Surrey and Borders Partnership NHS Foundation Trust

Courthill House

Inspection report

Court Hill
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Court Hill House provides personal care and accommodation for up to 10 adults with a learning disability. At the time of the inspection there were eight people living in the home.

This inspection took place on 6 January 2016 and was unannounced.

There was a registered manager in post, although he was absent from the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The area manager was acting as the manager and had begun the application process to become the registered manager. As the registered manager was not present during our inspection and we were assisted by the shift leader and the Trust service manager.

Although we found staff treated people in a kind and caring manner at times we observed occasions when staff did not treat people with the respect they deserved. We heard staff use outdated language and display outdated practices in relation to the information they recorded.

Staff carried out checks to make sure that any risks of harm to people were identified however we found these assessments lacked information and guidance for staff. Staff deployment around the home meant people did not always have regular interaction from staff.

People were not provided with a nutritious or varied diet and staff did not always monitor people to check they remained at a healthy weight.

People had access to the community although at times this was limited due to lack of drivers. Activities were not always recorded to show what people had participated in. Care records for people did not contain information for staff on people's preferences, likes or dislikes.

Where there were restrictions in place, staff had followed legal requirements to make sure this was done in the person's best interests. Staff understood the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

Staff were aware of their responsibilities to safeguard people from abuse and were able to tell us what they would do in such an event. People's care would not be interrupted in the event of an emergency and people needed to be evacuated from the home as staff had guidance to follow.

Staff were provided with induction and training to help them carry out their role in a competent way. Staff had the opportunity to meet with the line manager on a regular basis to discuss aspects of their work.

Appropriate checks were carried out to help ensure only suitable staff worked in the home. Accidents and

incidents were recorded and staff took appropriate action to reduce the risk of further accidents. Staff followed safe medicines management practices and people received their medicines when they required them.

People were supported to access external health services and professional involvement was sought by staff when appropriate. Guidance was in place for staff to identify when people may be in pain.

We saw some good examples of caring practice by staff and where possible people were encouraged to do things for themselves.

A complaints procedure was available for any concerns and relatives and people were encouraged to feedback their views and ideas into the running of the home.

The provider and staff carried out a number of checks to make sure people received a good quality of care.

During the inspection we found breaches 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Individual risks of harm to people had been identified but guidance for staff was sparse.

There were enough staff to meet people's needs but we found they were not always deployed appropriately.

People's medicines were managed safely.

The provider employed staff to work in the home who had undertaken appropriate checks.

Accidents and incidents were monitored and people would continue to receive care in the event of an emergency because there was a contingency plan in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not provided with nutritious food and people's weights were not monitored regularly enough.

Staff received appropriate training and were given the opportunity to meet with their line manager regularly.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People had involvement from external healthcare professionals.

Is the service caring?

Requires Improvement

The service was caring but staff did not always show respect.

Staff did not always show respect to people or consider the way they acted in front of people.

People did received some caring interaction from staff and were

encouraged to do some things for themselves.

Relatives and visitors were able to visit Court Hill House at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care records did not reflect their preferences, likes or dislikes in enough detail for staff who may not know people.

People were able to take part in activities, but records relating to people's leisure time were not complete.

Information about how to make a complaint was available.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although the home had a registered manager they were absent from the service.

Staff had not always felt supported by management.

Staff carried out quality assurance checks to ensure the home was meeting the needs of people. Actions from these audits were being addressed.

People, relatives and staff were involved in the running of the home.

Courthill House

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 an unannounced inspection that took place on the 6 January 2016. The inspection was carried out by two inspectors.

Prior to this inspection we reviewed all the information we held about the home, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

We had not asked the provider to complete a Provider Information Return (PIR) on this occasion. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This is because we carried out this inspection sooner than we had planned.

As people who lived at Court Hill House were unable to tell us about their experiences, we observed the care and support being provided and talked to relatives and other people involved following the inspection.

As part of the inspection we spoke with two staff, three relatives and the Trust service manager. We spoke with one health care professional to gain their feedback as to the care that people received. We looked at a range of records about people's care and how the home was managed. For example, we looked at three care plans, medication administration records, risk assessments, accident and incident records, complaints records and internal and external audits that had been completed.

We last inspected Court Hill House in June 2014 where we identified some breaches in the regulations in relation to the premises and records.

Requires Improvement

Is the service safe?

Our findings

A relative told us they felt their family member was safe. They said, "Totally safe because there are always staff about."

We found a sufficient number of staff working in the home, however deployment of staff was not organised so people received regular interaction from staff. Staff were responsible for all domestic tasks including the cleaning, cooking and laundry and staff often appeared focussed on these tasks rather than spending time with people. For example, following breakfast (which had just finished when we arrived) we saw staff carrying out daily tasks around the home. We noticed this happened regularly throughout the day and there were many occasions when people where sitting in the lounge areas for long periods of time without staff being present. One staff member told us they felt there were not enough staff to support people how they would like to. They said they would like to spend more time with people during the lunch. We noted during lunch time staff were rushed and people's meals were interrupted because staff were continually walking to and from the kitchen to fetch things.

We recommend the provider reviews deployment of staff to enable them to interact with people regularly.

People's care plans contained specific sections on keeping people safe. We saw risk assessments were in people's care records however due the format of risk assessment they did not allow for much detail to be completed and were quite generic. For example, one person's care records stated they were at risk of falls, however there was no conclusion to the falls risk assessment to show how these may be mitigated. This person had a visual impairment, but this was not mentioned in the risk assessment. Another person had recently been advised to use a wheelchair around the home however this this person's risk assessment had not been updated. The Trust service manager told us they were currently in the process of updating the care records and he planned to have this completed within the next few days.

We recommend the provider reviews information relating to potential risks for people.

Accidents and incidents were logged and staff took action to mitigate the risk of the accident or incident occurring again. We read the log included the details of any incident, how it had been dealt with by staff and what actions had been taken to avoid reoccurrence. For example, one person had several falls and staff had booked an appointment the GP to see if the person had an ear infection.

Staff were knowledgeable about their responsibility should they suspect abuse was taking place. Information on who to contact if abuse was suspected was displayed in the office. Staff told us who they would go to if they had any concerns and they knew about the local authority and their role in safeguarding people. Staff had access to a whistleblowing policy which meant they had guidance on how to raise concerns about any aspect of the home.

People's medicines were managed safely. We found the medicines cabinet was neatly organised and people's medicines were labelled. Staff medicines training was up to date and there was a 'good medicines

practice' reminder in place for staff. Medicines Administration Records (MAR) were completed accurately and each contained a photograph of the person to ensure the medicine was given to the right person. This was signed by staff. PRN (as needed) and homely remedy (medicines which can be bought over the counter without a prescription) medicines were used and we read assessments for these were in place with the involvement of the GP. Clear guidance was provided to staff on when to give PRN medicines, which included the reason the person may need it together with the types of behaviour a person may display to indicate they required it.

Medicines were dispensed to people safely. We observed medicines being given to people in the way they preferred them. For example, with water. We also found that people who suffered from epilepsy had a 'seizure' record and treatment plan developed by the GP in order that staff could ensure they administered treatment in a safe way when people experienced a seizure.

The provider carried out appropriate checks to help ensure they employed suitable people to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

People's care and support would not be interrupted or compromised in the event of an emergency. Guidelines were in place for staff in the event of an unforeseen emergency and there was a contingency plan in place in the event the home had to close for a period of time. Each person had an individual personal evacuation plan which detailed their needs should they need to evacuate the building.

Requires Improvement

Is the service effective?

Our findings

Staff told us people were involved in decisions about what they ate and drank. They (staff) said that pictures were used for people to select what they would like to eat. However, we found there were very few pictures available for people and nothing displayed to show people what choice they had. Staff said there were two choices of meal at dinner time and those people who could understand were offered a choice, but those who could not were given a meal based on staff knowledge.

People did not always receive a well-balanced diet. We looked at the four-week rolling menu and noted there were few choices. Where choices did appear they were limited to a variation of the same item for example, two types of pasta bake or soup. At lunch time we saw people were offered tinned soup served with large chunks of white bread. We saw one staff member use their hands to put the pieces of roll into someone's soup to encourage them to eat it. We looked in the cupboards and at the shopping list and found quantities of mainly processed foods such as tinned stew or curry, hamburgers, chicken nuggets, ready meals and hotdogs. Staff told us they were unaware of how the shopping was done as the registered manager had always done this and that people were not routinely involved in the shopping for food.

Staff did not monitor people regularly enough to check whether or not they were losing weight, particularly when people routinely did not eat their meal. Staff told us they weighed people every two to three months. However, we had noted during lunchtime four people did not eat their meal and staff did not offer them an alternative. As a member of staff took away one person's lunch they commented, "She doesn't want lunch. That's not an unusual thing." We spoke with staff about this who told us they were certain this person would eat their dinner. However, they said they did not regularly weigh this person to see if the lack of eating was having a detrimental effect on them. Another person's weight showed a loss of seven kilograms in a three-month period, although staff told us this was an error, but they had not recorded the person's correct weight.

The lack of nutritious food was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff identified risks to people in their eating and drinking. We saw that people who required a particular diet (because they may be at risk of choking) had guidance from the Speech and Language Therapy team on how their meal should be served. For example, soft or pureed. We read how one person required a long-handled spoon to eat their meal and another had to be fed by staff using a desert spoon. We saw both of these happen on the day.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) processes were implemented appropriately. 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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that staff knew of the implications of the MCA and DoLS. Mental capacity assessments had been completed for people when making specific decisions such as having a flu jab or blood test. DoLS applications made where necessary. For example, in relation to the outside locked gates. We read in one person's care records that staff should, 'hold a best interest meeting for any major decisions'.

Staff had received training in the MCA and DoLS and told us it was about people making choices and decisions. One staff member told us, "When I'm out shopping for clothes with x I hold them up and if he smiles I know he likes it."

People received support from staff who had the necessary skills. This was confirmed by staff who told us about their induction and training programme. One member of staff said they were fully up to date with their training. We looked at the training records which showed us that staff were up to date with the Trust's mandatory training. Training included safeguarding, fire safety, medication and basic life support.

Staff told us they had regular supervisions and an appraisal each year which meant they had the opportunity to meet with their line manager on a one to one basis to discuss progress, training requirements or aspirations. It also meant the manager could ensure staff were putting their training into practice.

Relatives told us the care provided to their family member was effective. One relative said their family member who did not speak now spoke a few words, laughed and was, "Transformed" due to the care of staff.

Each person had a health action plan in place which detailed the various health care professionals involved in their care, for example the GP, optician or dentist. We read people were referred to health care professionals when appropriate, for example one person had recently been referred to the physiotherapy team following a number of falls. People's care records contained details for staff on how to tell or react if someone was in pain.

Requires Improvement

Is the service caring?

Our findings

Relatives told us they were happy with the care provided. One said, "Totally happy." Another told us, "Very happy. Staff are very good. It's a lovely place, we are lucky to have her there." A further commented, "He is looked after very well indeed."

Despite these comments however we observed staff display outdated practices in relation to the language they used with people. Some staff did not always think about what they were saying in front of people which meant they were not always respectful. For example, we heard one member of staff say to one person, "Yes, your nails are beautiful but you can't sit and stare at them all day." Later on staff they said to another person, "Good grief, have you seen the chocolate around your face?" When the person did not successfully clean their face the staff member said, "I'll do it because you are lazy." During lunch we heard staff give orders to people. For example, we heard, "Choose one", "Sit down you" and, "Come with me." One staff member said in a firm voice to one person, "Are you going to eat it or not?" And on another occasion said, "No, no, you are not going anywhere" very loudly to another person who wished to leave the dining room before they had their drink.

Staff did not always treat people in a considerate way. We saw during the lunch time staff were constantly in and out of the dining room which meant people's meals were interrupted. We saw one person being given two spoonfuls of their lunch but the staff member then walked away, without explanation, to do something else before returning to continue with the lunch. Staff did not tell people what the lunch was when it was put in front of them and despite two people sitting staring at their lunch and not eating, staff ignored them and did not encourage them to eat until the end of lunchtime at which point their soup would have been cold. We saw staff move people in their chairs out of the way so they could get past without telling them they were about to do.

Staff did not give people time to make their own decisions. We heard one staff member during lunch say to one person, "Would you like a yoghurt?" But before waiting for the person to make a choice of yoghurt one was put in front of them by staff. After lunch when people were being offered a cup of tea, a staff member said to another staff member, "Give her a cold drink. She's had a cup of tea" rather than asking the person what they would prefer.

Staff spoke about people in front of other people. For example, we heard two staff members discuss a rash on someone's face during lunch openly and loudy in front of other people and as though the person they were discussing was not in the room. We also heard staff ask people very loudly if they would like the toilet. Just before lunchtime one staff member said, "I'm just going to put x on the toilet, the girls have all been" in front of people.

The language staff used was not always caring. We read in daily notes staff had written comments such as, 'playing with toys' or 'x was in a foul mood this morning, lots of hitting chair arms and screaming' and 'a second bath put him in a bad mood for rest of afternoon, left to his own devices to relax.'

Staff had not always ensured people were living in a homely environment. We noted a large noticeboard in the dining room of the home. This was used to display information for staff, rather than for people living in the home. It was full of poster's and information relating to aspects of working at the Trust. In one hallway in the home there was a montage of photographs displayed on the wall, but we found many were curled at the edges and the display looked untidy.

The lack of treating people with respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received some personalised caring care from staff. For example, we saw staff give people privacy when they wanted it. One staff member told us they were always conscious of people's privacy. They said they would always knock on people's doors and ensure doors and cutains were closed during personal care. One member of staff spent time with two people painting their nails and we saw another member of staff offer people a drink and biscuits during the morning. One person refused and the staff member then offered them a biscuit softened with liquid in a bowl which the person accepted.

Staff promoted independence where they could by encouraging people to do little things for themselves, such as pulling their trousers up on putting on their jumper. People were able to move freely around the home and we observed staff offering reassurance to people when they were doing so.

Relatives were able to visit when they wanted and were made to feel welcome and relatives told us they felt involved.

Requires Improvement

Is the service responsive?

Our findings

Care plans reflected what care people required but were functional and brief. We found care plans did not include people's personal history, likes or dislikes in any detail. For example, one person's care records noted they liked to watch TV, but it did not say which programmes they preferred. Another person liked to go for drives and meals, but the records did not state where they liked to go. The plan was split into times through the day for example, 'get dressed at 07:30, offer hot drink and biscuit at 10:30'. The Trust service manager told us he was updating all of the care records and we viewed some of these. We found some of the language had been changed, but in others there was little difference. We looked at the one-page profiles for people which were being developed, but again these gave little guidance to staff about people's likes and dislikes. For example, in the 'what's important to me' section it was written for one person, 'I'm a loner, laying on sofa, musician, sister, soft sweets' but there was no further detail.

People had personal care plans which covered their physical health, medicines and daily care needs. However, these were not always cross-referenced with their risk assessments. For example, one person who liked going out in the car did not have reference to the fact they should sit away from the car door as they 'fiddled' with the locks.

People may not receive responsive care. We read in one person's healthcare checklist reference to their visual impairment, stating their vision was so impaired they may not be able to see the food on their plate. However, this was not recorded anywhere in this person's care records or personal care plan. Another person did not like waiting for their food when they ate out, but there was no guidance for staff on how this person may react or indicate they were becoming impatient. A further person's care records had not been updated to reflect their use of a wheelchair within the home.

The lack of person-centred assessment of needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to the community, but we found activities were not always recorded appropriately to show people had participated in them. For example, we read staff used a 'shift planner' in which they recorded what people did during the morning and afternoon. We carried out an audit of three people's activities over a period of five days. We found that during that time staff had recorded activities such as, 'enjoying chocolates', 'laundry' or 'face and hands creamed'. One person's activity plan stated they should have eight one to one sessions per week, however we found no consistent records of this within their daily notes for a period of one month. Some of the activities they liked to participate in were mentioned a few times, but not consistently.

We did not see much written evidence of people participating in constructive activities and noted that most trips out in the community were as a result of people being taken out by staff from day services. Some people liked to go to church services, however we did not read that staff had supported them to do this for over four weeks. Staff told us this was the case, however there was an in-house service each month. One person was supposed to walk to the shop on the morning of the inspection, but this did not happen. A

member of staff told us one person liked to go to the cinema, however when we asked the last time this happened they told us, "We aren't going to the cinema at the moment."

Staff told us they were restricted at times because of a lack of staff available to drive the home's vehicle. One staff member told us that of 12 staff only three were able to drive the vehicle and they would have to think about whether or not people could use taxis. They said, "The activities are lacking. We know this. We need to improve." We asked staff if people were encouraged to participate in, for example, preparing meals and were told this wasn't possible because, "We can't get more than one wheelchair in the kitchen at one time." A healthcare professional told us they had identified this as an area that was lacking and had made suggestions to staff on how to establish routines whereby people could get involved in the cooking. We did however see an external musician came in during the afternoon of the inspection. We saw initially staff were not present during this session, but later saw staff dancing and joining in.

Relatives told us however they were happy with the activities that were organised. One relative said, "They do an awful lot with him. He goes on holidays now which he's never done in his life before." Another told us, "There is enough for her to do." A further relative did tell us there had been a lack of activities when their family member first moved into Court Hill House, but things were now being organised which were meaningful to him.

We recommend the provider remind staff of the importance of recording comprehensive notes in respect of people's leisure time and that they ensure people have access to activities which are individualised and meaningful for them.

Complaint information was available and there was a system in place for recording if complaints were received. We were told no formal complaints had been received about the home. Relatives told us they knew they would speak to the manager if they had any concerns.

Requires Improvement

Is the service well-led?

Our findings

Staff told they had not always felt supported by management, but they thought things were improving. One staff member told us, "From today things will be managed well, we will be going out with people again and working as a team." Another member of staff said, "We are getting there now. The service manager is very good and he has supported us." The Trust service manager told us the registered manager would be absent from the home for the foreseeable future and that he and another registered manager would be taking over the management oversight of the home.

We recommend the provider supports staff to create an environment which is caring and respectful.

We observed staff working together and it was evident they knew people well as staff had worked in the home for a long time. One member of staff told us, "We need to ensure everything is here for them as they get older." One relative told us they felt staff worked well together and another said that staff knew people well.

Staff held meetings with people so they could be included in decisions about the running of the home. We read the notes of the last two meetings and saw activities, the premises and general topics were agreed or discussed. We read people had gone on holiday's during the summer and a Christmas party had been planned.

Relatives were encouraged to give feedback about the home. We read some comments from the most recent survey which included, 'first class, high quality of life' and 'looks after my brother very well.'

Staff were involved in the decisions about the home. We read there were regular staff meetings where staff discussed a variety of topics. These included activities, the premises (which had recently been decorated) and other subjects relating to the home or the Trust. There was also a weekly e-bulletin produced by the Trust in which staff could obtain general information and updates that may be relevant to them.

The home was quality assured to check that a good quality of care was being provided. Staff carried out a number of checks and monthly health and safety and environment checks. For example, in relation to water temperatures, vehicle checks, fire checks and medication. We saw actions for issues identified in audits had been carried out. For example, repairs to fire doors.

The Trust carried out regular audits of the home which focussed on different elements. For example, we saw one visit had concentrated on training and another care records. We saw actions identified during these audits were being carried out. For example, it had been noted care records were out of date. The Trust service manager was currently carrying out this piece of work.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people's preferences for care and treatment were recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not ensured people were always treated with respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had not ensured people were provided with nutritious food.