included, "I would know if my relative was not happy or felt unsafe" and "My relative has not displayed any negative behaviour which tells me they must be safe and comfortable".

People were cared for by staff that the provider had deemed safe to work with them. Prior to staffs' employment commencing, identity, employment history and security checks had been completed. Staff's suitability to work in the health and social care sector had also been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. There were further checks to ensure that temporary staff, who sometimes worked at the home, were suitable to work with vulnerable groups of people. The registered manager had obtained information from the agency that employed the temporary staff to assure themselves that suitable checks had been carried out. A healthcare professional told us, "It is frustrating on occasions; there has been a huge turnover of staff, which has made it difficult as a professional coming in as you have to rely on staff to tell you what has been going on". However, relatives and records showed that the use of temporary staff had decreased and that there was a core team of staff that knew people's needs well. People's needs had been assessed and staffing levels were aligned to meet those needs. Some people required one staff member to support them, whereas others, if accessing the community, required two members of staff. Staff rotas demonstrated that this had been considered and that there was sufficient staffing for people's needs.

Risk assessments for people's social and healthcare needs were in place and regularly reviewed. People were involved in the development and on-going review of care plans and risk assessments through monthly keyworker meetings. Each person's care plan had a number of risk assessments which were specific to their healthcare and social needs; these identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. Staff were made aware of risks to people's safety through verbal handovers, daily records and regular staff meetings, as well as having access to risk assessments, which were stored securely to maintain confidentiality. This meant that staff were aware of how to support people and were aware of the measures they needed to take to assure people's safety.

Accidents and incidents that had occurred had been recorded and monitored and relevant action had been taken to reduce the risk of the accident or incident occurring again. For example, a behaviour analysis spreadsheet had been implemented, this looked at all of the incidents that had occurred that were related to people's anxiety and behaviour. The spreadsheet monitored the type of behaviour and the causes and triggers, to enable the management team to have an oversight and identify patterns and trends. The results of this monitoring had been used to inform people's care plan and guidelines to ensure that staff were aware of how to support people in such a way so as to minimise situations that made people feel more anxious. There were also guidelines on how best to support a person and diffuse a situation when a person's behaviour and anxiety escalated. When people's needs had changed, risk assessments and care plans were updated to reflect changes in people's needs or support requirements.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment was regularly checked and maintained to ensure that people were supported to use equipment that was safe. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency.

People were protected from discrimination and harm. Observations showed that people appeared comfortable in the presence of staff. Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. Mechanisms were in place to raise people's awareness of their own personal safety and to enable them to raise concerns. Monthly keyworker meetings provided an opportunity for people to raise issues and discuss any concerns they had. The provider and management team had worked with the local authority when they had undertaken safeguarding enquiries and the management team had demonstrated a reflective approach to ensure that they learned from the outcomes of the enquiries to ensure people's safety. Records showed that the provider had been proactive and had raised safeguarding alerts to the local authority when they were concerned about people's well-being.

The home was clean and people were protected by the prevention and control of infection. Staff had access to infection control training and there were safe systems in place to ensure that the environment was kept hygienically clean. Staff undertook safe infection control practices; they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People, when appropriate, were supported with their continence needs and had access to hand-washing facilities. Personal protective equipment was available for staff to use to ensure that infection control was maintained and cross-contamination was minimised. Comments from relatives included, "It is clean and safe" and "The premises are in good condition".

People were assisted to take their medicines by trained staff that had access to relevant organisational policies and who had their competence regularly assessed. Observations demonstrated that safe procedures were followed when medicines were being dispensed and administered and people's consent was gained before being supported. When people experienced pain staff would offer them pain relief and records confirmed that this had been provided. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines and appropriate guidance for staff. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People, who were able, were encouraged to self-administer their own medicines and there were safe mechanisms in place to enable this. People told us that they were happy with the support received. Regular medicines reviews ensured that medicines to support people to manage their behaviour were monitored and their excessive use minimised. Appropriate documentation was in place so that information about people's medicines could be passed to relevant external healthcare professionals if required, such as when people had to attend hospital.

Good

Is the service effective?

Our findings

People and relatives told us that staff asked for people's consent before offering support and our observations confirmed this. People were provided with choice and were able to make decisions with regards to their day-to-day care.

The Mental Capacity Act 2005 (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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).

The registered manager and staff had an understanding of MCA and DoLS. DoLS applications had been submitted to the local authority when staff had recognised that people's freedom was being restricted. Some DoLS had been authorised and were subject to conditions imposed by the local authority. Records showed that the registered manager and staff had worked in accordance with these conditions. Staff ensured that practices that restricted people's freedom were minimised. When people demonstrated signs of apparent anxiety or distress, staff supported them appropriately, using distraction techniques and engagement as opposed to physical restraint to manage potentially challenging situations.

People were involved in day-to-day decisions that affected their care and staff ensured that they provided choice and asked people's consent before offering support. When people demonstrated signs that they did not fully understand or have the capacity to consent to some aspects of their care, the registered manager had sometimes involved people's relatives or their Lasting Power of Attorney (LPA). Best interests meetings had also taken place, involving relevant people and professionals, to ensure that decisions that were made on people's behalves were made in agreement with others and in people's best interests.

People's physical and mental health, as well as their social needs, were assessed prior to, as well as when they moved into the home. Assessments took into account people's abilities and skills as well as their needs and care was centred on these. Health action plans (HAP) documented people's health needs and demonstrated that people had regular contact and reviews with external healthcare professionals to maintain their health and well-being. These included GPs, dentists, consultants and speech and language therapists (SALT). People were treated fairly and had equal access to healthcare services. One person, who had an autistic spectrum condition, had a fear of healthcare professionals and hospital-type environments. Measures had been put in place for the person to receive home visits. Staff had also supported the person to regularly visit the local hospital to enjoy a drink in the café to support the person to become more familiar with the environment so that if their health deteriorated in the future, and they required hospital treatment, the environment would be familiar to them. Staff explained that this was a slow but necessary process to gradually build-up the person's confidence and allay their fears. Staff told us about an innovative approach that was being considered for another person to monitor their health through the use of technology. The

technology is used to monitor people who have complex long-term health conditions. A handheld device is used to monitor people's physiological observations and if concerns are shown they could then be treated before any conditions escalated.

People's healthcare needs were met. People and their relatives were involved in explanations and decisions about their healthcare needs. Relatives told us that they were confident in staffs' abilities to recognise when people were not well and to seek medical assistance when required and our observations and records confirmed that people received timely intervention from healthcare professionals when required. People's healthcare needs were monitored and reviewed on an on-going basis to ensure that the care that was being provided was meeting their needs.

People and relatives told us that staff were competent. Comments from relatives included, "They seem to be trained well", "They are on the ball" and "They seem very skilled and have a way of working with my relatives that works". A healthcare professional told us, "The staff I have been in contact with appear to be competent and have the skills to support individuals with complex needs. I have observed them advocating choice and delivering person-centred care". When staff were asked about access to learning and development opportunities, one member of staff told us, "We do get a lot of training, we recently had training in Autism awareness, it was really good and makes me more aware of why people might prefer set routines, it also helped me to understand why people can sometimes feel 'overloaded'". Staff that were new to the home were supported to undertake an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures as well as an orientation of the home, an awareness of the expectations of their role and the completion of the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. All staff had access to on-going learning and development to equip them with the necessary skills to support people effectively. In addition to completing the provider's core training, staff undertook courses that were specific to the needs and experiences of people that lived in each of the bungalows. For example, supporting people with learning difficulties, those on the autistic spectrum and promoting positive behaviour. Some staff held diplomas in health and social care or were working towards them.

People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive, however, could also approach the management team at any time. When asked if staff felt supported within their roles, one member of staff told us, "I am now definitely, they make me feel super-valued".

People's diversity was respected and people were treated fairly and equally. Person-centred and individualised care was promoted throughout the staff team. People were supported by staff that knew them, their needs and wishes, well. Technology was used to enable people to communicate with others and to promote their independence. People were supported to make telephone calls to their relatives and other types of technology, such as laptop computers and Kindles were used to occupy people's time. One person proudly showed us the work that they had been doing on their laptop, whilst another was observed looking at maps on their Kindle, something which they told us they enjoyed doing.

Regular meetings took place to share information on each person to ensure people were provided with appropriate care that was consistent. The sharing of information extended to external services and records showed that there had been good communication with external services to ensure people received coordinated care.

People told us that they enjoyed the food that was provided and had access to drinks and snacks throughout the day and our observations confirmed this. People were able to assist with meal planning, shopping and preparation to promote their independence and records documented people's level of involvement. One person's care plan informed staff that they enjoyed peeling potatoes and should be encouraged to do this. When people and relatives were asked about the food they told us that people were provided with choice and that there were alternatives available at short notice if they changed their mind about their original choice. Comments from relatives included, "My relative likes the food and helps with the cooking" and "The food is very good and they involve my relative in shopping and cooking". When meals were being offered, prepared and served, people were provided with choice and were observed enjoying their meals. Each bungalow had a dining room and most people chose to sit at the table, one person was not feeling well and staff were observed assisting the person to eat their meals in their armchair to maintain the person's comfort. Another person was provided with adapted cutlery, cups and a plate guard to enable them to maintain their independence and dignity whilst eating and drinking. People had a pleasant dining experience. Staff ensured that the mealtime experience was pleasant and took time to sit with people and enjoy meals with them. This created a sociable experience and staff and people could enjoy communicating with one another.

People were able to live in a homely environment that was suited and adapted to meet their needs. Some people used wheelchairs to mobilise and each bungalow had been made accessible with ramps, extra-wide corridors and doors. People had appropriate space to enable them to have time on their own in their own rooms as well as enjoy the company of others in the communal areas of the home. One person had a sensory impairment and fairy lights had been placed around the person's bedroom door and along the corridor walls so as to assist the person to navigate the building. A relative told us that the management team had been responsive to their relative's needs, they told us, "Staff have removed heavy furniture which had been a risk to my relative and replaced it with more suitable items". Each person had their own bedroom and en-suite bathroom and these too had been adapted to meet people's needs. For example, the provider had installed overheard tracking hoists so that people could comfortably and safely transfer from their wheelchair to the bathroom. People had been involved in the decoration of their rooms, some preferring a calmer, minimal space whilst others had personalised their rooms with decorations and memorabilia that was important to them. One person proudly showed us their room and smiled and laughed when communicating with us about the photographs and items on display. There was a large garden that people could use and each bungalow had access to the garden. Relatives told us about events that had been held in the garden in the warmer weather, such as BBQs where they could also meet other people and their relatives.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion from staff that knew them well. Warm and personable interactions were observed. Comments from people and relatives praised staff's caring attitudes. When asked what they thought of living at the home, one person told us, "10 out of 10". Comments from relatives included, "The staff team are very good, my relative gets on with most", "Very good, my relative is very happy" and "My relative enjoys being there". Another relative described the staff as having "Endless patience". A healthcare professional told us, "Oh yes, they do their best". Another healthcare professional told us, "Yes, during every visit I have witnessed care and compassion from all staff towards their residents. The staff appear to treat all of their residents with dignity and respect, using different approaches that suit the individual. Residents are encouraged to maintain their independence with activities of daily living, as well as accessing the community".

People told us that they were happy, that they liked the staff and thought that they were fun. People smiled and laughed when telling us about the staff and it was clear that positive and warm relationships had developed and grown. Staff were aware of people's needs, abilities and preferences and tailored their support to meet people's individual needs. Some people were unable to verbally communicate their needs, however, staff knew people well and it was apparent that they were able to interpret people's communication. Staff used different communication techniques to include people and enable them to communicate their needs. These included verbal communication, hand gestures and objects of reference. Staff told us and our observations confirmed that staff used people's possessions and activities that were important to them to encourage communication. For example, one person was holding a baby doll; the person clearly loved the doll and staff spoke with the person about the doll to engage the person in conversation. Another person had a love of art and staff worked with the person to create artwork and used this time to interact with the person. These differing forms of communication had a positive effect on people; they were observed smiling and were content and calm.

Staff had collated information about people's lives, backgrounds, interests, education and preferences. These were regularly reviewed and added to, so that when staff became more familiar with people and relationships developed further, the records could be updated to further inform other staff and ultimately enrich the positive relationships between people and staff. These mechanisms provided staff with an insight into people's lives before they had moved into the home. Deployment and allocation of staff was based on people's assessed level of needs and enabled staff to support people appropriately. Some people required two members of staff when being supported and staffing levels ensured that this was accommodated so that people could be supported in a way that maintained their dignity if they displayed behaviours that challenged. Staff were patient and supported people promptly when they showed signs on anxiety. It was clear that staff were proactive and supported people in a way that minimised people's distress, supporting people to go out for drives or to local facilities to de-escalate people's anxiety. Staff were compassionate and respectful when supporting people and it was evident that staff held people's well-being in high regard. Relatives told us about the caring nature of the staff and management team. A relative explained that when their loved one had been in hospital, staff had stayed with them to ensure that they were provided with a familiar face and with someone who knew their needs and preferences well.

People and relatives told us that they were fully involved in decisions that affected people's care, that they were able to share their views and that they were listened to. People were asked for their opinions within monthly keyworker sessions where they were able to spend time with their keyworker and communicate any concerns or make suggestions as to what they wanted to do with their time. For people who required further assistance to communicate their views, staff liaised with people's relatives or representatives, if appropriate or signposted people to advocacy services. An advocate is a person who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. The provider acknowledged that people and relatives may prefer to share their views and concerns in a different way and regular questionnaires were sent to gain feedback.

There was a warm, homely, and friendly atmosphere. This was echoed in comments made by relatives who told us that the home was a "Family environment" and had "A family-home atmosphere". Each bungalow was occupied by people with a similar outlook, for example, one of the bungalows was for older people and had a calm and sedate atmosphere, whilst another was for younger people who preferred a more lively and vibrant atmosphere. Visitors were welcome and people told us and observations confirmed that people's relatives regularly visited them and were made to feel welcome.

The provider's values stated that they were committed to supporting each person to enjoy maximum independence and this was observed in practice. People's independence was promoted and encouraged. A relative told us, "My relative is encouraged to be very independent". People could choose how they spent their time, some spending time in the communal areas of the home, whilst others preferred their own space in their rooms or quieter areas of the home. One person independently accessed facilities in the local community such as shops and cafes. Whilst other people were supported by staff to enjoy regular trips out. People were supported by staff to maintain and develop independent living skills such as cooking, shopping, laundry and household chores as well as continuing to be independent with their personal care needs. People who enjoyed shopping were supported by staff to buy the weekly grocery shop for the home. By promoting people's independence staff were ensuring that people felt empowered and had a good sense of self-worth. One person told us, "I've been cleaning out my wardrobe. We help when we can, we make dinner".

People were treated with respect and dignity and afforded privacy by staff who took time to explain their actions and involve people in the care that was being provided. Staff were mindful of the impact receiving support, particularly with aspects of people's personal care needs, could have on a person's dignity. Observations showed staff knocking on people's doors and waiting for a reply before entering people's rooms and asking people's consent before supporting them with tasks. Staff attended to people's needs in a sensitive and discreet manner. People's privacy was respected in relation to the information that was held about them. Records were stored in locked offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. Care plan records for one person clearly stated that staff should obtain the person's consent before discussing their care needs with their relative; this demonstrated that people were provided with choice with regards to parental involvement in decisions that affected their care.

People's diversity was respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Guidance produced by Skills for Care advises on the importance of promoting equality, diversity and human rights within the care planning and decision making processes. Care plans considered people's religious and spiritual needs. Records for one person showed that the person's faith had been considered when devising

and implementing their care plan.

Good

Is the service responsive?

Our findings

People and relatives told us that people were happy and led fulfilled lives. People were encouraged and enabled to be part of the local community and had regular trips out to local cafes and facilities. People told us that they enjoyed going out and thought that it was fun.

Prior to moving into the home, as well as when people first arrived, their needs were assessed and numerous care plans were devised, dependent on their needs and these were included within their care records. These care plans contained specific information about people's abilities and needs in relation to their physical, mental, emotional and social well-being. People's interests, hobbies and preferences were documented in person-centred care plans. Staff told us that for people who were unable to fully communicate their preferences in relation to their care needs and requirements, that they used information from previous places of residence, relatives and healthcare professionals. In addition they gauged people's reactions to various activities and interactions to enable them to build a picture of the person's preferences and devise their plan of care. Recently introduced one-page profiles provided staff with essential information on how to support people. Care plans identified what the person could do and asked the question, 'What do people appreciate about me'? In response, one person's care plan stated, 'My sense of humour', 'My sayings' and 'That I am helpful'. Another person's stated, "My cheeky sense of humour" and "I am determined". By starting the care plan in this way this demonstrated that the focus was on what people could do and what made them the person that they were. Care plans also detailed people's assessed levels of need, what they needed support with and how staff could best achieve this. These records ensured that staff were provided with relevant and up-to-date information to guide their practice and to ensure that people were supported according to their needs and preferences. People and their relatives, if appropriate, were involved in the development and on-going review of care plans. Meetings with external healthcare professionals as well as the local authority had been arranged to ensure that people were receiving the correct amount of support. These reviews helped to ensure that care plans were person-centred and reflected people's wishes.

People were not socially isolated. They had access to one-to-one interaction, group social events and outings within the local community that were tailored to their interests and abilities. The provider and management team had ensured that they had taken into consideration people's younger ages and the fact that they may want to go out during the evenings and have later nights. Support and staffing levels had been adapted to enable people to spend time out of the home during the evenings. For example, over half of the people living at the home were younger adults; provisions had been made to ensure that there were sufficient staff to enable people to enjoy evening events such as clubs, discos and shows. One person was laughing loudly and was clearly very animated and excited when telling us about a recent trip to a pantomime. The person told us, with a beaming smile, who they had gone with and who supported them and that they had caught some sweets that had been thrown into the audience. People were encouraged to develop new skills. One person was supported by staff to learn new spellings of words and to do word searches and art work. Another person told us that they used to attend college and that they had completed their course. Observations showed that staff took time to interact and communicate with people when undertaking tasks or offering support. People were encouraged to maintain contact with people that were

important to them. Observations showed people visiting each other in different bungalows. A relative told us, "My relative now attends lots of events in the community such as evening clubs, going out for coffee, doing the house shopping and these have made a big difference".

People were informed of their right to make a complaint. Leaflets informing people of the standard of care they had a right to expect were displayed in the entrance to the bungalows alongside instructions as to how people could review the home on an external website. People were asked their views within their monthly keyworker meetings and records showed that these had been adapted to meet people's level of understanding. For example, questionnaires asking people various questions had been devised to enable staff to have conversations with people. Symbols of faces were displayed underneath the question so that people could rate their response, for example, a smiley face or a sad face. People told us that they were happy and relatives confirmed this and explained that they would feel able to approach the management team if they had any concerns or queries. One relative told us that they had made a complaint in the past and that this had been dealt with appropriately. Observations showed that people and their relatives were able to speak freely and air their views and concerns. Complaints that had been made had been dealt with in accordance with the provider's policy and demonstrated that the provider was transparent and open with people who used the service. The management team and staff demonstrated a reflective approach to their practice and were constantly reviewing how they worked and learned from instances.

The provider took precautions to ensure that they were prepared for people's conditions deteriorating. Advanced care plans were in place for some people and advice had been sought from external healthcare professionals to ensure people were comfortable and pain-free when their health deteriorated. Relatives were welcome and able to spend time with people when people were unwell or at the end of their lives. Observations of people who were receiving care when their health had deteriorated showed that people had access to external healthcare services and were supported by staff that cared.

Good

Is the service well-led?

Our findings

People, relatives and staff were positive about the leadership and management of the home. People told us that they liked the registered manager and observations showed people smiling and laughing when in their presence.

Coppice Close is the only residential care home owned by the provider. At the last inspection on 1 December 2015, there was a registered manager in post. However, they no longer worked at the home and another registered manager, as well as a quality manager, had been recruited. The registered manager had been in post for ten months. A registered manager is a '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 home is run. Relatives and staff told us that the management of the home had improved since the changes in management and they were complimentary about the changes and improvements that had been made. Comments from staff included, "The manager is very supportive, she does a great job of managing things, she works very hard and is very professional". Another member of staff told us, "It's miles better, really good now. They [the managers and provider] are awesome". A relative told us, "The home is well-managed and there has been a vast improvement over the last 12-18 months, it was more chaotic in the past but is much more structured now".

The management team were competent. They had appropriate qualifications and experience to support staff to ensure that people received a good quality of care. They ensured that staff felt supported and equipped to support people effectively. Staff told us and observations showed, that management had a visible presence in the home to ensure that both people and staff knew who to approach if they had any queries or concerns. Staff told us that they were involved and kept informed of any changes within the organisation. Records demonstrated that the provider was open and transparent with staff, regardless of their roles, through a range of regular meetings. Staff had access to regular one-to-one meetings with the management team and told us that they could approach management at any time if they had any concerns or needed further support. Staff were provided with regular feedback on their practice to enable them to reflect on and develop their knowledge and skills to improve the support that people received.

There was a relaxed, friendly and welcoming atmosphere and people, relatives and staff consistently told us that the home was a nice place to live and that people were happy. When asked how they would describe the home to others, a member of staff told us, "Its very homely, staff are very friendly, people go out a lot. Staff and people have a really good relationship". The provider had a set of objectives which provided staff with clear guidance as to the aims of the service provided. These objectives incorporated person-centred care, enabling people to live a healthy and happy life and promoting people's human rights. It was apparent that staff shared these values and worked hard to ensure that the provider's objectives were implemented in practice. The provider ensured that staff were recruited who shared the values and who would work to achieve the objectives. Staff had access to training that would further inform and guide their practice. Support was offered to staff though formal supervision meetings during which staff were able to reflect on their practice. These forums also provided an opportunity for the registered manager to review the culture of the staff team and home to ensure that staff were still mindful of the provider's aims and objectives.

The provider and registered manager demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. Records showed that there had been regular communication with relatives to keep them informed of people's health conditions or if there had been any incidents. The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had communicated with us and notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. Staff were encouraged to identify areas that could be improved upon and open and transparent discussions had taken place in regular staff meetings. A whistleblowing policy informed staff of their responsibilities to raise any concerns. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace.

The provider and management team had developed relationships with external healthcare professionals and local authorities to ensure that people received a coordinated approach and service and so that staff learned from other sources of expertise. Management and staff ensured that there was a quality management system in place. Manual and electronic quality management systems ensured that regular audits of the service were conducted by the registered manager. When shortfalls were identified and raised with the provider and registered manager they took immediate action to ensure that these were rectified. The local authority undertook their own quality monitoring visits to ensure that the home was a safe and suitable place for people to live. There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting people's needs. There were mechanisms to obtain feedback from people and relatives to enable the management team to have an oversight of the service people were receiving. This ensured that people were receiving the quality of service they had a right to expect.