Four Seasons 2000 Limited

Copper Beeches

Inspection report

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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 14 November 2017. This inspection was unannounced.

At the last Care Quality Commission (CQC) comprehensive inspection on 09 and 10 August 2016, this service Required Improvement in the Effective and Responsive domains and had an overall rating of Requires Improvement. We returned to the service on 18 April 2017 to check that the provider had taken action in the Effective and Responsive domains. At the inspection on 18 April 2017, we changed the ratings in the Effective and Responsive domains to Good. We also changed the overall rating for the service to Good.

You can read the report from our last comprehensive inspection and subsequent focused inspection, by selecting the 'all reports' link for Copper Beeches on our website at www.cqc.org.uk

At this inspection, we found the registered manager and provider had consistently monitored the quality of their service to maintain a rating of Good.

Copper Beeches is a nursing home. The service provides accommodation, nursing and personal care for up to 36 older people, some of whom may be living with dementia. The nursing and care was provided in an environment that had been adapted to enhance people's experience of the care. There were 35 people living at the service at the time of our inspection.

The improvements and changes implemented since our last comprehensive inspection in August 2016 had been embedded. Nurses and care staff demonstrated they shared the provider's vision and values when delivering care. People were supported to maintain their purpose and pleasure in life and offered choice.

The registered manager was employed at 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.

The provider and registered manager wanted to offer an inclusive service. They had comprehensive policies about Equality, Diversity and Human Rights. The provider was working with and learning from external organisations with expertise and experience of reaching out to the lesbian, gay, bi-sexual and transgender communities and people living with dementia.

The registered manager and provider were consistent in measuring the quality of people's experiences and continued to work at putting people at the heart of the service.

The quality outcomes promoted in the providers policies and procedures were monitored by the registered manager and leaders in the service. There continued to be multiple audits undertaken based on cause and effect learning analysis, to improve quality. Staff understood their roles in meeting the expected quality

levels and staff were empowered to challenge poor practice. The provider shared their learning with all the services in the group.

The registered manager consistently understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff protected people's privacy and confidentiality whilst delivering care, but at other times, people could be observed in bed as their doors were open. It was not clear if people had consented to their doors being left open. We have made a recommendation about this.

People's right to lead a fulfilling life and to a dignified death was understood and respected at all levels. People, their relatives and health care professionals had the opportunity to share their views about the service either face-to-face, by telephone, by using 'on-line' feedback forums or by using the comment box in the reception.

There continued to be enough nursing and care staff on duty to meet people's physical and social needs. The registered manager checked staff's suitability to deliver personal care during the recruitment process. People's medicines were managed, stored and administered safely.

The registered manager continued to train staff so that they understood their responsibilities to protect people from harm. Staff were encouraged and supported to raise any concerns. Staff understood the risks to people's individual health and wellbeing and risks were clearly recorded in their care plans.

Meals continued to be suitable for people's individual dietary needs and met their preferences. People were supported to eat and drink according to their assessed needs. Staff supported people to maintain a balanced diet and monitor their nutritional health.

Staff received training that matched people's needs effectively and nursing staff were supported with clinical supervision and with maintaining their skills and their professional registrations.

The environment continued to be resourced and maintained by the provider. They had refurbished some of the bedrooms and the garden. They continued with an improvement plan. The premises and equipment were regularly maintained and serviced to minimise risks to people's safety.

Management systems were in use to minimise the risks from the spread of infection and keep the service clean and odour free.

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 service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Copper Beeches

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 was a comprehensive inspection. We re inspect services that have been rated as Requires Improvement at a comprehensive inspection within twelve months of the report publication date.

The inspection took place on 14 November 2017 and was unannounced. The inspection was carried out by one inspector.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

Many of the people living at Copper Beeches were receiving complex care due to their illness or condition and were not able to express their views to us verbally. However, in these situations we observed how care and support was delivered in the communal areas.

We spoke with three people and two relatives about their experience of the service. We spoke with eight staff including the registered manager, the deputy manager, the provider's regional operations manager, one nurse, one senior care worker, one care worker, one housekeeper and the activity lead. We asked for feedback about the service from three local authority commissioners.

We looked at records held by the provider and care records held in the service. This included two care plans, daily notes; safeguarding, medicines and complaints policies; the recruitment records of three staff employed at the service; the staff training programme; medicines management; complaints and compliments; meetings minutes; and health, safety and quality audits.

Good

Is the service safe?

Our findings

We observed that nurses and staff delivered safe care. People and relatives we spoke with told us the service was safe and that if they did not feel safe they would speak to staff. One person said, "I am happy with the staff, they look after me well." Another person said, "The staff are alright, I can talk to them."

A relative who visited her loved one most days said, "I am happy with his care, if not I would say, he seems happy to me." Another relative said, "Yes I definitely think my father is safe here."

People were consistently protected from the risks of potential abuse. The provider had a comprehensive safeguarding policy that informed staff about their responsibilities to safeguard people and what constituted abuse. Staff received training in safeguarding, knew what signs to look out for and felt confident the management team would listen to and act on any concerns they raised. Staff told us they understood how abuse could occur and how they should report abuse. Staff said, "You are supported to say what you feel." They clarified this by telling us about scenarios of abuse they may encounter and how they would respond. For example, if staff noticed bruising or changes in people's behaviours. Staff we spoke with were confident they could challenge any poor practice within the service and report it appropriately. Staff had read and understood the provider's whistleblowing policy. There had been five recorded safeguarding notifications since our last inspection. These had been appropriately reported and investigated under the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse).

There continued to be policies about dealing with incidents and accidents. Staff received training about how to report accidents and incidents to the nurses and the registered manager. These were recorded, and investigated to reduce the risk of future incidents. The registered manager analysed the accident and incident reports to identify whether there were any patterns or trends. Records showed the registered manager took steps to reduce risk and notified us (CQC) when they referred concerns to the local safeguarding authority. For example, the number of falls had been reduced to zero in the service after people were reassessed and their falls care needs prioritised.

People continued to receive their medicines safely to protect their health and wellbeing. People who required nursing care continued to receive their medicines safely from nurses and from senior care staff who had specialist training in this area. Medicines were ordered, stored and managed to protect people. 'As and when' required medicines (PRN) were administered in line with the providers PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

The provider had an up to date policy on the administration of medicines that followed published guidance and best practice. Nurse's medicines competences were checked by the registered manager against the medicines policy to ensure good practices were maintained. Senior staff trained to administer medicines were mentored by qualified nursing staff. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended

ranges and these were recorded. Nurses described how they kept people safe when administering medicines. We saw records of referrals to GPs and of staff seeking advice from other external professionals when required. Records showed that medicines were reviewed with people's GP's. Nurses had specific skills and training around end of life care to enable people to have a pain free and dignified death.

The registered manager continued assessing risks to people's individual health and wellbeing. For example, they assessed people's nursing needs, mobility, nutrition and communication. Audits of medicines and specific risk to people from the care being delivered were in depth and frequent to ensure people's safety. Where risks were identified, people's care plans described the equipment needed and the actions care staff should take to minimise the risks. If the actions taken to minimise identified risks restricted people's rights, their consent was sought or their rights were protected with the guidelines set out in the Mental Capacity Act 2005. For example, to maintain safety people may need bed rails to reduce the risk of falls or could require pureed foods to prevent choking. We found that staff followed risk assessments to maintain people's safety when they delivered care.

People had risk assessments that were specific to their needs. People's risk assessments addressed communication, mobility, falls, and bed rails when appropriate. Sleeping risk assessments instructed staff about the frequency of night observations and repositioning, to check that people were safe. Care plans had actions to be taken to minimise risk. Staff were observed assisting people to transfer and move around and this was done in a safe way. Staff were following these instructions in practice. Infection control risks were managed through maintenance and cleaning practices. For example, cleaning was completed following a daily, weekly and monthly schedule. A member of the cleaning staff said, "We always follow the cleaning plans and the quality of our work is checked by a manager." Cleanliness and infection control practices were recorded and audited as part of the quality management systems in the service.

Emergency policy and procedures continued to be understood by staff. Staff had training in fire safety and practised the routine. Evacuation response times were recorded and staff involved were debriefed to improve practice and understanding. Signage advised the 'fire plan' to everyone and people's personal evacuation plans (PEEPs) were kept with the emergency pack.

Nurses and care staff were deployed with the right skills and in the right numbers to meet people's care needs. The provider's recruitment policy and processes continued to ensure risks to people's safety were minimised. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants had references, full work histories and had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Information about people was recorded on a secure computerised care planning systems and paper documents were kept securely in an office and the access was restricted to staff. When staff completed paperwork this was either stored in people's bedrooms or kept at the nursing stations to maintain confidentiality. Information about medicine's were securely stored in clinical rooms between medicine rounds. Care plans were kept in locked cupboards. Detailed daily records were kept by staff. Records included personal care given, well-being, activities joined in, concerns to note and food and fluids taken. Many recordings were made throughout the day and night, ensuring communication between staff was good benefitting the care of each person. Staff understood their responsibility to maintain people's confidentiality.

The provider had checked that the environment was safe for people. Other environmental risks were

monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, to minimise the risks from water borne illnesses. There were up to date safety certificates for legionella, gas appliances, electrical installations, portable appliances, lift and hoist maintenance. Staff logged any repairs in a maintenance logbook and the maintenance staff monitored these until completion. The maintenance staff carried out routine health and safety checks of the service including regular checks of water temperatures, fire safety equipment and fire drills. Comprehensive records confirmed both portable and fixed equipment was serviced and maintained. Records showed they had implemented a system of regular checks of the premises, the fire alarm and essential supplies such as the water, gas and electricity. Equipment, such as hoists, profiling beds and wheelchairs, were serviced and staff regularly checked that items such as slings and walking frames were safe and fit for use.

Good

Is the service effective?

Our findings

People told us that staff met their care needs and we observed this happening. One person told us, "The staff ask me what I want for breakfast, I've just had a cooked breakfast, cereal, orange juice and a cup of tea which I really enjoyed." And, "When they ask me what I want for lunch I can chose what I like." Later we observed a member of staff asking the person what they wanted for lunch and they chose chicken pie.

We spoke with another person who said, "I go to the lounge when I want, but often prefer to stay in bed." Another person said, "Staff let me do things for myself, I like reading a lot." We noted this person was reading a book in the lounge with a plate of biscuits and a cup of tea by their side. They were happy and relaxed with a smile. This person also said, "Staff do talk to me about my care plan, they help me attend events in the home."

A relative said, "The staff talk to me about my husband's care plan and tell me if there have been any changes." And, "The managers are very approachable and very fair and the staff meet his needs."

The registered manager undertook an initial assessment with people before they moved into the service. The assessment checked the care and support needs of each person so the registered manager could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. The registered manager also assessed people's dependency levels to capture how much staff care was required and how independent people could remain. This was translated into the number of nursing hours and the number of care or social contact hour's people needed. The registered manager involved people and their family members in the assessment process when this was appropriate.

The initial assessment led to the development of the care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. Some people had hourly checks in place. These were recorded with the required detail. For example, person X in bed asleep or person X awake having lunch in lounge. Where people's health was at risk from not drinking enough a plan was in place to monitor and respond to the risk. For example, people had been assessed by a speech and language therapist (SALT) or other professional who advised the staff of the amounts someone should drink in a day. Staff recorded what people drank in their care plan. At the end of each day the total drunk was calculated. If people had not drank enough to maintain their health, staff referred them back to the SALT. Staff said, "If people's fluid totals are low we encourage them to drink and report this to a nurse." Staff told us they had all the information they needed within the care plan to support people well. People at risk of choking were assessed and measures were put into place to minimise the risk through foods that were easily digested or pureed. People's nutritional risk and allergy needs were shared with the chef. One member of staff said, "Communication within the team is good so we all know what is happening."

Staff were managing pressure ulcers and wounds effectively. Referrals to the community tissue viability

nurses (TVN's) were made promptly. There were people identified as at risks from pressure ulcers developing and others were at risk from skin tears. These skin/pressure areas were being managed by staff using prescribed creams, body repositioning and air flow mattresses to minimise the risks of serious ulcers developing. At the time of this inspection there were no reported pressure ulcer concerns. This meant that people's skin care was well managed. However, the correct settings for people's air flow mattresses were not always recorded in care plans. This meant that when we checked one person's mattress air pressure we could not confirm the setting was correct. The registered manager corrected the issue before the end of the inspection. They confirmed that mattress settings were now recorded and would be checked daily against the recorded settings. The documentation was kept up to date showing when people had been repositioned. Wound care plans showed frequent review. People's care plans had a Waterlow Score. A Waterlow score gives an estimated risk for a person to develop a pressure ulcer and these were reviewed monthly. Records showed that staff were identifying any pressure ulcers at the early stages and were recording their healing appropriately with pictures and body maps. For example, dates were being recorded along with any health care guidance from people's GP or Tissue Viability Nurse (TVN). This meant that it was possible for staff to identify the person if the picture was separated from the care plan or to monitor any deterioration or improvement effectively.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The service was working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles. There had been eight applications made by the registered manager in the last twelve months. This included authorisations about the use of bedrails to prevent people falling out of bed and for people who lacked capacity and needed to remain in a secure environment. The applications had been made within the MCA 2005 principles. Where people could consent to decisions regarding their care this had been documented, and where people lacked capacity, the appropriate best interest processes had been followed. For example, a recorded discussion had been held with people involved in the person's care and/or their advocates. It was then agreed if any imposed restriction remained in the persons best interest. This showed that the registered manager applied the principles of MCA 2005 within the service in a person centred manner which involved people in decisions about meeting their needs effectively.

People's consent and ability to make specific decisions had been assessed and recorded in their care plans. Where people lacked capacity, their relatives or representatives and relevant healthcare professionals were involved to make sure decisions were made in their best interests. Staff had received training in MCA and DoLS and understood their responsibilities under the act. Applications made to deprive people of their liberty had been properly made and authorised by the appropriate body. Records showed the provider was complying with the conditions applied to the authorisation. The registered manager told us that people's DoLS were regularly reviewed with the local authority. Most people who lived in the service had authorised DoLS in place to keep them safe. These were appropriately notified to CQC. However, we noted that some people's bedroom doors were routinely left open which meant they could be observed from the passageways. People's consent and preferences in relation to their doors being open or closed had not been routinely recorded in their care plan.

We have made a recommendation about recording and acting on individual preferences in relation to people's consent.

Staff feedback about the standards of training and supervision was consistently good. Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The nurses on shift told us they had received training to carry out their roles. Since our last inspection, records showed staff had undertaken training in all areas considered essential for meeting the needs of people in a care environment effectively. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Nurses had training in life support, first aid and the management of diabetes. The first aid training had provided them with information on how to manage/support people who may be bleeding or choking. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development.

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. They confirmed to us that they had started with an induction. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised. Staff were encouraged to complete a Diploma/Qualification and Credit Framework (QCF). To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard. Staff said, "We get supervision and my line manager lets me know if things need doing differently."

The registered manager checked how staff were performing through an established programme of regular supervision (one to one meeting) and an annual appraisal of staff's work performance. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Staff confirmed to us that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings.

The registered manager provided us with information about the support qualified nursing staff received from the provider to maintain their skills and Nursing and Midwifery Council (NMC) registration as part of the revalidation process. The registered manager held information about qualified nurses registration with the NMC and held information about agency nurses training, qualifications and NMC registration. The nursing staff team consisted of both Registered General Nurses (RGN's) and Registered Mental Health Nurses (RMN's). This meant that people's physical health and mental wellbeing was protected by staff who were qualified and trained to meet these needs.

People health and wellbeing was consistently monitored and reviewed in partnership with external health services. The registered manager contacted other services that might be able to support them with meeting people's health needs. This included the local GP, the community nursing teams, occupational therapist, (SALT) team and the tissue viability nursing team. People accessed a range of health and wellbeing services. For example, opticians, podiatry and dental care. Health services also provided preventive input such as flu vaccinations, blood monitoring and health reviews. For example, on 08 November 2017 a nurse had visited the service to administer flu jabs for people who had consented to this or where their best interest for this had been recorded. On 26 September 2017 a person's GP had asked for a urine test to be done. A nurse at Copper Beeches did the test and informed the GP of the results on the same day and recorded this in the person's care file. This demonstrated the provider promoted people's health and well-being. Contacts with external health and social care professionals about each person were recorded in care plans. There were records of contacts such as visits, phone calls, reviews and planning meetings. Contact varied from every

few weeks to months, which meant that each person had a professional's input into their care on a regular basis. The care plans were updated and reviewed as required. For example, where people's dependency had changed.

People continued to be supported to have enough to eat and drink and were given choices. Staff were aware of people's individual dietary needs and their likes and dislikes. Care records contained information about their food likes and dislikes and there were helpful information on the kitchen notice board about the importance of good nutrition, source and function of essential minerals for both staff and people to refer to. There was a picture based food menu available to people. We saw that at lunchtime, people were provided with elements of their meal individually pureed where required to ensure their meal remained appetising whilst safe to eat. People were provided with adapted crockery where required, which ensured they could remain independent when eating their meal. Staff supported those who required assistance with their meal.

Care plans covered all aspects of people's daily living and care and support needs. The areas covered included medicines management, personal care, nutritional needs, communication, social needs, emotional feelings, cultural needs and dignity and independence. The cultural needs plans identified the support required by each person for example, if they needed support to attend the Church. Information such as whether people were able to communicate if they were experiencing pain was detailed. Sometimes people were reluctant to wash or shower and this was addressed in the care plan for personal care, giving guidance to staff. Most people changed their minds if staff returned a short time later and asked again, or if a different member of staff asked. If people still chose not to wash then this was respected as their decision at that time.

The registered manager and staff had continued creating an enriching and self-stimulating environment, specifically tailored to meet the needs of people living with dementia. By providing meaningful stimulation and occupation, people became more engaged and interested and could continue with their hobbies and interest. Activities were planned and coordinated. They were designed for people with cognitive impairment. For example, staff had set up a reading group.

There were displays of key calendar dates which included the diversity of religious celebrations. For example, Muslim and Jewish festivals. Other people pursued hobbies they liked such as knitting, art and crafts and there was a garden planting group. These activities helped people maintain movement and dexterity. We saw records of 1-1 sessions people received in their bedrooms if they chose not to participate in group activities. For example, staff sat and chatted to people or provided pampering sessions by doing people's hair and nails. People who liked animals had been involved in pet therapy sessions. One person told us how much they enjoyed seeing the 'pat dog' and we noted they were a former dog owner. People could easily see the day, date, time, season and weather in communal areas. People also had clocks and other items in their bedrooms to help them orientate to the here and now. For example, we observed that staff had placed an important photograph of someone so that a person who was cared for in bed could still see it when they were positioned on their side.

Good

Is the service caring?

Our findings

People described their care positively. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care.

A relative said, "The staff are friendly, I know who the manager is, we are very happy with the care."

The service had received a number of recent compliments about the care provided. One relative commented, 'I can say hand on heart you all showed Mum nothing but kindness, care and love.' A health care professional commented, 'The staff are knowledgeable about people and are very caring.' And, 'The staff are lovely and welcoming.'

The care people received was person centred and met their most up to date needs. People's life stories and likes and dislikes had been recorded in their care plans. Staff encouraged people to advocate for themselves when possible. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations. We saw people had been supported to start creating person centred engagement flowers. (The engagement flowers assisted people to identify a circle of friends to help somebody accomplish their personal goals in life.) Some relatives were also volunteers in the service. They came in at various times and got involved in activities or sat with people for a chat. This helped minimise the risk of social isolation for people who preferred to stay in their bedrooms.

The staff on shift knew and understood each person's needs very well. Staff knew people's preferred names and they spoke to them in a caring and almost affectionate way. They had knowledge of their past profession and who was important in their life. They understood the importance of respecting people's individual rights and choices. People's right to privacy and to be treated with dignity was respected. We saw staff did not enter people's rooms without first knocking to seek permission to enter. Staff kept doors to people's bedrooms and communal bathrooms closed when supporting people with their personal care and medicine administration as we observed to maintain their privacy and dignity.

The provider had a range of policies setting out their approach to dignity, equality, diversity and human rights. There were also policies about spiritualty and friendships. These were accessible to staff at any time and included in people's initial assessments. Staff received training about the culture of the organisation in promoting dignity and human rights. As a reminder, areas in the service displayed information about treating people with dignity, for example, a 'resident's charter' and information about dementia care. Other staff training included how to respect people's privacy and about people's needs if they were living with dementia. Relatives were included in learning about dignity issues. The staff and some relatives had recently completed experiential dementia awareness training. This training simulated some of the issues and challenges people living with dementia may face, for example in doing up buttons.

Staff were tested on their attitude to care when they applied to work at the service. All of the staff we spoke with displayed a caring attitude. They also told us that the experiential dementia awareness training had

enhanced their understanding of dementia. We observed that people continued to be supported by caring staff that were sensitive in manner and approach to their needs. We saw that people looked relaxed, comfortable and at ease in the company of staff.

We observed positive interactions between people and staff. Staff gave people their full attention during conversations and spoke to people in a friendly and respectful way. For example, at lunch time we observed staff encouraging a person with their meal. They said, "X shall we get you sitting properly, then we can have lunch together," And, "Y you don't have to eat all this food, but it would be good if you could, would you like me to cut it up a bit for you." They gave people the time they needed to communicate their needs and wishes and then acted on this.

People's bedrooms were filled with their personal items, which included; photographs, pictures, furniture and ornaments. This combined with information in their care plans, provided staff with a wealth of information about people, for staff to use to engage them in conversation. Staff had a good understanding of people's personal history and what was important to them.

The registered manager continued to ensure people's individual records provided up to date information for staff on how to meet people's needs. This helped staff understand what people wanted or needed in terms of their care and support. For example, we noted from one person's care plan that they had an interest in aircraft. During the inspection we observed staff sitting with this person going through pictures and books of aircraft. We also sat with the person and they showed us their favourite aeroplanes. This demonstrated that the things staff knew about people were used as points of interest and to stimulate conversation and positive memories.

Good

Is the service responsive?

Our findings

We observed that nurses and care staff consistently delivered responsive care. People told us the registered manager and staff were responsive to their needs. In response to concern about most people being regularly washed in bed, people were now given more opportunity for choosing to bath or shower. For example, 13 people were living on the ground floor. Over a 15 day period prior to our inspection there had been 40 recorded baths or showers. Staff told us this had improved people's wellbeing and hygiene levels, was more dignified and got people out of their bedrooms more often. If people used their nurse call bells, we observed these were responded to quickly. We observed staff popped in to see people when they were cared for in bed or relaxing in their bedrooms to check they were okay.

One relative commented, 'We are happy as a family with the care for Mum. We attended a review of her care and she told the assessor the staff looked after her, which was the first whole sentence she had spoken in a long time.'

Staff continued to help people to stay in touch with their family and friends. For example, we observed relatives freely coming into the service to visit their family member throughout the day. Staff maintained an open and welcoming environment and family and friends continued to be encouraged to visit. One relative said, "Yes the staff are very friendly." Relatives confirmed that they were informed regularly about meetings or any incidents and found the service to be very responsive. Relatives said they were kept up to date about care plans and called in or notified if there were any changes. Their involvement was recorded in people's care plan files.

There was an established activities program. This was advertised for people to see and work had been done to make the activities person centred. Information about activities was in an accessible format using pictures.
As part of the, 'Me and my care' initiative there was now more emphasis on people's life stories at their initial assessment. This now included, 'My wants and wishes' which family members, friends and staff members contributed too. This information can be printed and formulated into a scrap book. This meant that people could look at the scrap book and see the person and their likes, dislikes, hobbies and interests.

Three volunteers worked with staff giving support to people with arts and crafts, playing games and reading with people. The volunteers also helped with hand massage, social interaction and general pampering to help raise people's feeling of wellbeing. There were activities located around the service for people to engage with independently or as a part of a group. People who were more able contributed to the activity plan and staff did their best to encourage people to continue with any activities they enjoyed prior to coming into the service. For people less able to say what they liked to do, the activity coordinators spent time with individuals on a one-to-one basis so that they have a good idea of what activities they would like to join with. For example, staff told us that as they got to know people, they learnt new things about them and these were recorded in their 'Me and my care books.'

All staff took the time to sit and engage with people and take an interest in what people were doing. When

people had taken part in an activity, with their consent a photograph was taken. This was a reminder for people and also gave their visitors topics they could talk about. The registered manager played back a video record of people getting involved in the recent Halloween party. The recording showed that people were engaged, smiling and in some cases dancing. We noted that staff read the bible on a regular basis to one person who had stated their religion was important to them. Another person had been supported to attend an engineering workshop because they had stated an interest in engineering from their previous career and told staff they wanted to go and reminisce. The planned activities gave people an interest and helped them remain physically or mental more active.

Staff knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs. The staff showed in discussion with us they understood people's dementia and how this impacted on their life.

End of life care was person specific and compassionate. Nurses and care staff worked methodically and closely with people and their relatives to meet people's end of life needs. Palliative care from nursing and care staff was flexible and kept under review. End of life care planning included input from external specialist palliative care nurses. Their recommendations and visit dates were recorded in people's care plans. The end of life care plans were routinely reviewed at least monthly or at any time people's condition changed.

People continued to receive personalised support which met their specific needs. Each person had an up to date care plan which set out for staff how their needs should be met. Care plans were personalised and contained information about people's likes, dislikes and their preferences for how care and support was provided. Care plans were reviewed annually with people, or sooner if there had been changes to people's needs. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff.

The provider had a comprehensive complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was on display on the notice board in the service. The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman. There had been four complaints received in the last twelve months. These complaints had been dealt with in line with the provider's policy. Complaints were logged on a system which fed into the providers quality audit processes, giving the provider oversight and enabling lessons learnt to be shared across other services the provider managed.

Good

Is the service well-led?

Our findings

The registered manager and provider proactively sought people's views and took action to improve their experience's. The provider's quality assurance system asked people, relatives, staff and healthcare professionals about their experience of the service. This included questionnaires being sent to people and an electronic key pad feedback system in the reception area. People were asked what they thought of the food, their care, the staff, the premises, the management and their daily living experience. Other meetings were advertised and took place for people who used the service and their relatives. The provider had a history of taking action to improve the quality of the service based on the results of their surveys. For example, the garden had been improved and made accessible to people. The lasts survey results showed a ninety six percent satisfaction rating for the service.

Residents' and relatives meetings were held. The minutes showed that they were able to contribute to the meeting and to make suggestions concerning their welfare and future service provision. An annual customer satisfaction survey was carried out. The findings of the 2016 residents and relatives' satisfaction survey showed the feedback was positive from the people using the service and relatives of people who used the service. In response to feedback the registered manager had set up a 'You said, we did' notice broad in the reception area of the service. This board informed people of what changes the management and staff had made to improve the service.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service.

The provider's policies and procedures relating to safety were implemented. The registered manager's approach to risk management and their response to issues was effective. General risk assessments affecting everybody in the service were recorded and monitored by the registered manager and provider. Quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits covered every aspect of the service and were fed into and monitored within the provider's organisational governances systems. This gave the provider oversight of the performance of the service against the risks and quality standards the provider had set.

A health and safety maintenance checklist was in use and other periodic risk management systems were in place to check for hazards that may cause harm, for example checks on bed rails, furniture and wheelchairs. If faults were recorded these had been responded to and the hazard repaired or removed. Risk auditing and periodic maintenance checks minimised the risk of accidents and harm.

The registered manager was proactive in keeping staff informed on equality and diversity matters as set out in the provider's policies. Wellbeing, equality and diversity was discussed with staff. We observed that the staff group were diverse from various ethnic backgrounds. Staff told us that they all worked well together as a team.

The service continued to have a clear vision and set of values that were person centred. The registered manager had previously described their values for the service as, "We ensure that our residents are treated with kindness, compassion and dignity." The registered manager gave examples of this in practice. This included that the person centred care planning process ensures that people receive appropriate information, are involved in decisions regarding their care and that their views are obtained which includes for example, privacy requirements, ensures dignity and respect and people's inter-dependency requirements. They also told us that, "At Copper Beeches we are currently introducing a new dementia framework programme with four dementia e-learning programmes which all staff have to comply with." The registered manager had developed a positive person centred culture that ensured people were at the heart of the service.

Staff were formally asked their views about the service by the provider. Staff described their values which were in line with the care values of the service. They said, "The atmosphere in the service is now different and we have a good team." Another said, "I love my job, the dementia framework I have just completed was very informative." We observed staff delivering compassionate care. Staff told us they felt supported by the registered manager. One member of staff said, "The management are very fair, any problems you have they sort it out." There were various meetings arranged for nursing and care staff. These included daily shift hand over meetings and monthly team meetings. These meeting were recorded and shared. The staff team meetings supported the improvements in the service. For example, staff were being asked questions and having discussions at staff meetings to confirm their learning. Information about how staff could blow the whistle was displayed and understood by staff. This meant that staff were involved in how the service was run.

The provider's regional operations manager was often on site. They had assisted the registered manager to develop the service systems and they were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed through the quality audit systems.

The registered manager participated in meetings with other managers within the Four Seasons services group. This gave them the opportunity to exchange views and information that may benefit the service. Records indicated the registered manager worked with the local authority when appropriate to discuss how to keep people safe, and kept them involved in decisions concerning their safety and welfare. The registered provider understood their legal responsibilities and consistently notified the Care Quality Commission of any significant events that affected people or the service and promoted a good relationship with stakeholders.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the reception area and on their website.