Coach House (Carleton-In-Craven) Limited

The Coach House

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

Overall summary

This was an unannounced inspection carried out on 8 December 2014.

The Coach House Residential Home is registered to provide care for up to fifteen adults. The Coach House is not a nursing home. The house is a large detached property, set in its own grounds in Carleton near Skipton in North Yorkshire. There are both single and shared rooms. The three double rooms are also used for single occupancy, depending on individual choice and availability. A stair lift is provided to take people from the ground floor up to the first floor.

There was a registered manager in post, who is also the registered provider, along with her husband. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People who used the service told us they were very happy living at the service. They said they felt safe and knew how to report concerns if they had any. We saw care practices were good. Staff respected people's choices and treated them with dignity and respect. People were encouraged to maintain good health and received the support they needed to do this. Medication was managed safely and people received their medication when they needed it and as prescribed for them.

People told us they enjoyed the food in the home and that staff knew what they liked and provided food they could enjoy. Meal times were organised in a way which made them a social occasion for people.

People told us they thought they had enough to do to occupy them through the day and they told us their visitors were made to feel welcome. Our observations on the day of our visit, showed people were engaged in meaningful activity and socialisation.

Staff said they felt well supported in their role and knew what was expected of them. Staff told us they received supervision every two or three months and one member of staff confirmed they had had an appraisal recently. Staff told us they could discuss their role and learning needs during their supervisions. The registered manager was not available during our inspection so the joint registered provider assisted with the inspection. It was evident that the registered manager and registered provider were aware of their responsibilities regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, staff had not been trained in this area and therefore we could not be confident that they were aware of the implications of this legislation for people who used the service. The registered provider told us there were plans to provide a training event for staff in the New Year.

We found people were cared for by a sufficient number of suitably qualified, skilled and experienced staff. However, we asked the registered provider to make sure they were providing enough staff during the night time and that staff on duty could meet the needs of those needing assistance during the night and continually assess the needs of people during this time. There was a training programme being developed for staff to ensure they were kept up to date and aware of current good practice. Robust recruitment procedures were in place and appropriate checks had been undertaken before staff began work.

Staff and people who used the service spoke in positive terms about the management team; saying they were approachable and that it mattered to them to provide a good service. We found that systems were in place to monitor the quality of the service and that the registered provider was continually looking at ways to make improvements in the home.

People told us they were confident to make a complaint if they needed to. Staff were aware of how to support people to raise concerns and complaints and we saw the registered provider learnt from complaints and suggestions and made improvements to the service when necessary.

Summary of findings

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 was safe.

Good

People who used the service said they felt safe. We saw robust safeguarding procedures were in place and staff understood how to safeguard people they supported. There were effective systems in place to manage risks to the people who used the service.

People received their medicines at the times they needed them and in a safe way.

There were sufficient staff to meet the needs of people who used the service. However, we asked the registered provider to make sure they were providing enough staff during the night time and that staff on duty could meet the needs of those needing assistance during the night.

Recruitment practices were safe and thorough. Policies and procedures were in place to make sure any unsafe practice was identified and people who used the service were protected.

Is the service effective?
The service was effective.

Good

Staff had received training on a number of mandatory courses, however this had not included the Mental Capacity Act 2005 and staff could not fully demonstrate their understanding of this to ensure people's rights were protected.

The system used to record staff training did not allow us to assess the level of training all staff had undertaken and if training needed to be repeated. The provider told us they were in the process of reassessing the training needs of all staff and that a training programme was to be organised accordingly. Despite this, staff told us they had received good training which helped them carry out their individual roles properly.

Health, care and support needs were assessed and met by either the staff in the home or by regular contact with other health professionals. Care plans were up to date and gave a good account of people's current individual needs.

People said they enjoyed the food in the home.

Is the service caring?
The service was caring.

Good

People had detailed, individualised care plans in place which described all aspects of their support needs.

People were supported by staff who treated them with kindness and were respectful of their privacy and dignity.

Is the service responsive?
The service was responsive.

Good

People were supported to be involved in person-centred activities, which they told us they enjoyed. People who could not occupy themselves were offered activities on a group or individual basis.

Summary of findings

There were good systems in place to ensure complaints and concerns were fully investigated. People who used the service and their relatives were aware of how to report concerns.

People's needs were assessed before they moved in to the service and whenever any changes to care needs were identified.

Is the service well-led?

Good

The service was well-led.

People who used the service were protected because systems for monitoring the quality of the service were effective and the registered provider and registered manager were available daily.

People spoke positively about the way they were looked after and cared for by all the staff, the registered manager and the registered provider. Staff were aware of their roles and responsibilities and knew what was expected of them.

The Coach 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 unannounced inspection was carried out on 8 December 2014. The inspection team consisted of a lead inspector and an Expert by Experience, who had personal experience of older people's care services and particularly people who are living with dementia.

During the visit, we spoke with twelve people living at the home, two relatives, two care staff, one visiting health professional, the registered provider and the administrator.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We observed care and support in communal areas and also looked at some people's bedrooms.

We reviewed a range of records about people's care and how the home was managed. This included the care plans for four people, monitoring records for food and fluid, daily records for five people, district nursing notes for four people, three staff files, twelve people's medication records and the quality assurance audits that the home had completed.

Before the inspection we reviewed all of the information we held about the provider. We also contacted commissioners of the service and Healthwatch to obtain their views about the care provided in the home. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We asked the provider to complete a Provider Information Return (PIR). This 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. We visited the service before the PIR was due to be returned to us. However, we took this into account when we made the judgements in this report.

Is the service safe?

Our findings

All the people we spoke with said they felt safe at the home. People's relatives also told us they felt their family members were safe and security at the home was good.

Staff showed they had a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of the external agencies they should contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us about the homes whistle blowing policy and that they felt able to raise any concerns with the registered manager knowing that they would be taken seriously. The provider's policy on safeguarding included information on staff's roles and responsibilities, referrals, identification of abuse, prevention of abuse, types of abuse and confidentiality. We saw the contact details for the local safeguarding team were available to enable staff to use them if needed.

Care plans had been improved over recent months and demonstrated individual risk assessments had been carried out. There were risk assessments in place which identified the risks for the individual and how these could be reduced or managed. We saw risk assessments relating to such matters as mobilisation, tissue viability, nutrition and support needed. For example, where the person had swallowing difficulties. Discussions with staff indicated to us that they were fully aware of the benefits of robust risk assessments in delivering safe care and monitoring people's wellbeing.

Appropriate recruitment checks were undertaken before staff began work. These checks helped to make sure job applicants were suitable to work with vulnerable people. We looked at the recruitment process for three staff, one who had recently started work at the home. All the relevant information was available in the file to confirm these recruitment processes were properly managed, including application forms and evidence of qualifications and written references. Records of Disclosure and Barring Service checks were available and held securely. We saw enhanced checks had been carried out to make sure prospective staff members were not barred from working with vulnerable people.

The home also supports work experience with specialist support where needed. For example, on the day of our visit a trainee was working in the communal areas with people using the service, the trainee was being supported by a signer. People using the service told us they enjoyed the interaction.

We looked at staff rotas and along with our observations found that adequate staffing levels were provided during the time we were in the home, 8.30am until 4.30pm. We spoke with the registered provider to determine the method of calculating the staffing on each shift. The registered provider's response confirmed that the dependency of each person was taken into account for calculation of the staffing requirements. We were also told by the registered provider that extra staffing was used if a particular person's care needs increased. And staff we spoke with confirmed this to be the case.

However, we discussed at length the needs of people during the night, and the fact one carer is provided, with the registered provider and registered manager on call. It was acknowledged that the lone worker wears a panic alarm, which if activated by them, sounds in the house, where the registered provider and registered manager live, which is in the grounds. We were told by the registered provider that if alerted they can be at the care home, from their own home, in two minutes. However, we also noted that three people, who used the service, required two people to support them to dress, wash and walk during the day. Two of the three people also required two hourly turns during the night to help prevent pressure ulcers. The registered provider told us the night staff had not raised any concerns about lone working and that they could manage to care for people during the night, because people were in 'profiling' beds and could follow instructions when their position was being changed or if they needed assistance with their personal care whilst in bed. A profiling bed is an adjustable bed, the type often found in hospital. We also spoke with a member of staff, who had recently worked a night shift at the home, who confirmed what the registered provider had said. However, when asked, the registered provider had not been present during the night to evaluate if the care being delivered was safe and acceptable. It was agreed with the registered provider, that the registered manager would work alongside the night staff to review the care practice and carry out a risk assessment and record the outcome of a lone night staff and how this was being safely managed.

Is the service safe?

The registered provider agreed to monitor the staffing arrangements during the night to ensure the regulations were being met and keep a record of the action taken to confirm this.

One person who used the service said, “There are enough staff around to give me a hand if I ask for a bath or shower. There is always someone 24/7 to look after me.” Another person told us they thought there were enough staff and they did not have to wait long when they asked for assistance or used their call bell.

We looked at a sample of medicines and records for twelve people living at the home as well as systems for the storage, ordering, administering, safekeeping, reviewing and disposing of medicines. Medicines were stored securely and the medication trolley was stored securely when not in use. We found there were adequate stocks of each person’s medicines available with no excess stock.

The home had policies, procedures and systems for managing medicines and copies of these were available for care staff to follow. Medicines records were clear and accurate. We checked a sample of twelve people’s medicines against the corresponding records and these showed that medicines had been given correctly.

One person we spoke with said they always received their medicines on time and when they needed them. This included pain relief. Some medicines, such as painkillers, were prescribed to be taken only ‘when required’. Some people living in the home could ask for these medicines when they needed them. However, some people had poor communication skills and were unable to do so. However, staff explained to us how they could tell if someone was uncomfortable by how they were or how they were sitting.

Personalised information had been prepared for staff to follow to enable them to support people to take their medicines safely and with due regard to their individual needs and preferences.

Medicines were only handled and administered by trained staff. Further refresher training sessions had been booked and the registered provider told us that staff would be undertaking assessments to ensure they continued to have the appropriate skills to manage medicines safely.

We spoke with staff about the training they had received to allow them to deal with emergencies. We were told first aid training was covered in the induction programme. Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence.

Our inspection of the building showed it was a safe environment overall, in which to care for vulnerable people. We discussed the stairwells, which people have access to, and whether they would benefit from having a gate at the top and bottom, to help prevent people from falling down the stairs or having access to these areas. The registered provider told us he had discussed this with the fire safety officer and consideration had been given to this under The Regulatory Reform (Fire Safety) Order 2005. The decision had been made in consultation with the fire safety officer to not provide these at the present time. We also discussed the equipment used for assisted bathing and hoisting. Although we were told, and could see the equipment was new, there was no evidence to show that the equipment had been serviced recently or checked to make sure it was safe to use.

Is the service effective?

Our findings

Throughout our inspection we saw that some people who used the service were able to express their views and make decisions about their care and support. People were asked for their choices and staff respected these. Our discussions with staff, people using the service and observed documentation showed consent was sought and was appropriately used to deliver care. In addition we saw staff seeking consent to help people with their needs. When people were not able to verbally communicate effectively, we saw staff accurately interpreting body language to ensure people were comfortable and their needs were being met.

People told us they received good support and staff carried out their jobs well. People's comments included; "The staff are lovely. The doctor always comes out if there are any problems." One relative told us, "[Name] is looked after well. They don't communicate much now but the staff ensure that the routine they keep ensures their health is put first."

Whilst the staff had tasks and duties to complete, they did this in a way which was inclusive and they managed to interact and provide support to people as required. This made for a relaxed and lively atmosphere, which people seemed to relate to in a positive way.

Residents were encouraged to sit in a communal lounge or they could sit in their individual rooms, wherever they felt more comfortable.

The staff were all familiar to the residents with staff covering for each other during sickness and holidays meaning agency staff were never used, creating an environment that was familiar for all residents.

Staff encourage residents to use their walking aids to move between rooms which offers them independence but also safety from falls and trips.

One person told us, "The care here is spot on, you get a few laughs out of them, they are all great." Relatives also spoke positively of the staff. One said, "Some of the staff have been here a long time. The owners are around a lot and they make sure we are kept informed and my [relative] couldn't be happier."

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff had not received training in the Mental Capacity Act 2005 (MCA) or DoL's. Staff demonstrated variable understanding about this legislation. The less experienced staff could not adequately demonstrate to us the most basic understanding. The registered provider was able to give examples of instances when best interest decisions had been made, but not formally or involving other relevant professionals. However, training was to be arranged to ensure staff had a better understanding of the MCA and DoL's. They told us they were in the process of looking for a local training provider and planned to arrange this for early 2015.

Work had been carried out recently to improve the information recorded in care plans. Risk assessments had been rewritten to include more information, care plans had been reviewed and additional details provided to reflect the care required by individuals. Work was progressing to complete documentation entitled, "This is me" and relatives and those who knew the person well were being consulted in the completion of these. The final document was intended to be used if someone was moved to an unfamiliar place, for example hospital, and provide information which would help those providing support. Some care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions where appropriate. We saw that the registered manager had worked with the local doctor's surgeries to make sure the decisions were still valid and relevant.

Records showed that arrangements were in place that made sure people's health needs were met. We saw evidence that staff had worked with other healthcare professionals and made sure people accessed appropriate services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community district nurses, speech and language therapists and chiropodists.

People who used the service were complimentary about the food overall and the choice offered at meal times. At the time of our visit there were fourteen people using the service. The cook told us she knew everyone's likes and dislikes and catered for those. One person told us they were not offered an alternative if they did not like a particular dish, however everyone else told us they could

Is the service effective?

ask for an alternative and this was provided. Another person, who had lived at The Coach House only a few months, told us, "The food is lovely. I really enjoy it. I settled in quickly."

We observed the lunch time meal in the dining area of the home. People were given a choice of where they wished to sit in the dining room. Some people were served their meal in their own rooms. The food looked appetising and well presented. We saw people received the assistance they needed and staff gave this assistance in a sensitive and dignified manner. The dining experience we saw was unhurried, calm and people looked as if they were relaxed.

The system used to record staff training did not allow us to assess the level of training all staff had undertaken and if training needed to be repeated. The provider told us they were in the process of reassessing the training needs of all staff and that a training programme was to be organised accordingly. Despite this, staff told us they had received good training which helped them carry out their individual roles properly. Some staff had attended training on topics such as, dementia care, safeguarding, moving and handling and infection control. We saw there was an induction plan in place for staff to go through when they first began work at the home and this included working alongside a more experienced member of staff until they were competent to work unsupervised.

Records we looked at showed some staff had received supervision meetings and an appraisal. Staff told us they were given an opportunity during their supervision to discuss their training needs and progress. However, they also wanted us to know that the registered manager and registered provider were regularly visible in the home and were available at all times to discuss work related matters or offer advice.

Is the service caring?

Our findings

People who used the service told us all the staff were kind and friendly. One person told us, “You couldn’t wish for a nicer group of young women; the staff are very kind.” Another person said, “It’s alright, friendly and the staff are very patient with me.” People’s relatives were positive about the care provided. One relative told us, “I feel I could discuss anything with the staff. The staff make it easy for me to give an opinion.” Another said, “The staff are kind and compassionate, the care given by them is very good.”

On relative told us their relative had been in the home for over four years and, “There has never been any problems” they said. When their relative had been assessed and told maybe a nursing home would be more appropriate, “We fought to keep her here.” The home had made sure the person was using the right equipment and provided a specialist bed to make caring for their relative easier and more comfortable. Other comments included; “Both night and day support is good.”

Care records had information showing care needs had been discussed with people who used the service and/or their relatives. However, people we spoke with did not recall having had any involvement in the development or review of their care plans. The registered provider agreed to review this with people who used the service and their relatives to ensure people felt fully involved in decisions about care needs.

We saw all people at the home appeared at ease and relaxed in their environment. We saw that people responded positively to staff with smiles when they spoke with them. We observed that staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. People looked well cared for, clean and tidy. People were dressed with thought for their individual needs and had their hair nicely styled. People appeared comfortable in the presence of staff. We saw staff treated people in a patient and considered way, having regard for their individuality.

Staff knew how to respect people’s privacy, dignity and confidentiality. Throughout our inspection, we saw that staff respected people’s privacy and dignity when they were supporting people with personal care. They were sensitive and discreet. They responded quickly to any requests for assistance and were alert to people’s subtle nonverbal communications. They listened to people and acted upon what people said to them; for example, when an alternative drink was requested or when a person asked for support to be provided at a different time from when it was offered. We saw that staff were patient and gave encouragement when supporting people to take their medicines. People were able to do things at their own pace and were not rushed.

Care plans recorded what the person could do for themselves and identified areas where the person required support. The care plans had sufficient detail to ensure staff were able to provide care consistently. We saw that care was delivered as stated in the care plan and that staff were able to easily access any aspect of defined care from the paper record. When not being used, records were locked away, therefore protecting people’s privacy.

Is the service responsive?

Our findings

People who used the service said they could make individual choices at the home and that their choices were respected. Comments included; “You can get up when you want, I can have a lie-in if I want to, I just tell them I’m having a lie-in today and they leave me.” Another person, who preferred to spend most of their time in their own room, told us, “I can turn the TV on when I want and I can stay up late to watch snooker matches. They come and check on me. It’s all right here, nice and quiet.”

We looked at four care plans that had been developed for each person. The registered manager had made some improvements to the care plans and included additional information to help staff to understand the individuals care needs. The service is relatively small, and it was clear to us that staff knew people well and that they had developed trusting and enriching relationships with people. The care plans were person centred, with individual information on people's wishes in relation to how they wished their care was provided. The care plans showed how people liked to spend their time and how they liked to be supported. The plans also showed what people or their relatives had told staff about what provoked their anxieties and inappropriate behaviours. This meant that care could be provided in a sensitive way to avoid anxiety for people. Care planning was developed out of a dependency profile written at the point of admission. The profile covered such issues as mobility, continence, eyesight, hearing, memory and nutritional needs. The care plan focussed on the need to maintain a safe environment and promote personal independence and dignity.

The registered provider told us there was an activities co-ordinator, available for eight hours every Thursday. In the absence of the activities co-ordinator, staff covered these duties. The activities provided included group and individual events. During our visit we saw staff encouraging a person to do ‘chair exercises’ and a group playing with a large floor game involving the throwing of a hoop to score points. People were getting involved and could be heard cheering and shouting to encourage their peers.

We saw some people did not easily interact with others and preferred to sit alone. However, staff did not miss an opportunity to engage with the person or provide a reassuring gesture when offering a drink or checking they were comfortable.

The layout of the lounge area, which also included the dining area, was such that everyone could see or hear the television if they wished or sit away from the television to be quiet.

The people we were able to communicate with told us they had no complaints about the service but knew who they should complain to if necessary. They said they would not hesitate to raise concerns and complaints. Most said that they would speak to the registered manager or registered provider who they knew by name. No-one we spoke with had any concerns. One person said, “If I was unhappy I would talk to Jean or one of the staff. No problem with that, they would sort it out straightaway.”

We looked at records of complaints and concerns received in the last 12 months. We saw people had their comments listened to and acted upon and that there had been no complaints recently. We saw from minutes of meetings that issues were discussed at staff meetings in order to try and improve the service.

Is the service well-led?

Our findings

There was a registered manager in post who was also the joint registered provider along with her husband. People who used the service spoke positively about the management team and knew them by name. They told us the registered manager and joint providers were 'good people and trustworthy.' Relatives told us they thought the home was well managed and that the owners and staff were always around, making sure things ran smoothly.

Records showed decisions about people's care and treatment were made by the appropriate staff at the appropriate level. There was a clear staffing structure in place with clear lines of communication and accountability within the staff team. We observed the registered provider and administrator interacting with the care and ancillary staff. A common line of communication involved staff sharing information, asking for guidance and timely guidance being given in return. Staff said they knew when and how to report any issues or concerns and they were confident management would provide any necessary advice or support if required.

The last staff meeting was in June 2014. We saw from the minutes that staff who attended had signed in and those giving apologies were given the opportunity to read and sign the minutes when returning to work. One point of discussion had been breakfast times and how this was to be organised when people wished to stay in bed. On the day of our visit, six people out of fourteen residents, were still in bed at 8.30am. Staff told us this had been the person's choice and we observed people being brought to the dining area throughout the morning and being offered a light breakfast prior to lunch being served at 12.30pm.

We saw a relatives satisfaction survey was conducted in August 2014 and seven completed responses had been returned. Most of the comments were of a positive nature and some suggestions had been made to improve the service. This included providing a conservatory, additional parking and a separate area for visitors to use when visiting their relatives. The registered provider was considering these improvements.

There were systems in place to monitor the quality and safety of the service. Records showed this included monitoring of safeguarding issues, accidents and incidents. We saw that regular checks were made of medicines administration and a health and safety check was made of the building by the maintenance person on a monthly basis. There were safety certificates for the electrical installations and gas appliances, however there was no evidence to show that equipment, such as bathing aids and hoists had been serviced and were safe to use. The registered provider agreed to contact the manufacturer to check when this was required and if necessary arrange to have the work completed.

We looked through the policies and procedures manual and the staff handbook. We noted that the staff handbook was up to date and included matters relating to their employment and some key policies for their attention, for example, confidentiality and safeguarding vulnerable people. However, the policy documents in the manual were dated between 2002 and 2007 and few had been reviewed or updated since that date. The registered provider contacted the company who provided the documents and arranged to have them updated. The plan was to have these in place early 2015.