Larchwood Court Limited

Copperfields Residential Home

Inspection report

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Kent
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Date of inspection visit:
31 January 2017

Date of publication:
29 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 31 January 2016 and was unannounced.

The home provides accommodation and personal care for older people, some of whom may be living with dementia. People's needs varied, but people had predominantly low to medium needs. Only one person required the use of a hoist due to their physical mobility needs. The accommodation was provided over two floors. A lift was available to take people between floors. There were 14 people living in the service when we inspected.

At the previous inspection on 15 December 2015, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach was in relation to people's care not always taking account of the recommendations made by health and social care professionals. The provider sent us an action plan telling us what steps they would be taking to remedy the breaches in Regulations we had identified. At this inspection we checked they had implemented the changes and we found improvements.

There had not been a registered manager employed at this home since 25 August 2016. 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 had appointed a manager who had been in post since July 2016, but they had not registered with CQC at this inspection. Not registering a manager with CQC limited the providers rating or this home to requires improvement. We have made a recommendation about this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after an application had been made to the appropriate supervisory body as required under the Mental Capacity Act (2005) Code of Practice. The manager understood when an application should be made.

People's care was delivered safely and staff understood their responsibilities to protect people living with dementia from potential abuse. Staff had received training about protecting people from abuse. The management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes.

The premises and equipment in the home was clean, odour free and maintained to protect people. Safety systems in the home, like fire alarms, were serviced by an engineer and tested to ensure people's safety. Risk within the home had been assessed and maintenance issues were reported and dealt with in a planned and timely manner. However, the fire procedure in place advocated a 'stay put' policy. Staff were aware of the procedure, but did not know how to use the evacuation chair that had been placed on the first floor. Also, the most recent fire risk assessment completed by a qualified consultancy company did not identify any additional protections needed for people who may not be able to evacuate the premises quickly. We have

referred this to the fire service.

The manager involved people in planning their care by assessing their needs prior to and after they moved into the service. People were asked if they were happy with the care they received on a regular basis.

The structure of the staff team had changed since our last inspection. Care staff were now supported by other staff who did the cleaning and laundry. There was a new cook and most of the care staff team had been recruited since our last inspection. When new staff started working at the home, they received a five day induction and followed a recognised pathway of basic training to gain the skills required to meet people's needs. We observed that staff knew people well, staff displayed a kind and caring attitude and people had been asked about who they were and about their life experiences. This helped staff deliver care to people as individuals.

There were policies and a procedure in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs, community nurses and they accessed opticians, dentists and foot care professionals. People's health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

We observed staff were welcoming and friendly. Staff provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered.

Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected. Staff were trained and understood the importance of respecting people's privacy and dignity.

Incidents and accidents were recorded and checked by the manager to see what steps could be taken to prevent these happening again. The risks in the home were assessed and the steps to be taken to minimise them were understood by staff.

Managers ensured that they had planned for foreseeable emergencies, so that should they happen people's care needs would continue to be met. There was an up to date procedure covering the actions to be taken in emergency situations.

Recruitment policies were in place. Safe recruitment practices had been followed, before staff started working at the service. The manager ensured that they employed enough staff to meet people's assessed needs. Staffing levels were kept under review as people's needs changed.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink.

If people complained, they were listened to and the manager made changes or suggested solutions that people were happy with. The actions taken were fed back to people.

The provider and the manager consistently monitored the quality of the service and made changes to improve the service, taking account of people's needs and views. The manager of the home had provided leadership to new staff, they had undertaken training for their role. The provider and manager developed plans to improve the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Fire risk assessments and procedures needed to be reviewed in line with current practice.

Staff knew what they should do to identify and raise safeguarding concerns.

There were safe recruitment procedures and sufficient staff to meet people's needs.

Medicines were managed and administered safely. Incidents and accidents were recorded and monitored to reduce risk.

The premises and equipment were maintained to protect people from harm.

Is the service effective?

Good

The service was effective.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink enough.

Staff received supervision, an induction and on-going training.

The Mental Capacity Act and Deprivation of Liberty Safeguards were followed.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

Staff protected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments. Information about people was updated.

Activities were available based on people's needs.

People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager had not applied to register with CQC in a timely manner.

There were clear structures in place to audit, monitor and review the risks that may present themselves.

The manager promoted person centred values within the home. People were asked their views about the quality of all aspects of the care they received.

Staff were informed and enthusiastic about delivering quality care. They were supported to do this on a day-to-day basis by managers and senior staff in the home.

Copperfields Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 31 January 2017 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law.

People who were living with dementia were not able to verbally communicate their views with us or answer our direct questions. 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. We observed staff interactions with people and observed care and support in communal areas.

We spoke with three people and one relative about their experience of the home. We spoke with eight staff including the manager, a senior carer, two carers, the cook, cleaner, maintenance person and laundry person. During the inspection, we spoke with a visiting community nurse. We asked sought the views of the local authority contracts team.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at four people's care files, four staff record files. The staff training programme, the staff rota and medicine records.

Requires Improvement

Is the service safe?

Our findings

Some people in the home could speak to us about their experiences. Other people living with dementia were not always able to verbally tell us how safe they felt. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People described and we observed a service that was safe. One person said, "I feel safe, if anyone feels unhappy and shouts, staff will intervene to calm things down." Another person said, "I am very happy, the staff are good here."

We saw people smiling when staff spoke with them. We observed that people were relaxed and comfortable with staff when care was delivered.

A relative said, "I visit regularly, as do others in my family, we have no issues with safety in the home. The staff are very vigilant when people are on the move with walking frames to keep them safe."

The premises were maintained to protect people's safety. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. A hoist was available for emergencies, for example if people fell and needed help to get up. Other environmental matters were monitored to protect people's health and wellbeing. Firefighting equipment and systems were tested, as were hoist, the lift and gas systems, there was also an annual legionella water test. The management team kept records of checks they made so that these areas could be audited.

The provider had policies about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. The manager had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time.

People with mobility problems were not always protected by the emergency evacuation procedures practiced by staff. Staff received training in how to respond to emergencies and fire practice drills were in operation, although staff did not know how to use the fire evacuation chair. Staff had a good understanding of the fire procedure in place. The procedure staff practiced may not have taken into account current practice around horizontal evacuation and the additional protections people required. (Horizontal evacuation ensures that people who cannot be easily evacuated due to mobility problems are moved by staff to safe zones that have enhanced fire protection.) Staff told us they operated a 'stay put' policy for people who could not be evacuated quickly in the event of a fire. This meant that people would remain behind a fire door until help arrived.

However, it was not clear from the most recent fire risk assessment, which had been completed by a qualified person, if the fire protection available in the home supported the 'stay put' policy, in line with published guidance about enhanced fire protected zones. This meant that there was at least one person living on the first floor who may be at risk if they were not evacuated by staff in the event of a fire. We have passed this information onto the fire service and have recommended that the provider seeks advice from the fire service about appropriate fire polices and current practice that relates to care home fire safety.

This was a breach of Regulation 12 (1) (2) (a) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The risk from fire were not adequately mitigated by the procedures in place within the home.

The home environment had been designed for people living with dementia in mind. Signage was appropriately used to identify toilets, communal areas and the lounge areas. Toilet door frames and seats were finished in easy to identify colours, like bright blue or red. Different colours of décor assisted people to know where they were in the home. The premises were maintained to protect people's safety. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping and steps were clearly marked, and hand rails were provided. A sensory garden was accessible and flat. Maintenance records showed that faults were recorded, reported and repaired in a timely manner.

Staff were deployed in appropriate numbers within the service to keep people safe. In addition to the manager there were three staff available, including a senior staff member to deliver care between 7.30 am and 10 pm. At night there were two staff available for delivering care. Staff told us there were enough staff to meet people's needs. In addition to the care staff, there was a cleaner, cook and maintenance person in the home.

Staffing levels were maintained in a consistent way by staff that people were familiar with. The current night staff vacancy was covered by a consistently regular member of staff from an agency. The staff rota confirmed that staffing levels were planned and maintained to meet people's needs. The manager had recruited to cleaning and laundry staff roles since our last inspection. This meant that the care staff in the home had more time to spend with people. During the inspection staff were always available to people, and we noted if people pressed their nurse call bells these were answered quickly.

People were protected from the risk of receiving care from unsuitable staff. Recruitment to the staff team was on-going to fill two vacant posts. The manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Staff we spoke with confirmed that the manager followed the recruitment policy. Records confirmed that staff recruitment followed the provider's policy. Staff had been through an interview and selection process. Applicants for jobs had completed application forms and been interviewed for roles within the home. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All new staff 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.

Staff followed the provider's policy about safeguarding people and this was up to date with current practice. Staff were trained and had access to information so they understood how abuse could occur. Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place.

People had been assessed to see if they were at any risk from falls or not eating and drinking enough. If they were at risk, the steps staff needed to follow to keep people safe were well documented in people's care plan files. Additional risks assessments instructed staff how to promote people's safety. Actions had been taken to safeguard people. For example, people at risk were observed by staff to keep them safe. Staff understood the risks people living with dementia faced and made sure that they intervened when people became disorientated, or needed to be prompted to use a walking aid, like a frame.

Guidance about any action staff needed to take to make sure people were protected from harm were

included in the risk assessments. Each person's care plan contained individual risk assessments in which risks to their safety were identified such as falls and poor mobility. A nutritional tool had been used and any person at risk of malnutrition and dehydration had risk assessments in place and records of food and fluids being maintained. Incidents and accidents records were checked by the manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. If people had falls, this was fully recorded so that patterns and frequency could be monitored with actions taken to minimise the risks.

People were protected from the risks associated with the management of medicines. Appropriate assessments had been undertaken for people around their ability to take their medicines and whether they had capacity to make informed choices about medicines. Staff who administered medicines received regular training and yearly updates. Their competence was also assessed by the head of care to ensure the medicines were given to people safely. Staff administering medicines did this uninterrupted as other staff were on hand to meet people's needs. Staff knew how to respond when a person did not wish to take their medicine. Staff understood how to keep people safe when administering medicines.

There was an up to date medicines policy which staff followed. The manager confirmed there was a policy about the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. There were systems in place to ensure that medicines were always available as prescribed. Medicines were stored securely within a safe, temperature controlled environment. Temperatures were monitored and recorded to protect the effectiveness of the medicines. The system of MAR records allowed for the checking of medicines, which showed that the medicine had been administered at the right times and signed for by the trained staff on shift. The senior care staff were responsible for administering medicines and we observed they were doing this safely.

Good

Is the service effective?

Our findings

Some people in the home could speak to us about their experiences. Other people living with dementia were not always able to verbally tell us how about their experiences. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered, or by talking to us about things that were important to them. One person said, "The cook is good." Another said, "I like the food."

A community nurse said, "The staff know people's needs very well. I have just been accompanied by a member of staff to take a blood test. Everything was booked and planned and the person had been supported with fasting as instructed."

Staff understood people's needs, followed people's care plan and were trained for their roles. Relatives spoke highly of the staff. A relative said, "I am more than happy with Mum's care, staff monitor her so that she gets her shower and they always communicate with us so that we are up to date with Mum's care."

People were protected from poor health through not eating and drinking enough. People were given choices about the food and we observed people eating and drinking well. People were offered second helpings. The cook told us that the majority of food offered to people was home cooked from scratch. They told us that they were provided with mainly branded food, there were no corners cut and that they were able to order what they needed. We saw that food stocks were well maintained. There was very little food waste at lunch time, which indicted that people liked the food they had been given. People were offered more food if they wanted it. People could get snack foods and drinks at night and between meals if they were hungry or thirsty. There was fruit available and people could help themselves to sweets displayed in the lounge on a three tier cake stand. We observed snacks being provided, which included homemade biscuits. Menus were varied and seasonal, they were planned to provide a balanced diet for people. A vegetarian choice was also offered. People could choose foods that were not on the planned menu or that differed from their original choice. For example, one person preferred an omelette at lunch time and this was made for them. At lunch time staff were available to encourage people to eat and drink. We observed staff offering to assist people or cut their food for them.

The majority of care staff had been recruited over the last twelve months and many were still in their probationary period. We discussed the staff turnover with the manager and they told us that staff had left for a variety of reasons, but mainly they had moved onto other work. From what people told us, our discussions with staff and from our observations, we found that the staff delivering care in the home were competent in their roles.

New staff received inductions which followed nationally recognised standards in social care. For example, the care certificate work book. Evidence showed that all new staff were enrolled onto a Health and Social Care NVQ/QCF Certificate, a nationally recognised qualification that enables staff to deliver health and social care to a required standard. Staff confirmed they had shadowed more experienced staff and received basic training in the first five days of their employment. Training was planned to consistently provided staff with

the knowledge and skills to understand people's needs and deliver safe care. Staff told us that the induction and training had provided them with the skills to do their jobs well. The manager of the home held a training the trainer certificate for delivering training to new staff. For example moving and handling people. Training records confirmed staff had attended training courses or were booked onto training after these had been identified as part of staff training and development needs. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. The manager had been trained by the community nursing team to provide care in areas such as basic wound care and applying dressings. The manager said, "The community/district nurses were coming in every day to provide wound care. Now that I am trained to do this they only come in once a week or if we call them. We have a very good relationship with the GP and community nursing teams". Other training included awareness of end of life care and knowledge of other conditions people may have such as diabetes and dementia. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

Staff had received training in relation to caring for people with behaviours that may cause harm to themselves or others so that should any issues arise they could respond appropriately. This would enable them to de-escalate situations when people became agitated or anxious. We observed that staff stayed calm and respectful at all times. Staff understood how to keep people calm, which prevented people becoming agitated and anxious and displaying behaviours that other people may find challenging.

Staff were provided with one to one supervision meetings as well as staff meetings and annual appraisals were planned. Supervisions were planned in advance by the manager and were fully recorded. A new planner had started in February 2017. Staff told us that in meetings or at supervisions they could bring up any concerns they had. They said they found supervisions useful and that it helped them improve their performance. Staff confirmed they were receiving supervision and that they were able to discuss any concerns they had regarding care and welfare issues for people living at the home.

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 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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

When they were needed, MCA assessments were carried out by health and social care professionals such as people's GP's. These assessments demonstrated if people had capacity to make decisions about their everyday care, like taking medicines or receiving assistance with personal hygiene. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. These decisions included do not attempt cardio pulmonary resuscitation (DNACPR) forms, and showed that relevant people, such as

social and health care professionals and people's relatives had been involved. Records demonstrated that relatives had been involved in meetings and discussions about how best their loved ones should be cared for.

People's health needs were met and where they required the support of healthcare professionals, this was provided. People accessed support from the chiropodist, the GP, the community nurse and a community psychiatric nurse. Records showed that people, with consent, had received the flu vaccination and other health checks carried out by community nurses, such as blood pressure checks. This protected people's health and wellbeing.

Good

Is the service caring?

Our findings

People living with dementia were not always able to verbally tell us about their experiences of the home. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People described and we observed a caring staff team.

People described their care positively. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. Staff said, "I love this job, working with people is very rewarding." And, "The staff I work with are very caring." Another member of staff said, "People here tell us their needs, they choose how they want to be cared for, they can do things themselves if they prefer and can change their minds." The member of staff went on to describe how people changed their routines each day and how staff supported this. For example, bathing and showering. There were no set routines. We observed staff offering people lots of choices.

Relatives said, "The staff are very polite, friendly and pleasant. They let us know how Mum has been when we visit so that when we meet her we know her mood and how she has been."

A visiting community nurse said, "The staff have been welcoming and friendly, I like the homeliness of the home."

We observed that staff were polite and cheerful. Staff took the time to understand how dementia or other conditions affected people. They got to know people as individuals, so that people felt comfortable with staff they knew well. Staff were aware of people's preferences when providing care. The records we reviewed contained detailed information about people's likes and dislikes. Staff built good relationships with the people they cared for. Staff told us that as a team they promoted a non-discriminatory atmosphere and a belief that all people were valued. This resulted in people feeling comfortable, relaxed and 'at home'. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We observed that staff ensured a lively, jovial atmosphere. We saw staff listening to people, answering questions and taking an interest in what people were saying. When speaking to people staff got down to eye level with the person and used proximity and non-verbal's (good eye contact, caring gestures like a gentle touch, smiles and nods). People responded well to the quality of their engagement with staff.

We observed staff providing care in a compassionate and friendly way. People were able to see information about the time, date, year and weather forecast in the dining room. There was also highlighted information about which staff were on shift. This meant that people could orientate themselves with the here and now. Other people were reading the latest news in the daily papers. Staff spent time talking with people. We observed a member of staff listening to a person telling them about what they did before they moved into the home. People were able to personalise their rooms as they wished. They were able to choose the décor for their rooms and could bring personal items with them. The manager had started a programme of redecoration which included using feature wall, wallpaper. Two people told us they liked the way their bedroom had been decorated, especially the wall paper. People had personalised signage on the outside of

their bedroom doors or memory joggers to help them identify their room.

We observed that staff knocked on people's doors before entering to give care. Staff described the steps they took to preserve people's privacy and dignity in the home. People were able to state whether they preferred to be cared for by all male or all female staff and this was recorded in their care plans and respected by staff.

Staff operated a key worker system. Each member of staff was key worker for three or four people. (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 care.) They took responsibility for ensuring that people for whom they were key worker had sufficient toiletries, clothes and other supplies and liaised with their families if necessary. This enabled people to build relationships and trust with familiar staff.

People had choices in relation to their care. People indicated that, where appropriate, staff encouraged them to do things for themselves and stay independent. Staff closed curtains and bedroom doors before giving personal care to protect people's privacy. People told us that staff were good at respecting their privacy and dignity. Staff we spoke with understood their responsibilities for preserving people's independence, privacy and dignity and could describe the steps they would take to do this. Access to information about people was restricted to staff.

People described staff who were attentive to their needs. The atmosphere in the home was relaxed. There were quiet areas people could go to if they wished to sit away from others. For example, one person had chosen to sit in one of the lounges on their own. People told us staff came quickly when they called them. We observed staff speaking to people with a soft tone, they did not try to rush people.

People and their relatives had been asked about their views and experiences of using the home. We found that the manager used a range of methods to collect feedback from people. There were residents and relatives meetings at which people had been kept updated about new developments in the home. There was a newsletter provided to relatives giving feedback and keeping people updated about vents and changes in the home.

Good

Is the service responsive?

Our findings

People living with dementia were not always able to verbally tell us about their experiences of the home. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People described and we observed a home that was responsive.

Relatives told us they felt confident they could make complaints if they needed to and that their loved ones could take part in a range of activities. One relative said, "There are plenty of activities, we have been to some of the afternoon tea's they lay on. And, "We have never had cause to complain, but if we did need to we are sure the manager would listen to us."

At our inspection on 15 December 2015, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recommendations made by health and social care professionals about people's care and treatment had not always been followed by staff.

At this inspection we found the manager had improved the way staff worked with external health and social care professionals by ensuring that recommended treatments were followed.

The manager sought advice from health and social care professionals when people's needs changed. Records of multi-disciplinary team input had been documented in care plans for speech and language therapist, continence nurses and district nurses. Medicines were reviewed by people's GP. Staff followed guidance and recommendations made by health and social care professionals. This meant that there was continuity in the way people's health and wellbeing were managed.

People's needs had been fully assessed and care plans had been developed on an individual basis. Before people moved into the home an assessment of their needs had been completed to confirm that the home was suited to the person's needs. Assessments and care plans were well written, detailed and reflected people's choices. Care planning happened as a priority when someone moved in, so that staff understood people's care needs. Families were encouraged and participating in assisting staff to meet people's needs.

Staff consulted people's care plans and were aware of, and responded to people as individuals. The care plan for each person had been reviewed every six months or as soon as and when people's needs changed. The manager told us that they were in the process of developing new care plans to consolidate places where staff recorded information, like daily care records. Each person currently had three care plans. A working file in their bedroom and two care plans and assessments record files. Making the care plans more effective would improve the efficiency and quality of the care planning system in the home.

The care plans had been updated to reflect these changes to ensure continuity of their care and support. This had been completed when people's medicines or health had changed. We saw different parts of the care plans had been reviewed at different stages evidencing on-going responsiveness to changes. We saw examples of the manager being proactive when parts of people's care plan required updating. For example,

a person's DoLS authorisation was due to be renewed annually in February 2017. We asked the manager about this and they had already applied to the local authority to get this renewed. Staff knew about the changes straight away because the management verbally informed them as well as updating the records. The staff then adapted how they supported people to make sure they provided the most appropriate care.

The manager and staff worked hard to respond to people's changing needs. As people's dementia worsened, they made changes to keep people comfortable. Care plans evidenced input in people's care from health and social care professionals such as the falls team, dieticians and physiotherapist. People who needed pressure relieving mattresses accessed these and we saw evidence of input from tissue viability nurses. This reduced the risk of people developing pressure ulcers.

People were protected by staff who responded to medical emergencies appropriately. Records of multi-disciplinary team input had been documented in care plans for Speech and Language Therapist, Continence Nurses and District (Community) Nurses. These gave guidance to staff in response to changes in people's health or treatment plans.

Resources were made available to facilitate a range other activities. This promoted an enhanced sense of wellbeing, with staff responding to people's social needs. A large board displayed activities on a daily basis. Best practice guidance was being followed in relation to adaptations for people living with dementia. There was lots of use of photographs. Toilet door frames and toilet seats were brightly coloured so that they could be identified easily by people. The communal areas of the home had been decorated and furnished so that people lived in surrounding that may be familiar to them. For example, the dining room and lounge areas were reminiscent of the 1940/50's period. With a tea room, with dressers displaying vintage items, vintage pictures and decor and sweet shop shelves, with jars of sweets displayed and bright table cloths. People told us they liked the environment and we noted that everyone in the home was using the vintage spaces. Activities included arts and crafts, bingo, cooking, cognitive games and gardening. Newspapers were delivered daily for people to access as well as magazines which were handed out when they were available. These encouraged people to keep up to date with current affairs.

The staff and manager took account of people's complaints, comments and suggestions. There was a policy about dealing with complaints that the staff and manager followed. Notice boards were full of information for people which included how to make complaints. There had not been any recent complaints made about the service. There had been one in 2016 which had been fully investigated and responded to by the provider and manager. This ensured that complaints were responded to. There were examples of how the manager and staff responded to complaints. All people spoken with said they were happy to raise any concerns. People and their relatives said the management were approachable and felt they would listen to their concerns if they had any. The manager told us they always tried to improve people's experiences of the home by asking for and responding to feedback.

People and their relatives had been asked about their views and experiences of using the home. We found that the manager used a range of methods to collect feedback from people. We found that the results of the surveys/questionnaires were analysed by the provider. Information about people's comments and opinions of the home, plus the providers responses were made available to people and their relatives.

Requires Improvement

Is the service well-led?

Our findings

The provider was often in the home to oversee the management of the home. People told us they knew the provider and manager and often saw and spoke to them. A new manager had been appointed to run the home on a day-to-day basis. They were qualified and experienced in managing staff caring for older people. They had continued their professional development and had recently completed an enhanced management qualification and NVQ's relating to their role. They had taken on 'training the trainer' responsibilities for basic wound care, moving and positioning people and medicines. This meant that they could train staff within the home.

The manager often worked side by side with staff delivering personal care. This meant they knew people and their needs well. However, the new manager had already completed their application to register with CQC in July 2016, but had not completed the process. We have recommended that the provider supports the manager to register with CQC in a timely manner.

There was a 'People's Charter' for the homes which informed people of the mission, vision and values of the care they would receive. For example, it told people they had the right to feel safe, to be treated with dignity and respect and that people's rights to maintain their independence would be at the forefront of their care. We observed staff delivering care to people within these values and the manager had introduced things like flexible breakfast times to promote choice and independence for people.

The manager carried out regular audits of health and safety risks within the home and of the quality of the home provided. The provider told us that they listened to people's views about how to improve the home and that they considered and acted on requests made for additional resources. We saw examples of expenditure the provider had made in response to request for improvements.

General risk assessments were completed for the environment and the steps to be taken to minimise risks were recorded. Home 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 were effective and covered every aspect of the home.

Managers reviewed the quality and performance of the home's staff. They checked that risk assessments, care plans and other systems in the home were reviewed and up to date or fit for purpose. For example, the manager had identified that the care plans needed to be improved and was already working on these. Audits ensured that issues identified were actioned and checked to improve home safety and quality.

People benefited from staff with a strong sense of team spirit. We observed and spoke to staff who were motivated and engaged in their roles. Staff were asked their views about the quality of the home. Staff were able to attended team meetings to discuss their views about the home and receive information from managers. Staff described the culture and values of the home as being grounded in respect and on promoting people to retain what independence they could. Staff told us there was an emphasis on creating

normality and a 'home from home' for people who lived at Copperfield's. Staff told us that team work and communication at Copperfield's was excellent. They said that they were not worried about sharing any concerns that they might have about the care provided. They talked about person centred care and about shaping the home to people's individual needs. Staff said that they could talk openly with the manager and that she made herself easily accessible to encourage them to do so.

Maintenance logs ensured that repairs were carried out safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. Maintenance records were kept to ensure that specialist servicing of fire safety systems and equipment such as lifts underwent preventative maintenance. This ensured that people were protected from environmental risks and faulty equipment.

The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the home. The provider had been working closely with the local authority commissioning team to improve the quality of the home. This ensured that people could raise issues about their safety and the right actions would be taken.

Managers were committed to making the home a good place for staff to work in and they promoted good communication within the team. The manager was very hands-on and was well respected by people and staff, who had good things to say about her. She communicated freely with staff and seemed at ease, staff were happy to engage with her. Staff told us they enjoyed their jobs. New staff told us they were made to feel part of the team from the day they started. Staff felt they were listened to, they were positive about the management team in the home. Staff spoke about the importance of the support they got from senior staff, especially when they needed to respond to incidents in the home. One member of staff said, "People get the care they need from motivated staff, the manager listens to us and we support each other as a team". Other staff told us their experiences were similar and they confirmed they attended team meetings. The manager ensured that staff received consistent training, supervision and planned appraisal so that they understood their roles and could gain more skills. This led to the promotion of good working practices within the home.

There were a range of policies and procedures governing how the home 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 home. Staff told us they were aware of the policies. We saw that staff read and signed the policies that covered their work.

Audits within the home were regular, responsive and drove improvement. Senior staff carried out daily health and safety check walk rounds in the home and these were recorded. Audits clearly identified improvements needed and these were recorded. We saw examples of the actions the manager had taken in response to the audit that took place in September 2015. For example, more staff needed training in the techniques to manage challenging behaviours and general risk assessments in the home needed updating. We saw that more training for staff had been organised and that the general risk assessments had been updated. This showed that audits were effective and covered every aspect of the services provided at the home.

The manager produced development plans showing what improvements they intended to make. These plans included improvements to the premises. The provider was kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed.

The manager was proactive in keeping people safe. They discussed safeguarding issues with the local

authority safeguarding team. The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the home. We saw that they attended meetings with the local authority about safeguarding matters and carried out investigations into allegations of staff misconduct and took appropriate action to keep people safe. This ensured that people and staff could raise issues about safety and the right actions would be taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b). The risks from fire were not adequately mitigated by the procedures and control measures in place within the home.