The Court Retirement Residence

The Court Retirement Residence

Inspection report

Rockbeare
Exeter
Devon
EX5 2EF

Tel: 01404822632

Date of inspection visit:
06 September 2018
07 September 2018

Date of publication:
22 October 2018

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

We carried out an unannounced inspection of The Court Retirement Residence on 6 and 7 September 2018. The Court Retirement Residence is a 'care home' without nursing. Nursing care, if needed, is provided by the community healthcare team. The Court Retirement Residence also offers temporary respite stays and one person was staying as respite during this inspection with a view to permanent support. People in care homes receive accommodation and personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The Court Retirement Residence accommodates up to 21 people in one adapted building but the service rarely goes above 16 as they use double rooms as singles. At the time of our inspection there were 13 people living at The Court Retirement Residence.

There was a registered manager at the service. A registered manager is a person who has registered with the CQC 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. They had worked at the home for many years and were planning to retire in early 2019.
The last comprehensive inspection was in September 2016; at that inspection the overall rating for the service was good and we found that people were safe. At this inspection in September 2018, people were not always enabled to take part in meaningful activities on a regular basis that reflected their needs, preferences and interests. There were no audits about how people were spending their day. Activities offered by staff and external entertainers, did not ensure each person had their social and leisure needs met.

Some checks and audits were carried out but these had not always identified issues that were found during the inspection. Audits were not completed around maintenance and room checks, care plan reviews or falls. At the last inspection in September 2016, we noted there were some elements of good quality monitoring systems but these were not fully evidenced and the provider was making improvements to ensure systems were effective. This was not shown at this inspection in September 2018. Care records did not always fully reflect people's risks and needs when changes occurred and staff relied on verbal communication and recording in the daily notes. When incidents had happened, plans did not always record how staff were to reduce the risks of reoccurrence, although they knew this information verbally. Although records were not always up to date staff were very knowledgeable about people's needs through verbal communication and a small, stable staff team.

There was no system such as a dependency tool to enable the provider to know what level of staffing was required to meet people's needs. Staff felt there was not enough staff and people told us they sometimes had to wait for support. In addition, staff did not have time to spend quality time with people and offer regular meaningful activities. We recommended that the provider use robust systems to ensure there were enough staff at all times.
This inspection was brought forward because of safeguarding concerns. Prior to our inspection, the service

became part of an individual safeguarding relating to pressure area care. This meant the local authority safeguarding team had informed us of their concerns. We found this was substantiated and pressure area care management was not robust to ensure people were safe.

On the day of the inspection there was a calm and relaxed atmosphere in the home, with music playing in the entrance hall. Staff interacted with people in a friendly and respectful way and were keen to deliver good support, for example ensuring people received full personal care at their own pace. People were able to choose where they wanted to spend their day and staff respected their privacy. However, the service was not fully caring and improvements were required to ensure there was a homely feel rather than a workplace. Most people required one care worker to support them and preferred to stay in their rooms. This meant that some people spent long periods alone other than when staff completed tasks. However, people and relatives said they liked the staff and were happy with the service.
Staff ensured they had identified those who could not use their call bells easily, and they were checked regularly, other people used pendant call bells and these were answered promptly. People were encouraged and supported to maintain their independence and risk and independence was well balanced in the least restrictive, safe way. Staff engaged with people in ways which reflected people's individual needs and understanding, ensuring people mobilised safely from a discreet distance, for example.

People and relatives said the home was a safe place for them to live. Comments included, "I like it here, they look after me" and "[Person's name] seems happy and we enjoyed playing ball. I can leave and not worry." Staff had received training in how to recognise and report abuse. Any safeguarding concerns had been managed well with provider involvement and they had listened to any advice, and the service worked openly with the local authority safeguarding team. Relatives said they would speak with staff if they had any concerns or complaints and issues would be addressed. Staff knew people well, showing patience and understanding. Staff were genuinely happy when people were doing well, noticing improvements and chatting with people as they went about their tasks. People's human rights were protected because the management team and staff understood the Mental Capacity Act 2005 (MCA) and these records were good.

There were not always regular recorded reviews of people's health but there were many examples in daily notes of staff responding promptly to changes in need and accessing appropriate health professionals. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs. One person had seen paramedics and gone to hospital and they were now back at the home and doing well.

Medicines were generally well managed, except for recording amounts of medicines received into the home. The registered manager was ensuring this happened by the end of our inspection. Records were completed with no gaps, and there were regular audits of medication records and administration. Staff were well trained and there were good opportunities for on-going training and obtaining additional qualifications. There was a training programme covering a wide range of topics. The training matrix was being revised so management could easily see which staff required training. A comprehensive induction was completed by new staff and supervisions and appraisals were up to date and showed meaningful discussion. A matrix was being devised for this too, to ensure a consistent approach. The staff team was stable and many care staff had worked at the home for some years as the service was in a rural location.

People's privacy was respected. Staff ensured people kept in touch with family and friends and there was open visiting with people made welcome. Most people living at the service had family and friends able to visit. There was a home newsletter and the administrations manager was looking at ways to encourage easy ways to communicate such as by email, meetings and the staff photo board.

The management team said they were keen to give people good care and valued their staff team. The service was a family run business and the provider and their family lived on site. People living at the service had been included in the administration manager's wedding in the village church (situated next door to the home) in recent years. Staff said they enjoyed working at the home and felt able to raise issues. The home was seen as important in the local area as it is in a small rural community. Although improvement was required in some records and quality assurance, staff delivered care in individualised ways. The management team immediately began to address our findings and acknowledged that there had been recent management changes which may have contributed to the need for improvement.

Observations of meal times showed these to be a positive experience, although only four people chose to eat in the dining room. People were offered a choice of meals to suit their preferences and dietary needs. They could choose where they wanted to eat their meals, and meals were offered at times of the day to suit their appetite. People were supported discreetly to be as independent as possible, using adapted crockery, having finger food or snacks when they most had an appetite. People's risks relating to nutrition were addressed, although not always recorded.

The premises were clean and smelt fresh. The building was an older style premises but had been well maintained. The administrations manager was devising a more robust maintenance programme and room check system to address tidiness and storage issues to make the environment more homely. People and relatives appreciated the spacious accommodation and views over the countryside.

There were systems in place to share information and seek people's views about the running of the home, including relatives and stakeholders. The last survey had not been analysed to show actions taken from comments but the registered manager assured us that the current satisfaction survey would include an action plan which would be shared with people. There were no complaints from people or relatives.
We found four breaches of our regulations.

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 always safe.

People were generally supported with their medicines in a safe way by staff who had appropriate training although some improvements could be made to make medicines management more robust and secure.

People were not supported by sufficient staff to meet their needs at all times.

People benefitted from well-maintained and equipped accommodation.

People were protected from the risk of harm or abuse whilst independence was promoted in a balanced way.

People were protected from the spread of infection, because safe practices were in place to minimise any associated risks.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a risk that information could be missed as the staff were very busy and not always very visible around the home and there were ineffective care plans and written communication.

People and/or their representatives were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

Staff ensured people's human and legal rights were protected.

Is the service caring?

Requires Improvement

The service was not always caring.

Although people benefitted from a spacious, well maintained and equipped environment it was not always homely.

People and/or their representatives were verbally involved in their care and were cared for in accordance with their preferences and choices but this could be improved on and recorded.

Staff had very good knowledge of each person and how to meet their needs although they relied on verbal communication.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

Staff ensured people's human and legal rights were protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although staff were knowledgeable about people's needs these were not always reflected in the care plan records.

People received personalised care and support which was sometimes responsive to their changing needs but people's social and leisure needs were not well organised to ensure each individuals' needs were met consistently.

People and/or their representatives were verbally involved in planning and reviewing their care but this was not regularly recorded.

People made choices about aspects of their day to day lives.

People and/or their representatives shared their views on the care they received and on the home more generally but improvements were needed in analysis and feedback.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were not effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

There was an honest and open culture within the staff team who felt well supported although getting to used to recent management changes.

Staff worked in partnership with other professionals and listened to advice to make sure people received appropriate support to meet their needs but were not always pro-active in relation to pressure area care.

The Court Retirement Residence

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 6 and 7 September 2018. This was an unannounced inspection and was carried out by two adult social care inspectors on the first day. We did not use the Short Observational Framework for inspection (SOFI). This was because there was only one person in the communal areas most of the time; people chose to spend their time in their rooms. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This inspection was brought forward because of safeguarding concerns regarding pressure area care for one person.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law.

At the time of this inspection there were 13 people living at the home. The home was registered for 21 people but rarely went over 16 as double rooms were used as singles. During the day we spent time with all 13 people who lived at the home, speaking with six people in more depth and two relatives. We also spoke with the provider, the provider's son who was the administrations manager, assisted by their wife, the registered manager, the deputy manager, four care workers, the cook and a domestic. We also spoke with two visiting health professionals.

We looked at a sample of records relating to the running of the home, such as audits, quality assurance, medicine records and care files relating to the care of three individuals in depth as well as looking through all 13 computerised care files. We discussed staff recruitment processes with the registered manager and

looked at three staff files.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. The last comprehensive inspection was in September 2016; at that inspection the overall rating for the service was good and people were safe. At this inspection in September 2018, we found there were some areas that required improvement.

There was a very stable staff team and low turnover of staff. However, people told us that at times there were insufficient staff available to meet their needs, and they sometimes had to wait for assistance when they pressed their call bell. One person told us "There is not enough staff. They seem to be short staffed." They told us they like to go to bed at 6pm but sometimes they had to wait until 8pm for assistance. They also told us they sometimes needed two staff to assist them in and out of bed but said, "More often than not there is only one staff member to help me." We looked at the person's moving and handling assessment which said the person's needs were variable, and sometimes they were able to move safely with one member of staff. Another person required two hourly position changes during the day and night. The care plan did not state how staff were to do this, although staff said they used a slide sheet. It was unclear whether one or two staff at night were assisting as there was only one staff member awake, with one asleep each night. There was no audit showing when that sleeping night staff member was waking to give care during the night. Following our inspection the provider ensured there were two staff awake at night from then on.

Another person said, "Staff are busy. Sometimes I have to wait for help to go to the toilet." Another person told us they sometimes had to wait 10 to 15 minutes for their call bell to be answered. They said they were concerned that there was only one waking member of staff at night and this meant they did not always receive the assistance they needed promptly at night. However, they also said they were happy with the support they received from staff to get up in the mornings and go to bed at night, and this was always at the times they had requested.

There was no system such as a dependency tool used to ensure the needs of people are used to ensure staffing levels are adequate. There was the registered manager, deputy manager and two care workers on duty at the time of the inspection supported by the provider's son. They said there were usually three care workers on duty. There was also a cook and a maintenance person. However, people looked well cared for and happy and we did not hear call bells ringing excessively. Staff did not appear rushed and we found people's needs had been well met, although some people described having to wait, we did not see this during our inspection. Agency staff were rarely used and shifts were covered with regular staff. Staff, although busy, worked hard to meet people's needs in a timely way during our inspection, although staff were not always very visible around the home. We did not see staff have time to sit and chat with people but they did offer six people some activity in the afternoon when it was quieter. Staff regularly visited people in their rooms to offer assistance and continence was well managed. The administrations manager said they would develop a dependency tool as soon as possible.

We recommend that the service seeks advice and guidance from a reputable source on ways of measuring people's dependency and determining safe staffing levels. For example, to ensure there are always enough

staff to meet people's needs and enable them to spend quality time with people.

We found that management of people's skin pressure areas was not robust to ensure people were protected from the risk of skin damage. One person was meant to be having their position changed to reduce the risk of their pressure sores deteriorating, every two hours, including at night. Staff said they were changing this person's position but electronic records sometimes showed longer gaps between turns; this could have been due to the time recorded when the record was made. A district nurse had raised concerns about the person's pressure area care in May 2018 and they had then been referred to the tissue viability team. In July 2018, the district nurse felt the sore 'appeared to have got worse'. We found that a formal 'turning' chart had only been commenced the day before our inspection to formally ensure these position changes were happening. Another person had a moisture lesion but this was not in their care plan. However, we found that staff all knew this and were taking appropriate actions to ensure position changes. District nurses we spoke to during the inspection felt staff were listening to their advice and following it but recording systems did not always give them confidence that this would continue consistently.

Creams and lotions were dated when opened and opened bottles and tubes were discarded at the end of each four-week period to ensure the creams and lotions were safe and effective to use. However, at the time of the inspection, there was no information for staff about where and when to use which cream for each person or any records to show this had been used. The provider's son had already identified this as an issue. The registered manager had devised topical cream charts, medication administration records and body maps with this information for staff to use in people's rooms. However, these were not in use at the time of our inspection.

Staff all told us they had not had any pressure care management training. The administration manager knew this and told us they were going to arrange some as soon as possible. This would help to ensure the service did not rely on external health professionals for pressure care management.

There was a lack of robust pressure care management which placed people at risk of pressure damage. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Otherwise, we saw good, supportive care being carried out. For example, one person had been assessed due to putting themselves on the floor. This had been well managed with discussions with health professionals to ensure the person had the correct equipment to keep them safe. The care plan gave good detail on this area of risk. Staff encouraged and supported people to maintain their independence in a caring way. Most people only required one care worker to assist or prompt them. For example, one person was very slow to finish a meal. Staff ensured they had appropriate aids to help them with a referral to an occupational therapist and gave them plenty of time. The person had gained weight and was now eating well. Oral care was also well managed with details of people's teeth and how they were cleaned. Staff checked if people had managed their clothes appropriately for example, helping them to change in a discreet way if needed. Care staff ensured they prompted people to dress themselves and assisted with ensuring people dressed in the correct order. People were wearing appropriate clothes for the weather.
There were very few falls and measures were taken to ensure people were safe whilst balancing promoting independence. We looked at falls records from July 2018 to September 2018, which were minimal. Where people had fallen, this had been evaluated and appropriate referrals made in a timely way, such as to the occupational therapist. However, there was no overall falls risk assessment audit to look at patterns or trends. The registered manager said they looked at each individually and had started a more formal audit by the end of our inspection. We saw no signs of any regular patterns to people's falls, they were mostly due to people who could ask for assistance trying to do something independently. One person was using a mobility

scooter in the home. The administrations manager was ensuring they remained safe and was devising a risk assessment and looking at ways to enable them to continue using the scooter.

Medicines were generally well managed, except for recording amounts of medicines received into the home and then carried forward on the medicine administration records (MAR). The registered manager was ensuring this happened by the end of our inspection. People received their medicines safely from staff who had completed training. Medicines were supplied every four weeks in monitored dosage packs. Staff completed the medicine administration records each time a medicine was administered and there were no unexplained gaps. Information about prescribed medicines to be taken when required (PRN), such as pain relief tablets, was held in the care plan records. The registered manager and provider told us they would review staff access to this information to ensure staff have ready access when administering medicines. On the first day of the inspection we noted that some MAR records did not have a photograph of the person to help staff identify to person and ensure they administered the correct medicine. The provider had ensured these were in place by the end of our inspection.

People were protected from the risk of harm or abuse because safe recruitment procedures had been followed. Care was taken to recruit and select the right staff for the job. References were taken up and checks carried out to ensure applicants did not have significant criminal records or any previous employment history that might indicate they were unsuitable for the post. We noted that the recruitment files did not always provide evidence to show the references and checks had been completed before new staff were appointed. The provider told us they will improve their recording system to ensure the date references and Disclosure and Barring Service (DBS) checks are received are recorded. They also told us they planned to put in place a risk assessment process that would be followed if they were unable to obtain sufficient satisfactory evidence of an applicant's suitability for the post.

The provider and management team had systems in place to make sure people were protected from abuse and avoidable harm. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected. Any safeguarding concerns had been managed well with provider involvement, and the service had worked openly with the local authority safeguarding team. Relatives said they would speak with staff if they had any concerns or issues, and that these were addressed. People seemed happy to go over to staff and indicate if they needed any assistance or told us they would be happy to speak to anyone at the home. Some people were not able to respond directly about their experiences due to living with dementia but appeared happy and comfortable with staff and each other.

The home was clean and tidy and there was a programme of on-going refurbishment and decoration. The administrations manager was devising a more comprehensive checklist to ensure there was a clear maintenance programme and regular room checks. There were no offensive odours throughout the home and rooms were fresh. Staff used personal protection equipment (PPE) when delivering care and changed aprons and gloves between rooms or when dealing with food. Staff had been particularly vigilant in maintaining a clean and fresh environment for one person who tried to remain independent but was not always thorough with cleaning their room. Staff had had training in infection control. A maintenance person was available who carried out repairs promptly ensuring the home was well maintained and homely. The kitchen had a food hygiene certificate of five stars, which is the highest rating from the environment agency.

The provider had systems in place to manage emergency situations such as fire. Each person had a personal evacuation plan (PEEP) to enable emergency services to know how to manage people. Accidents and incidents were recorded to show they were well managed and appropriate actions taken.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. There was a risk that information could be missed as the staff were very busy and not always very visible around the home and there were ineffective care plans and written communication. Staff did not read care plans but relied on verbal handovers, however each staff member was very knowledgeable about people's needs and there was a very stable staff team. Records of visits and liaison with medical professionals had not always been recorded in an effective way to enable the staff to monitor and evaluate each person's changing needs. For example, because staff did not read care plans, information was passed either verbally or through the daily notes. Therefore, if a staff member wrote 'no creams available today' issues were not always recorded as being followed up.

No-one reviewed the daily notes to formally ensure important information was noted and passed on. District nurses had also found that sometimes staff could not find creams when asked. Information from the district nurses was not always included fully in people's care plans. Staff relied on the district nurse to give instructions rather than recognising a risk and considering the actions they should take to prevent harm occurring. For example, they had not instigated a turning chart for a person until the day before our inspection despite high risk of pressure damage. Where a body map was used the issue had not been recorded showing the updated outcome so staff would know the issue had resolved. The administration manager had spoken with the district nurses and they had agreed actions to improve their communication methods. A notice board and staff rota had been displayed which meant that district nurses could check to see who was in charge when they visited the home. They had also agreed that district nurses would be accompanied by a member of staff when visiting people to ensure staff were fully updated on the person's current treatment. District nurses had their own records which were kept in the home. However, staff did not always read these so had been unaware of changes in people's treatment. A new form had been put in place which was used to record the outcome of their visits to people that day. While this system had improved the level of communication between district nurses and staff the form could not be filed in individual files and so linked to individual care planning. The administration manager was implementing a more individualised system.

Although there was a risk that health needs may not be met effectively because staff relied on verbal communication we did not find any issues of people's needs not being met other than in relation to pressure care. We heard lots of examples where people's health needs had been well managed and saw these recorded in the daily notes and no-one had any complaints. For example, staff knew how to access a referral for an urgent GP visit. Staff knew people well and noticed any changes. One person had been pale so staff had called the on-call GP and following a visit they were feeling better. Another person who was at risk of weight loss had seen the speech and language therapist (SALT), had their intake monitored and adjusted and seen an occupational therapist for special equipment. They were now doing well. Staff had also carried out speech exercises with the person to improve muscle tone. However, the care plan stated only 'working with SALT'.

We recommend that more robust, formal communication to staff of people's needs is put in place and that care plans are used as working documents to inform care delivery.

People were supported by staff who had completed training to meet their needs effectively, other than for pressure care management. New staff received induction training at the start of their employment. Staff who did not have previous relevant experience in the care industry were expected to complete a qualification known as the Care Certificate. This qualification ensured they had the basic skills and knowledge to meet people's needs effectively and included topics such as Equality and Diversity and Human Rights and safeguarding. The provider had identified a range of training topics they considered were essential, including oral hygiene, moving and handling, continence, and understanding human nutrition. The provider was in the process of updating and improving the way they recorded and planned staff training needs by introducing a new training matrix. They were also reviewing the range and quality of the training they provided. Training was delivered in a variety of ways including group training sessions and computer based training. We saw the General Data Protection Regulation 2016 (GDPR) and health and safety training was planned for staff in the near future, for example. The service would meet with each person and go through each of their records with them to ask what they were happy or not happy to share. They would re-visit all the consent forms and made sure all the confidentiality info was up to date.

Staff were also supported to gain further relevant qualifications such as diplomas and National Vocational Qualifications. Staff were supported through regular supervision, staff meetings and through daily communication with the provider, managers and registered manager. The provider told us they would improve the record of supervisions to ensure they had a more effective method of planning future supervision sessions, and ensuring planned supervision sessions were carried out in accordance with their supervision policies and procedures.

Each person during this inspection had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. Care plans included nationally recognised nutritional assessment tools to ensure staff knew who was at high risk of weight loss for example and what action to take with graphs. Recording of nutritional needs was computerised and showed how staff monitored all people's input and took action if there was a risk of weight loss.

People told us they enjoyed the meals. Staff knew the foods they liked and dislikes and they were always offered a choice of meals. We took lunch with four people in the dining room. The cook was very knowledgeable about people's likes and dislikes and people received individual meals tailored for them. However, there were no formal records of people's preferences or diets. Staff, when asked, all knew what these were and there were no risks associated with meals. The administrations manager said they would make this priority and as the cook was leaving they would ensure they gave a good handover to the new cook. Tables were attractive and people were offered a choice of drinks and condiments. Most people preferred their meals in their rooms and this was accommodated.

The premises in general was well maintained. It was a large Georgian house with spacious accommodation. There were signs of investment including new carpets and lino. Some people living at the home had a degree of living with short term memory loss. There was little pictorial signage to help people navigate independently. The administration manager said they would source some appropriate signage.

Some people who lived in the home were not able to fully choose what care or treatment they received due to living with dementia. The staff and management team had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Care planning was very good in this area and contained good information to assist staff. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Mental capacity assessments had been carried out or recorded to determine each person's individual ability to make decisions about their lives. Where restrictions were in

place appropriate applications had been made to the local authority to deprive the person of their liberty in line with the Deprivation of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005.

DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Where people were restricted, for example by the use of bed rails, best interest decisions had been made in consultation with other people involved in their care, and the decisions had been recorded. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who knew the person well and other professionals, where relevant. Staff were aware of the implications for people's care which was recorded in each care plan and shared verbally. Throughout the inspection staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes, other than reports that some people had to wait for support sometimes. Simple language was used to explain and involve people. Staff offered people living with dementia or short-term memory loss simple choices, putting out different clothes for people to choose for example

The provider ensured people had accessible information in line with the Accessible Information Standard (AIS). Care reflected people's diverse needs and social situations. The management team was looking at how the accessible information standards could be further incorporated into people's care (The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.) For example, they were introducing a large font menu board in the dining room and sourcing pictorial signage for bedrooms and bathrooms so people could find their own way around.

People and relatives all said they thought the staff had the correct skills and training to meet their personal needs. Relatives also spoke of how the staff knew the needs of family and friends too, treating them as part of the 'family'. One relative said they felt they were well supported by the staff and enjoyed joining in with a ball game in the afternoon.

People had the equipment and spacious environment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. People could access the garden but they had to ask to be able to go out the front door. We did not see anyone going out but some people who were more mobile were able to move freely around the home. People had individual personalised walking aids so they could identify them, wheelchairs or adapted seating to support their mobility. There were enough hoists and stand-aids available and all equipment was checked weekly as well as visually to ensure they were safe to use.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection in September 2016, we found this area was Good. At this inspection in September 2018, this area Required Improvement. The service was not always caring. Although staff were kind and passionate about caring for people, there were some elements that did not help to create a homely feel. Some people's rooms (those who were unable to mobilise easily), although clean, were not as tidy as they could be and a lack of storage did not ensure that personal care items such as continence aids were kept out of sight. Some en-suites were full of continence aids in full view. This did not promote people's dignity.

Lack of appropriate storage also meant that some communal areas were used as storage which was not very attractive or homely. Some furniture was a little shabby. The communal lounge was large but had chairs round the edge meaning that the television was far away from chairs and a table was not easily accessible.

The registered manager had moved their computer desk into the dining room. This meant that part of the dining room, a desk with cables and the computer and another table, had become work stations for staff, including answering telephone calls. This also did not promote a homely feel for people using the dining room. The provider's son said they would ensure an alternative area was found. The registered manager said they tried to make it their (people's) home as much as possible but this required improvement so that the environment was focused on the people who lived there rather than a workplace.

We recommend that the provider conducts an audit of the premises to ensure that people are living in a homely environment that promotes their dignity and wellbeing in the way that they wish.

We noted that as soon as we raised this issue the administration manager began to resolve it by the end of the inspection. Mostly, the home was a welcoming place, with fresh flowers replaced every week which people commented on. People's art work was proudly displayed and people told us which item was theirs. There was a lovely spacious entrance with a visitor's book, and various local information. People were invited to leave comments in a suggestion box. The administrations manager was collecting email addresses from people's advocates to promote ongoing communication. For example, to share the home newsletter. At the time of the inspection a survey was being conducted for people living at the home, friends and family and health professionals to look at people's views on The Court experience. The last annual quality assurance survey had collected people's views but there was no action plan on how these would be addressed or fed back to people. The registered manager assured us they would complete this when the survey was concluded to ensure ongoing improvement.

A staff photo board showed pictures of the staff team so people would know who to go to. The administrations manager was developing the key worker scheme so people would have a named contact with designated roles such as ensuring adequate toiletries. Visitors were welcomed at any time and offered drinks. For example, one person had a large group of visitors who were enjoying afternoon tea in the lounge. Relatives said they could always find a staff member to give them an update on their loved one. People were able to go out with friends and family whenever they wished and any meals would be saved for their return if

needed. There was a coffee machine and snacks trolley in the lounge for people to help themselves. The administrations manager said they were looking to introduce more drinks and snacks for people living at the home. A tuck trolley was also available for people to buy sweets and snacks.

There were positive comments about the home. We saw staff interacting with people in a compassionate and caring way. They supported people at their own pace and explained what they were doing. We saw staff on several occasions talking in a kind and gentle manner with people. The domestic clearly enjoyed chatting to people and there was lots of banter, which people enjoyed as staff went about their work. The registered manager told us, "It's like a family here. I like the closeness here." A person told us "The staff are always pleasant and kind." Another person said, "The staff are always kind and caring. I have a laugh and a joke with them." Although staff did not have much time to spend with people, we did see staff chatting and acknowledging people as they went about their work. Most people could use their call bells and there were pendant call bells so people could access them easily.

Recent comments on the care home review website included, "What has been a difficult and emotional decision that my mum now requires 24/7 care. I cannot thank The Court enough for the support they have provided to us as a family and the excellent care they have and are continuing to provide to my mum. All the staff are extremely dedicated and caring and go over and above to make mum feel at "home". The past four months have been hard for mum and us but without the support and care shown by all the staff at The Court it would of been so much harder. Mum is settling really well and we are extremely happy all her needs are being met totally with the sensitivity and understanding that mum requires. Thank you all so much" and "My grandparent was looked after by the wonderful staff for over 4 years, the care provided was always excellent and the location was perfect. It was difficult making the decision to place somebody you hold dear into care, but we felt safe in the knowledge she was being looked after by an excellent team of carers who are passionate about their jobs. I highly recommend The Court to anybody who has a loved one in need of care."

Staff and management, although not using the care plans as working documents did know people's needs very well. For example, the administrations manager chatted with one person about their previous career and retirement gift. Staff were quick to recognise when a person was not feeling themselves or checking if people were comfortable. People all had a call bell within reach, snacks and a drink accessible. Staff said, "We know we give good care in the best way we can but its always better to be on the safe side and ring the GP." When people had not been well all the staff knew about it and were heard asking one person if they were feeling better and making them comfortable, including management.

People's care plans detailed family and friends who were important to them and those with authority to make decisions on their behalf. Staff were knowledgeable about people's family dynamics and family members felt they were able to be involved as they wished. Regular reviews with people and those that mattered to them were not regularly in place formally but the administrations manager was already addressing this.

There were regular residents' meetings which were attended by people and relatives. Minutes showed people were able to openly comment, for example about menus. This showed people were listened to.

People felt their support was carried out to maintain and promote their privacy and dignity. We saw staff knocking on people's doors and waiting for a response before entering. People thought staff were friendly and polite. Rooms were very personalised, large and bright, although some needed tidying and items removed for storage. Relatives said they could decorate them as people wished. There was a good laundry service with care taken of people's belongings.

Staff understood the need for confidentiality, the safe storage of people's records, and knew not to share information without people's consent or unnecessarily.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. This was because there was not an established and regular range of activities to meet the social needs of all the people living at the home at that time. At this inspection, we found that although staff spent time with people and some activities were offered this did not mean that people were enabled to take part in meaningful activities of their choice on a regular basis. There were no audits about how individual people were spending their day and activities, although offered by staff and external entertainers, did not ensure each person had their social and leisure needs met. There was little life history and information in the care plans about what people's interests were.

There was evidence of some activities from external entertainers such as music and 'songs from around the world', craft activities and regular Holy Communion. However, care workers were expected to meet people's social and leisure needs at all other times. Six people did enjoy a ball game during our inspection but there was no other evidence to show people were receiving social interaction and engagement other than for tasks. We were unable to see any individual records showing what people had been doing other than in the daily records. This was very minimal and mainly people were going out with family and friends.

One person told us they sometimes felt lonely and bored. They told us most people chose to remain in their rooms each day rather than joining others in the lounge. This meant they spent long periods each day on their own without anyone to talk to. The registered manager told us most people had chosen to remain in their rooms each day. However, there were no records to show how staff met people's social and leisure needs in an individual way. Another person told us there were no regular activities or entertainments offered by the staff, and said they would like to do more exercises. They thought that staffing levels meant staff did not have sufficient time to support people regularly with the activities, exercises or interests they would like to participate in. We found this to be the case. There were some brief records of people's likes and dislikes or past life history but these were not used to enhance people's lives or inform activities. The registered manager said there had not been any outdoor trips or outings for a long time. The administration manager had some ideas about going out for a cream tea but a trip out had not been planned yet.

There was not an activity co-ordinator at the service and care staff were expected to meet social and leisure needs. However, this was in addition to their usual care work and tasks. Although we found staff were not rushed and there was thorough personal care support, there was no time to meet these needs for each person. Activities were offered on an ad hoc basis depending on staff workload. One care plan said, "The physical sensation of doing tasks will be important to [person's name] and to be involved in a wide variety of activities. It will help them have a stronger sense of self awareness and commitment." This was not being achieved.

On both days there was a cheerful, chatty atmosphere and people were noticed by staff but there were no meaningful activities offered in a consistent way to ensure each person had their social and leisure needs met. For example, most people stayed in their rooms all day with the television or radio, punctuated by meals and support from staff. Another person moved around the home all day but had no other meaningful occupation. No-one went outside or was offered assistance to do anything other than the ball game in the

lounge on one afternoon. The registered manager said activity records were included in the daily notes but they would not know who had done what. We saw very little mention of any activities in people's records.

The lack of meaningful, personalised and regular activity does not ensure that people's social and leisure needs are met and is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

We looked at the records of people living at the home at the time of the inspection. People had been assessed before they arrived at the home. The service undertook their own comprehensive assessment of people's needs to ensure they were able to meet them. Care plans were then developed to incorporate people's needs. The deputy operations manager assured us the provider's policies ensured people were treated equally and fairly. The assessment process also helped to identify when staff may require further training before they were able to support people, for example for a specific medical condition such as a stoma. If people were coming home from hospital, the service ensured all the necessary equipment was also in place to support a safe transition.

However, although people received care and support that was responsive to their personal care needs this was because staff had good knowledge of the people who lived at the home through experience and verbal communication. Care plans were not used as working documents and were not regularly reviewed or up to date. Staff were able to tell us detailed information about how people liked to be supported and what was important to them but there was a risk that they could miss important information. Staff wrote in the daily records but these were not looked at or reviewed either to ensure that all staff were using the correct information when supporting people. People were involved in discussing their needs and wishes if they were able and people's relatives also contributed.

Care plans were computerised but not easily accessible for staff as there was only one electronic device to work from. The administrations manager was looking at increasing devices for staff. The care plans we looked at showed person centred language and gave good detail about exactly how staff should care for people but often missed out information or were not up to date. For example, there was not clear information about how staff should manage risks due to pressure damage, monitoring kidney function or detailed manual handling instructions. One person's care plan described them as walking without purpose, but they were now less mobile. Other care plans did not show that some people needed two people to mobilise at times or how to manage pressure care despite having a moisture lesion. Another care plan said a person needed support with urinary continence but did not describe how the person often refused care and what actions to take. When we spoke to staff in detail about people's needs however, they were able to tell us how they cared for people consistently although they did not know details such as 'why' a person had a stoma or catheter. One person was having their catheter drainage monitored but this was only noted in the daily notes and not as an issue to follow up in the care plan. Therefore, communication depended on stable, experienced staff communicating verbally.

The lack of useful, up to date care planning records could put people at risk of not being cared for in a way that met their needs or preferences and is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Daily records showed that staff responded to the changing needs of people who were at the home. For example, staff recognised when people were not eating so well or were not themselves. Health professional records showed staff had spoken to appropriate health professionals in a timely way. Staff also sought appropriate advice about a possible urine infection or to report dry skin requiring cream or to source equipment. Staff were described by the community nurse as "Improving in relation to pressure area care.

They are doing a good job. We raised an issue and they responded." Recent daily records, although not always linked to care plan information did show that staff were recording about the condition of people's skin each day.

Relatives felt they were able to chat to staff or the management team at any time. People and their representatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. The registered manager had discussed putting up a photograph of who to speak to about a complaint to make it easier for people to understand. There had been few formal complaints this year and these had been managed well. Issues were taken seriously and responded to in line with the provider's policy.

There was no-one receiving end of life care during our inspection. Staff were involving families in adding end of life information within the care plans as an on-going process. For example, whether people were for resuscitation, what their wishes might be and information about power of attorney and arrangements. Staff knew how to access health professional support and equipment such as hospital beds or medicine 'just in case' bags. Staffing levels could be increased if needed to provide additional support for people at the end of their lives. Appropriate health care professionals and family representatives had been involved in end of life discussions. Staff attended people's funerals and there were thank you cards from grateful relatives. Relatives comments included, "[Person's name]'s last stage of their journey was with you and under your care. I want you to know that I and all the family members deeply appreciate the care you and your staff gave to them to ease them through. We especially value that you cared for them until they died in peace." Staff had received training on end of life care, including a training session provided by a funeral director. The registered manager told us they placed a high priority on treating people with respect and dignity before and after death.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. There was a registered manager, who had been at the service for some years. The provider who lived next door had stepped away from managing the home and their son (the administration manager) and his wife had recently begun to work alongside the registered manager with a new deputy manager. The administration manager, the provider's son, was keen to "give back and have a home to be proud of". They took on board our feedback about what areas required improvement and agreed that there was work to be done.

There were not robust and effective quality assurance systems in place to monitor care and plan on-going improvements. Provider governance was not well managed. There was no regular or effective monitoring of a range of topics such as individual's social and leisure engagement, records including care plans, risk assessments, care reviews and falls audits. Pressure area care was not well managed or recorded as the service relied on the directions given by visiting district nurses. This put people at risk. Systems to audit medicines were not fully effective. Stocks of medicines were checked every four weeks. However, staff did not record the amount of medicines remaining in the home and carried forward to the new medicine administration. This means they were unable to check accurately that the amounts of medicines held in the home were correct, or to identify any administration errors. We noted that the ad ministrations manager had already started to implement some checking systems such as maintenance and room checks and full care plan reviews looking at the whole care plan.

Systems and processes in place were not effective in ensuring robust regular quality assurance monitoring to promote ongoing improvement. This is a breach of Regulation 17 HSCA RA Regulations 2014 Good governance

The management team (registered manager, provider, administrations manager and their wife and new deputy manager) were open, transparent and spoke in a compassionate, person-centred way. They were keen to do their best for people and realised that clarity of role responsibilities may be needed. People knew who the management team were but we did not see any pro-active time spent with people. The administrations manager said they would introduce a regular 'hello' round so that management were more visible throughout the home for people. Managers were always available across the week and there was an on-call system for out of hours. The provider, administrations manager and his wife lived on site as the service was a family run business. People had been involved in the administration manager's wedding in the village church opposite some years ago. People and relatives told us they did feel the home was well managed. A relative told us "I am generally satisfied. Any problems, they listen and sort it out." There was a happy atmosphere with people being well cared for although they sometimes had to wait, they were noticed and treated well. People were going about their day as they wanted and choice was respected. The provider came to support staff during the inspection and the administration manager also arrived and were very responsive to our findings.

There were systems in place to share information and seek people's views about the running of the home as well as relatives, external stakeholders and professionals. A recent quality assurance survey was ongoing

and an action plan would be completed and fed back to people. The managers had an open-door policy and they were available to relatives, people using the service and health professionals. The office was small and not in a prominent area so the administration manager would source some signage.

Staff received regular supervision support and were consulted through staff meetings. The registered manager and provider had a range of organisational policies and procedures which were available to staff at all times. The provider's whistleblowing policy supported staff to question practice. It defined how staff who raised concerns would be protected. All staff were positive about working at the home but felt they were not always listened to or praised about the work they did as people's needs became more complex. The management team said they would use the arrival of a new staff member to address staff morale and embed new systems, recognising that there had been some changes in management.

The management team understood their responsibilities and were keen to improve the standard of care at The Court. They promoted the ethos of honesty and learned from mistakes, this reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment and apologise when something goes wrong.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The lack of meaningful, personalised and regular activity does not ensure that people's leisure and social needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of robust pressure care management which placed people at risk of pressure damage.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of useful, up to date care planning could put people at risk of not being cared for in a way that met their needs or preferences. Systems and processes in place were not effective in ensuring robust regular quality assurance monitoring to promote ongoing improvement.