Care Quality Commission

Court House Care Services (Devon) Ltd

Court House Residential Home

Inspection report

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

Overall summary

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.

The inspection was unannounced and took place on 5 and 6 November 2014. Twenty people were living at the home. This is the first inspection since the providers registered with the Care Quality Commission (CQC) in September 2014. The inspection was brought forward in response to some information of concern CQC received about low staffing numbers for the number and needs of people living at the service and people being unhappy with their care.

Summary of findings

Court House Residential Home is registered to provide accommodation for up to 23 people requiring personal care. A new manager had been recruited by the providers a week before the inspection started; they are not yet registered with the CQC. 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.

No-one living at the home was currently subject to a Deprivation of Liberty Safeguards. The provider understood when an application should be made and how to submit one but advised this had not yet taken place for four people. They were aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests, although the provider recognised records needed to be improved to show how best interest decisions had been reached. The MCA provides the legal framework to assess people's capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

The new manager and the provider had begun to identify where improvements were needed in staff recruitment, medication management, care planning and record keeping. They had already started to instigate some new ways of working. They recognised time was needed to establish effective quality assurance processes to include regular supervision and audits of the service. But they also recognised further training was also needed to support a change of approach for caring for people living with dementia.

People living at the home were positive about their care and the support they received from staff. This included having their medication provided on time. They told us staff listened to them and they could make choices about their daily routine. Most people felt there were enough staff on duty to meet their social and care needs. People were satisfied with the standard of cleanliness and the quality of the food. The overall view of visitors to the home was that people were cared for by helpful staff. External health professionals told us the staff managed risks to people's health well and followed advice.

Staff were positive about the appointment of the new manager and told us the manager had the right skills to support them.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place to obtain, and act in accordance with, the consent of people living at the home. You can see what action we told the provider to take at the back of the full version of this report.

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?
Some aspects of the service were not safe.

Recruitment practices in connection with references were not robust and some medication practice needed to be improved. People told us they felt safe with staff, call bells were responded to promptly and their medicines were given on time. They were happy with the standard of cleanliness. The provider was actively recruiting more care staff and changes had been made to shift patterns to encourage a stable staff team.

Requires Improvement

Is the service effective?
Some aspects of the service were not effective.

Improvements were required to ensure the Deprivations of Liberties Safeguards were applied for promptly. People's best interests were not protected when they were assessed as not having the capacity to agree to a decision. The recording and monitoring of one person's food and fluid intake was not effective.

People said staff listened to them and were helpful. They were positive about the quality of the food and the choice provided. People had access to health services and were supported by staff who communicated well.

Requires Improvement

Is the service caring?
The service was caring.

People praised the staff for their approach and attitude. Staff showed empathy towards the people they cared for and knew their personal preferences.

Good

Is the service responsive?
Some aspects of the service were not responsive.

Care records were not personalised. However, staff knew people well and there was good communication between staff. There was a range of activities and care records were up to date

Requires Improvement

Is the service well-led?
Some aspects of the service were not well-led.

The provider had not yet established quality assurance systems to measure the effectiveness of the service. A new manager had been recruited but until this appointment the provider had been in day to day control to ensure people's care needs were met, which impacted on implementing new systems. The provider had begun to consult people living and working in the home about changes in how the service was run but these processes needed to be embedded.

Requires Improvement

Court House 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 checked 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 5 and 6 November 2014 and was unannounced. It was completed by one inspector who spent time observing care and support. An expert by experience was part of the inspection team on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at all the information available to us prior to the inspection. This included feedback from health professionals who had regular contact with the service and from social care professionals who commissioned care at the home.

During the two days of inspection we spoke with 13 people using the service, six relatives and one friend. We spoke with eight staff, including care staff, housekeeping staff and a member of the activities staff. We also met with people and then looked at their care records. We also met with the provider who bought the service in September 2014 and with the new manager who started working at the home on 29 October 2014.

We looked at four care plans, including risk assessments, four staff training files, one recruitment file, staff rotas, medicine records and quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

Two people said they were concerned that sometimes there was not enough staff on duty in the morning, which impacted on the time staff could spend with them. Care staff said it was often busy and they could not always spend as much time as they wanted with people. Other people living at the home did not raise staffing levels as a concern. The provider acknowledged there had been weekend shifts that had initially been short staffed because of staff absence. This was evident when we looked at duty rotas for October 2014 but other staff had completed additional hours to help keep people safe. Staff confirmed they had completed additional shifts but hoped the planned recruitment of new staff would help address this problem.

As CQC had received an anonymous concern about staffing levels, we asked the provider how he assessed if staffing levels were adequate to meet the needs of people living at the home. He advised the current levels were based on his previous experience in similar care settings and on his observation on people's dependence during different shifts. He advised a new rota had been introduced to meet the needs of people living at the home; staff said they were getting used to this new way of working and hoped it would address previous staff shortfalls on some shifts. The provider said the changes would provide staff with more security and promote a stable staff team to meet people's needs. He also explained how a staff member was changing their role to provide 'bank' cover to cover sickness. One staff member said, "So far so good". The provider had responded promptly to changes in the management team and had appointed a new manager within two months.

Since buying the service in September 2014, the provider had recruited one person, the manager. Their file contained a completed application form, and a completed Disclosure and Barring Service check, which was dated prior to the manager starting their role. The DBS helps employers make safer recruitment decisions to help prevent unsuitable people from working with people who use care and support services. There were two positive references from previous work colleagues, rather than previous employers, which was not best practice and the provider said they would revise their recruitment practice to make it more robust.

Medicines were kept securely and managed appropriately with double signatures and correct recording of the stock. Medicine records were up to date and there were no gaps in the records, appropriate codes were used. And when medicines were counted they were correct. However, handwritten entries were not double-signed by two staff members so there was the potential for errors. The medicine fridge temperatures had not been recorded regularly so there was the potential for the effectiveness of medication to be compromised. The provider said they would ensure this would be addressed.

People said their medicines were given on time, and brought to them if they wished to stay in bed. Observation of a medication round showed staff knew how to administer medicines in a safe manner, including ensuring it was kept securely. Staff demonstrated safe practice by ensuring people took their medicine before signing the medicine records. Two staff members who administered medication told us they had received appropriate training, which was confirmed in one staff member's training file.

People said they felt safe and staff responded to their call bells on time. For example, staff responded promptly each time a person rang their bell in a fifteen minute period. People who had chosen to spend time in their rooms showed us their call bells were accessible and they knew how to use them.

External visiting health professionals said risks to people's health were well managed and that staff asked for support and advice appropriately. For example, pressure care was well managed. Staff confirmed there was no-one living at the home with a pressure sore ulcer and people used pressure-relieving equipment, which was documented in their care plan as being needed.

Staff knew how to recognise abuse; they were clear about their responsibilities to report abuse quickly to protect people's safety and well-being. This included reporting concerns internally to the manager and provider, and whistle-blowing to external agencies. For example, a staff member explained they had shared concerns with the manager about a staff member's attitude towards people living at the home. The provider said they had acted upon this information and took appropriate action.

CQC had been contacted anonymously by someone who raised concern that there was a smell of urine by the front door. This was not the case on the day of our inspection.

Requires Improvement

Is the service safe?

People said they were happy with the standard of cleanliness in the home. A relative who visited regularly said they had no concerns regarding unpleasant odours. During our two day inspection there were no unpleasant odours either in communal areas or in people's rooms.

Housekeeping staff showed us newly purchased cleaning equipment and confirmed they had a new cleaning routine, which included regular deep cleaning of people's rooms. They explained the colour coding system for cleaning equipment, which was used in appropriate areas. Care staff said the manager had instigated changes to infection control regarding the use of aprons, and they understood why this change had been necessary. Care staff knew how to transfer soiled laundry in an appropriate manner to prevent cross infection.

The provider said they had assessed the safety of the building; their conclusion was the building was safe but would benefit from decorative improvements and the addition of a wet room to offer more choice.

Requires Improvement

Is the service effective?

Our findings

The provider recognised records needed to be improved to show how decisions had been reached. For example, an accident form recorded a person had fallen at night and care notes made reference to equipment being used, which alerted care staff if the person moved around in their room. Staff identified the use of this type of equipment for four people living at the home. We checked the care plan for one of these people, who had been assessed as not having mental capacity to make a decision on this aspect of their care. There were no records of a best interest meeting where appropriate people would make a decision on the person's behalf about the use of a pressure mat. The provider recognised mental capacity assessments and best interest meetings were an area for review and improvement.

The Mental Capacity Act 2005 provides the legal framework to assess people's capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests

No-one living at the home was currently subject to a Deprivation of Liberty Safeguards (DoLS). DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The provider understood when an application should be made but had not completed applications for four people. They told us it had been a very period when they first bought the home due to staff changes. They were aware of a recent Supreme Court judgement which widened and clarified the definition of a deprivation of liberty. After the inspection, the manager sent information to confirm applications had been made. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place to obtain, and act in accordance with, the consent of people living at the home.

Staff described how they cared for each individual to ensure they received effective care and support. People said staff listened to them. Staff demonstrated a basic understanding of the Mental Capacity Act (2005). A person living at the home said staff encouraged them to change their routine to benefit their health but also listened to them if they chose not to follow their advice. Staff gained people's consent before they assisted people to move and they explained what they were doing and involved the person. They listened to people's opinions and acted upon them, such as where they wanted to spend their time.

People spoke highly of the staff and their skills. They said staff were "very helpful". Relatives were also positive and commented "staff always have a smile on their face" and "they remain calm and know what to say to people in a distressed or anxious state". The provider and the manager had begun to review the previous training records, which they said were generally up to date, although they had identified potential gaps in learning. For example, the manager had identified that some staff needed support to enhance their understanding of the needs of people living with dementia. The manager had experience in this area of care and was going to provide the training needed. Staff were positive about further training and recognised they had areas of care where they needed further development. For example, one staff member said they planned to request additional support from the manager when providing care for someone with end of life care needs. Most staff had benefitted from National Vocational Qualifications which is competence based training. Training records showed staff had up to date training appropriate to their roles with the exception of one member of staff who had not attended infection control training.

The provider explained how a recruited member of staff had been supported and what training they had received. He confirmed the person had worked alongside staff as part of their first week of work and there was evidence of a supervision session to check on their progress. After discussion, the provider recognised new staff members would benefit from a more comprehensive induction based on Skills for Care common induction standards to enhance their knowledge and to safely work unsupervised.

Three staff members said they had not participated in a supervision session in the last two months but confirmed team meetings had taken place to discuss new ways of

Requires Improvement

Is the service effective?

working. The manager said they were planning supervision sessions with individual staff. They had been observing staff practice and told us that "It was really important for staff to see the manager".

People were positive about the quality and choice of food provided. They said there was a choice of where they ate their meal and staff offered additional helpings. One person said their meals were being prepared in a different way to enable them to eat without discomfort, which they appreciated. Some people were identified at risk of malnutrition and dehydration. Staff said two people were at risk because of end of life care needs. Food and fluid charts had been in place for several days for one person, although it was unclear when they had been implemented. The quality of recording was variable, there were gaps and there were no goals or targets, which meant the records were not effective monitoring tools. By the end of the inspection, the manager had printed out alternative records to help promote better monitoring.

People said they had access to health care professionals to meet their specific needs. Care records showed they had access to appropriate professionals such as GPs, chiropodists and district nurses. One person praised the support they had received from staff when they visited the hospital for an operation, they said one staff was "always there for me". The district nursing team said staff at the care home made appropriate referrals to their service and followed the advice given. They also told us risks of pressure damage to people's skin were well-managed by staff.

Staff demonstrated through their conversations with people and their discussions that they knew the people they cared for well. A new system of communication had been introduced, which provided staff with a written update of changes to people's health and emotional needs using a laptop rather than a verbal handover. Staff checked this system at the beginning of their shift. Senior staff still gave a verbal handover to each other and then wrote up the key points for the care staff. Staff said a person had fallen during the night, an accident form had been completed and there was a comprehensive account by the senior on duty to update the care staff on the next shift. This information included prompts to monitor the person's well-being and the steps taken to reduce further incidents.

Good

Is the service caring?

Our findings

People said staff were caring and people looked well cared for. One person said their appearance was important to them and commented their clothes were well looked after. Another person shared they were concerned delicate items might not be washed appropriately due to previous problems; they said they would prefer to wash these items independently. They agreed for this concern to be shared with the provider. The provider responded positively by considering ways they could provide this option.

One person said, "I wouldn't change anything". Staff explained how they supported an individual who used their call bell regularly and recognised their need for reassurance. The person said, "I like it here". Throughout the day staff interacted with people who lived at the home in a caring manner. Staff were cheerful and relaxed; relatives said staff were approachable and friendly. Staff showed empathy and respect when they told us how they supported individuals in the home and staff checked with people to confirm their choices and decisions.

Some staff were skilled in supporting people who were distressed in a sensitive and discreet way. A staff member recognised a person was anxious and restless. They treated the person with kindness and involved them in collecting tea cups and pushing the trolley. They offered them reassurance and the person became more relaxed and responded well to their approach. One staff member was sometimes loud in their style of conversation, which startled people, and they communicated too quickly. This meant a few people had difficulty understanding what the staff member was saying. The manager recognised this was an area of training that needed to be developed for some staff.

All rooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were kept closed when people were being supported with personal care, although on one occasion a staff member still entered a room to deliver an item even when they realised the person was on the commode, which compromised the person's dignity.

During our visit, one person's radiator was not working in their room, this was addressed during the visit, but during this period staff made sure the person was warm and comfortable.

Requires Improvement

Is the service responsive?

Our findings

A review of people's care records showed they contained some individualised information but the guidance to care workers about how to support people's individual needs was variable in quality. For example, in one person's care plan it stated they 'can become distressed particularly in the evening' but there was no instruction to staff about whether there was a trigger and how they should respond, so there was the potential for an inconsistent approach. The provider recognised that where people lacked the capacity to make a decision for themselves staff should involve other professionals and family members in writing and reviewing plans of care.

Two care records out of four, which we reviewed, did not provide clear guidance to staff. This meant there was the potential for an inconsistent approach to care. Staff were attentive to a person who requested assistance on a number of occasions in a short period. Staff said specialist advice had previously been given as to how they responded; however there was a different style of approach from three different staff in a short space of time. One senior staff member said seniors would respond if care staff needed a break from this level of support; a care worker said that this level of support was not carried out by all seniors. The person's care records did not detail these approaches or how staff should respond.

People who wished to move to the home had their needs assessed to ensure the service was able to meet their needs and expectations. The provider showed us an example of a pre-admission assessment but it was not clear what the person had contributed, and it was unclear the source of different parts of the information. Therefore it did not demonstrate the views and opinions of the person moving to the home had been considered. The person who had moved to the home told us they could not remember details from the assessment.

The provider had asked the manager to transfer people's care records onto an electronic care planning system. The manager said their aim was to review these with people and their families once they had transferred all the information onto the new system; care staff confirmed the manager was checking information with them. At the time of the inspection, five written records had been transferred to the electronic system out of 21. The provider explained that people would be asked to agree the content at the time of the review to ensure they reflected their care and social needs.

External health professionals told us the provider had taken steps to ensure a person at risk of pressure sores, because of increased frailty and had the correct equipment in place to help minimise the risk.

People could not recall making a complaint and most said they would probably tell a family member first but also said they felt confident to speak with staff about their concerns. The provider said they had not received any complaints. However, they recognised that one person was unhappy about their care needs being re-assessed because of a change in the support they needed. The provider told us about the steps they had taken to reassure the person; the person did not raise any concerns about their re-assessment with us. There was no complaints procedure on display but a new one had been drafted which the provider was about to implement.

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the home. Staff gave detailed information about how people liked to be supported and what was important to them. Senior staff said there were verbal handovers between each shift, while other staff accessed an electronic written handover summarising people's changing needs. Recent key changes had been shared with the senior staff team and records showed the changes had been shared with care staff.

People said staff respected their choices but also kept them informed of activities happening around the home. There were two activities co-ordinators in post covering five days a week; people were positive about the range and variety of events, which were well advertised. Staff checked with people in their rooms if they wished to attend planned groups, such as quizzes, word searches, bingo and a knitting session to make chair back covers for the lounge. Records showed external activities also took place such as visits from the donkey sanctuary and a local befriending group. One person said they chose to spend time in their room and wished staff had more time to spend with them. Activity staff said they did visit the person in their room. They recognised the person preferred conversation rather than a specific activity, which was evidenced through records. Another person said they would like the

Requires Improvement

Is the service responsive?

opportunity to leave the home for a trip or to visit the local shops. One activities person said these activities had been temporarily postponed but would hopefully be started again so they could respond to people's individual interests, such as individual shopping trips.

Requires Improvement

Is the service well-led?

Our findings

Despite recently buying the home, there had not been a formal meeting with people living and visiting the home but the provider had sent a letter of introduction to people's next of kin encouraging them to meet with him. He said he planned to send out surveys in the future to gather feedback about the quality of the service.

The manager said they planned to complete a daily walkabout around the home and would keep records of this practice to help demonstrate it was a well-managed and safe home. Records confirmed supervision sessions had taken place for two care staff members out of a team of 24; the provider said the appointment of the manager would improve the number of these sessions so that training and individual development could be discussed.

The provider and the manager said they needed time to embed quality assurance systems in the home. A medicines audit had not taken place and the provider confirmed staff practice had not been observed to ensure medicines were being safely administered. The manager said this would be addressed; and a new quality auditing system would be introduced. On the second day of the inspection, an external pharmacist was auditing the medication system, and was due to feedback to the provider.

The provider had a number of auditing tools that he planned to introduce or had already been put in place. For example, housekeeping staff had a new checklist as the provider had identified that hygiene standards needed to be improved in some areas. The provider was still in the process of introducing their own policies.

There was no quality assurance record of the provider's assessment of the safety of the building but he said that he had appointed a new maintenance person, whom we met. A programme of routine maintenance and redecoration had started, including painting the dining room. Work was taking place to install a wet room to offer people living at the home more choice.

The new manager who had been in post for a week planned to use a social event linked to Bonfire Night to meet people living at the home and their friends and family. People said they had met the new provider; several people commented positively on his approach, including participating in activities with people living at the home. The provider said he had asked people about any changes they wished to make, which had included one person moving room. Another person said they were very pleased that the provider had listened and acted upon her request for her bedroom to be re-decorated in a colour of her choice.

Minutes from a staff meeting showed where the new provider had explained his plans for the service to the staff. Minutes from a second staff meeting with seniors showed the provider discussed with staff how to manage the changes within the service and responded to concerns.

Staff said the newly appointed manager was approachable and they felt confident in their ability to manage the home. They said the manager had training skills which they could learn from, which would benefit their practice. For example, staff told the manager had implemented improvements to infection control. Most staff confirmed the manager had met with them on an informal basis since their appointment a week before the inspection. The manager had provided feedback to help improve standards of care, which staff confirmed had taken place.

The provider explained how he had monitored staff performance through observation and regularly checking the senior's shift reports, which were automatically sent to him via the new electronic care planning system. He said this type of messaging system enabled him to keep up to date with people's well-being and audit staff actions, although monthly reviews had not yet started under the new system.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Suitable arrangements were not in place to obtain, and act in accordance with, the consent of people living at the home.