Akari Care Limited

The Court

Inspection report

West Felton
Oswestry
Shropshire
SY11 4LE

Tel: 01691610626

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 17 April 2018 and was unannounced.

The Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides accommodation with nursing care for up to 36 people.

At the time of the inspection there were 23 people living at the home.

At our last inspection in June 2016 we rated the service good. At this inspection we found the service remained good.

There was a registered manager in post. 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.

People felt safe living at the home. The way in which staff were deployed meant people's needs were met in a timely and unhurried manner. People's medicines were managed and administered in a safe way by staff who had been trained to carry out the task. People were protected from the risk of harm or abuse because the provider had effective systems in place which were understood and followed by staff. People were protected from the risk of the spread of infection.

People continued to receive effective care. People were supported by staff who were trained and competent in their roles. People's health care needs were monitored and met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported by kind and caring staff who took time to get to know people and what was important to them. Staff treated people with respect and respected their right to privacy. People lived in an environment which was welcoming and homely.

People were involved in planning and reviewing the care they received which helped to ensure people received a service which met their needs and preferences. There were daily activities for people which they could choose to join in with. Complaints were taken seriously and responded to. People's religious and cultural needs were understood and met by staff.

The provider had effective systems in place to monitor and improve the quality of the service provided. People's views were valued and any suggestions for improvement were responded to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains safe.	Good
Is the service effective? The service remains effective.	Good
Is the service caring? The service remains caring.	Good
Is the service responsive? The service remains responsive.	Good
Is the service well-led? The service remains well-led.	Good

The Court

Detailed findings

Background to this inspection

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

We were aware of an historic incident which had occurred at the home and at this inspection we checked whether on-going measures were still in place to mitigate risks and to protect the people who lived there.

This comprehensive inspection took place on 17 April 2018 and was unannounced. It was carried out by two adult social care inspectors and an Expert by Experience. 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 did not request a provider information return (PIR) prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We looked at statutory notifications sent in by the service. A statutory notification is information about important events which the service is required to tell us about by law. We looked at previous inspection reports and other information we held about the service before we visited. We contacted Healthwatch and local commissioners to seek their views on the service provided. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services. We used this information to plan the inspection.

During our visits we spoke with eight people who used the service and two visitors. We also spoke with two relatives on the telephone. We met with the registered manager and one of the provider's quality and compliance managers and five members of staff. We met with people in their bedrooms and communal areas where we were also able to observe how staff interacted and communicated with people. Most of the people we met with were able to tell us about their experiences of life at the home. Some people were being nursed in bed due to their frailty. However we observed them to be clean and comfortable. We observed staff regularly checking on people to offer drinks and to check they were comfortable, and whether they wanted anything.

We looked at a sample of records relating to the running of the home and the care of individuals. These included the care records of four people who lived at the home. We also looked at records relating to the management and administration of people's medicines, health and safety and quality assurance. We checked two staff recruitment files and staff training and supervision records.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and with the staff who supported them. One person said, "It's the support I get from the staff that makes me feel safe." Another person told us, "I feel very safe here. They [staff] always keep an eye on me when I walk around with my frame."

Visitors could only access the home when they were let in by staff. All visitors were required to sign the visitor's book on their arrival and when they left the home. This helped staff to know who was in the building in the event of a fire. One person who lived at the home told us that this procedure made them, "feel safe and less vulnerable."

There were sufficient staff deployed to meet their needs in a safe way. We observed staff were available when people needed them and staff responded quickly to any requests for assistance. When people used their call bells to summon assistance, we observed staff responded in a timely manner. A person who lived at the home said, "I don't have any complaints. They [staff] are very quick if I use my bell."

People received their medicines in a safe way from staff who had been trained to carry out the task. A person who lived at the home said, "I always get my tablets when I should. Sometimes I need my pain killers and I just tell the nurse and they bring them straight away." Medicines were safely transported around the home in a locked medicine trolley. During medicine rounds, the registered nurse wore a red tabard to alert staff and visitors that they should not be disturbed. This helped to ensure the nurse was not distracted whilst administering medicines to people. The home used a hand-held computer devise which maintained a record of each person's prescribed medicines and when they should be administered. The device alerted nursing staff if a medicine was late being given. This helped to reduce the risk of errors. There was a record of medicines received from the pharmacy and of those destroyed. This meant there was a clear audit trail of medicines held at the home. Medicines were securely stored, including those medicines which required additional secure storage. We randomly checked medicines which required additional secure storage and these tallied with the records maintained.

People were protected from the risk of harm and abuse because staff had been trained to recognise the signs of abuse. Staff knew how to report any concerns and they told us they were confident that these would be fully investigated to keep people safe. Staff knew how and when to report concerns to other bodies such as the police, the local authority and the Care Quality Commission. A member of staff said, "I would report any concerns straight away. I know [name of registered manager] would definitely deal with it straight away. If I saw any poor practice by another carer I would tell them why I thought it was poor and would again report it." Where allegations had been made, or reported to the local authority by the registered manager, they had worked in partnership with appropriate authorities to make sure issues were fully investigated.

The provider's procedures for staff recruitment helped to protect people from the risk of harm or abuse. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work with the people who lived at the home. These checks included seeking references from previous employers and carrying out Disclosure and Barring Service (DBS) checks. The DBS checks people's criminal record

history and their suitability to work with people. Staff were not permitted to start work until satisfactory checks and employment references had been obtained.

There were effective procedures in place to mitigate risks to the people who lived at the home. People's care files included a wide range of risk assessments in areas including environmental risks, mental capacity, moving and handling, medicines, weight loss, nutritional needs, continence care and skin integrity. People also had individualised risk assessments on behaviours that may challenge the service and their medical conditions. These provided guidance to staff on how they should support people so that the risk to them could be minimised. For example, where people were assessed as being at high risk of malnutrition, there were plans in place to support them with this such as monitoring their intake and fortifying foods.

Records of accidents and incidents were maintained. All accidents and incidents were regularly analysed which helped to identify any traits and actions needed to reduce the risk of reoccurrence. For example, the registered manager used the 'falls safety cross' to establish whether there were any environmental factors which could have contributed to the person falling. The falls safety cross is a visual data collection tool which is used to record where a person has fallen and in what part of the home. This helped to identify any areas for improvement. The most recent falls safety cross had been clearly displayed in the reception area of the home. This demonstrated an open and honest culture.

There were arrangements in place to deal with foreseeable emergencies. Systems were in place to safely evacuate people from the home in the event of an emergency. Each person had a personal emergency evacuation plan which gave details about how to evacuate each person with minimal risks to people and staff. Records confirmed that staff received regular training on fire safety and we saw records confirming that the fire alarm was tested on a weekly basis. Moving and handling equipment such as hoists, had been regularly serviced by external contractors.

There were policies and procedures in place to reduce the risk of the spread of infection and these were understood and followed by staff. The home was clean and smelt fresh. Designated domestic staff were employed and all staff had access to sufficient supplies of personal protective clothing (PPE) such as disposable aprons and gloves. We observed staff using PPE appropriately. For example nursing and care staff discarded PPE after assisting a person with their personal care needs. Staff carried out regular checks on people's mattresses to ensure they were clean and appropriate for use. There were two separate laundry areas: one for dirty laundry and the other for clean laundry. This helped to reduce the risk of the spread of infection.

Maintenance staff were employed and we were informed that any repairs were dealt with in a timely manner. The records we looked at showed the maintenance person carried out regular checks on the environment to ensure it remained a safe place for people. Checks included hot water temperatures, window restrictors and visual checks on the environment and equipment used by the people who lived at the home.

Good

Is the service effective?

Our findings

People were supported by a staff team who were trained and competent in their role. A person who lived at the home said, "All the staff seem to know what they are doing. They take good care of me." Another person told us, "I would say the staff are well trained." A relative we spoke to told us they thought the staff were competent and well trained. A member of staff said, "The training is really good and there's quite a variety." Another member of staff told us, "I feel confident in my role because I've had the training I need to care for our residents."

There was always a trained nurse on duty to monitor people's health and respond appropriately. Trained nurses were able to access training which kept their clinical skills up to date and enabled them to remain registered as nurses. The registered manager monitored staff training to ensure refresher training was provided when required. Training undertaken by staff included health and safety, safeguarding adults from abuse and additional training to meet the individual needs of the people who lived at the home. This included the care of people who were living with dementia, specific communication needs, diabetes, the use of syringe drivers and the management of percutaneous endoscopic gastrostomy (PEG) feeding tubes.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. In the care plans we looked at we saw examples where best interest decisions had been made. These included the use of bed rails to help keep people safe when in bed and assisting with personal care needs. Records demonstrated that the person, their relatives and staff who knew the person well had been involved in the decision making process.

Staff had received training about the MCA and they understood the importance of ensuring people's rights were respected. A member of staff said, "If a resident refuses assistance or help with washing it's their choice. You can't force them. We would document it and try again later." Another member of staff told us, "Some residents' capacity fluctuates throughout the day. You just need to be aware of this and offer reassurance and a clear explanation of how you are trying to help them. You must never force a resident to do something." Records made by staff in people's care plans showed a consistent approach when a person had refused care or support.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had a good understanding of the MCA and had made applications to the local authority for those people who required this level of restriction to help keep them safe.

People were offered enough to eat and drink and staff were aware of people's assessed needs and preferences. A person who lived at the home said, "I've just had my lunch and it was lovely. The food is very

good here." Another person told us, "There's lots of food and I never go hungry. It's marvellous food." Where people had been assessed as being at high risk of malnutrition or dehydration, this had been documented in their care plan. We observed that staff supported people in accordance with their plan of care. For example some people required their intake to be monitored. Records showed people had been offered regular food and drink and where there were concerns, these had been shared with the registered nurse. Care records showed that where concerns had been identified, these had quickly been brought to the GP's attention. Referrals to dieticians had been made in a timely manner. The mealtime experience was relaxed and sociable. Where people needed assistance to eat their meal we observed staff supported people in an unhurried and dignified manner.

People were supported to maintain their health and well-being. A registered nurse was always on duty with care staff to ensure people's nursing needs were monitored and met. People saw health care professionals when they needed them. These included visiting GPs, opticians, chiropodists and dentists. Records showed that where there were concerns about people's health, these were quickly referred to the GP who then made referrals to appropriate health care professionals. People also saw professionals to meet specific health needs such as diabetes, dementia and continence care.

Before people moved into the home, the registered manager or registered nurse visited them to carry out an assessment of their needs. This helped to ensure the service could effectively meet the person's needs and aspirations. The care plans we read contained pre-admission assessments and, where appropriate, assessments from the local authority and/or hospital discharge assessments. Information from the assessments helped to formulate a plan of care which detailed the person's needs and how these should be met by staff.

The environment had been suitably adapted to meet the needs of the people who lived at the home. There were grab rails to assist mobility and a shaft lift gave access to bedrooms on the first floor.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring. A person who lived at the home told us, "I am very happy here indeed. The staff are lovely. This is my home and it's a lovely home." Another person said, "I love a bit of banter with the staff. They're all great. Can't fault them." The atmosphere in the home was relaxed, happy and welcoming and we observed lovely caring interactions with people by staff. For example, a gentle touch, reassurance and friendly banter.

People looked relaxed and comfortable with the staff team. One person said about a member of staff, "Oh she's so lovely." We heard one person laughing and joking with the registered manager. The person told us, "We always have a laugh. She [registered manager] would do anything for you and wouldn't let anything bad happen to you."

Staff took time to get to know what was important to the people they supported. A person who lived at the home said, "Staff know me well. They make me feel like I matter and they are always interested to hear how my family are." Staff were able to tell us about people's preferred daily routines, their social and employment history and people who were important to the person. Information in people's care plans helped staff to care for people in the way that they wanted. For example, night care plans gave information about the person's preferred time for going to bed, whether they preferred a duvet or blankets, the number of pillows they liked and whether they preferred the light on or off.

Staff communicated with people in a warm and respectful manner and they respected people's right to privacy. We observed people moving freely around the home choosing where they wanted to spend their time. Two people had chosen to sit in a quiet lounge area where we saw them having a chat and a cup of tea. People could spend time in the privacy of their bedrooms when they wanted to. One person me met with said, "I like to spend most of my time in my room. I occasionally go to the dining room for lunch, but they [staff] don't mind at all." We observed staff knocked on people's bedroom doors before entering.

People had their own bedrooms which they could personalise in accordance with their tastes and preferences. People had been involved in choosing paints, carpets and curtains for their bedrooms and lounge areas. The administrator showed us books which had been used to help people make a choice of colour schemes. They had also sourced swatches of curtain materials and carpets which enable people to see and feel the textures.

Staff supported people to overcome obstacles which enabled them to enjoy a good quality of life. For example where people had limited sight, the registered manager had arranged for a visiting library to come to the home. Books were available in large print and we saw some people had chosen talking books. Audio newspapers were also provided. A person who lived at the home said, "I've just had a new delivery. It helps me feel a bit more independent and keeps me in touch with the outside world."

People were supported to be as independent as they could be. The care plans we read provided information for staff on how to promote independence. For example, the care plan for a person who was visually

impaired gave information about how to support the person with washing and dressing. It prompted staff to wet a flannel and pass it to the person and also gave information about how to help the person chose their clothes and get dressed.

There was information for people about advocacy services and community organisations. On the day of our visit one person was being visited by an advocate which they had requested.

The provider had procedures in place relating to confidentiality and these were understood by staff. People's care records were securely stored and we observed that staff ensured they did not discuss people in front of others.

Good

Is the service responsive?

Our findings

The people who lived at the home and their representatives were encouraged to be involved in planning and reviewing the care they received. This helped to ensure people received a service which met their needs and preferences. The registered manager had introduced a 'resident of the day' initiative which meant that each person and their representative had the opportunity to discuss their care needs with a member of staff. This time also provided the opportunity for people to discuss the quality of service they received.

There were good links with health and social care professionals. Care plans showed that they had been involved in monitoring and reviewing the care people received. This ensured people received a service which was responsive to their needs.

Staff made entries in people's daily care records during the day and at night. Records contained detailed information about the person's well-being and how they had responded to interactions. This information helped staff review the effectiveness of the plan of care and helped to ensure people received care and support which was responsive to their needs and preferences.

There were organised activities for people if they wanted to join in. These included music, crafts, reminiscence, visits from outside entertainers and visits from animal handling workshops. One person who lived at the home said, "I really enjoy the entertainment. Another person told us how they could continue to enjoy their love of fishing with their relative. There were annual fetes and events to celebrate special occasions such as birthdays, Christmas and Easter. We saw photographs of people enjoying a variety of activities and social events. A hairdresser visited the home each week. On the day of our visit we observed several people relaxing whilst having their hair done.

The provider had systems in place to deal with any concerns or complaints. The people we spoke with told us they were confident that any concerns would be appropriately dealt with. One person said, "If I told [name of registered manager] I wasn't happy she'd be right on it." Another person told us, "We are all encouraged to speak up if we're not happy." There had been six complaints in 2017 and records showed these had been taken seriously. We saw the registered manager had investigated and responded to complaints within agreed timescales and to the satisfaction of the complainant. A copy of the complaints procedure was clearly displayed in the home and each person had been provided with a copy in their welcome pack. The complaints procedure was produced in an easy-read format for those who required it.

People could see their relatives and friends when they wanted. One person said, "My [relative] visits often and they are always made to feel welcome." During our visit one person requested to use the telephone to call their relative, which was facilitated by staff. The person was given privacy and there were no time constraints on the use of the telephone.

There were procedures in place to ensure people's wishes during their final days and following death were respected. There were discussions with people about their preferences and these had been recorded in their plan of care. We read the care plan for one person who had not felt ready to discuss their wishes and we saw

this was regularly reviewed by staff. Where a person was nearing the end of their life, the registered manager and registered nurses liaised with the person's GP to ensure they had the medicines they needed, when they needed them, in order that the person was not in pain or discomfort.

People were able to see religious representatives which enabled them to practice their faith even if they were unable to attend services or meetings outside the home. A religious representative regularly visited the home to hold services and communion for those that wanted to attend.

Good

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was very visible in the home and it was evident that the people who lived there knew them well. People responded positively when they saw the registered manager and enjoyed friendly banter and laughter. The registered manager told us about their commitment to the people who lived at the home and the quality of the service they received. They told us, "I want this home to be the best home in Shropshire and for our residents to have the best possible care." They said, "Staff will continue to be well trained and I will always be a strong advocate for the residents we care for." A person who lived at the home said of the registered manager, "Nothing gets past her. She's straight on it if the staff aren't doing things right." Another person said, "I am happy here because it all runs very well." A member of staff told us, "[Name of registered manager] runs a tight ship. It's well organised and we all want the best for the residents."

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The registered manager was supported by a deputy manager and registered nurses, who were supported by a team of care staff. The skill mix of staff meant experienced staff were available to support less experienced staff. Staff were clear about their roles and of the responsibilities which came with that. Catering, domestic, administrative, maintenance and activity staff were also employed.

People were cared for by a team of staff who were well supported. Staff had the opportunity to discuss their role, performance and training during regular one to one sessions with senior staff.

There were audits and checks in place to monitor safety and quality of care. In addition to audits carried out by the registered manager, audits and visits were carried out by the provider's quality team and regional manager. We saw that where shortfalls in the service had been identified action had been taken to improve standards and practice. Examples included the refurbishment and redecoration of the home.

People and their relatives had opportunities to express their views about the quality of the service they received through regular meetings and satisfaction surveys. At the most recent meeting, one person had requested that salads were introduced into the menu. We heard how this was being implemented. The results of the most recent survey demonstrated a high level of satisfaction in the quality of the service provided. We read a number of cards from the relatives of people who had used the service. Comments included, "From the very first moment we stepped into the home we had a homely and safe feeling. All the staff have been wonderful in their caring attention not only to [name of person] but to us too, especially during their final hours and following him passing." A further card read, "Thank you for the kindness that had your special touch and dedication for our [relative]."

The registered manager and team of staff had developed links with the local community. Local school

children visited the home to celebrate special occasions and the local group of brownies visited the home and spent time with people whilst working towards their award badges. The home hosted fetes where the local community were invited and there were links with the local church. The administrator explained and showed us flyers about events they had sourced within the community. These included information about the local women's institute, a military wives' choir and information sharing visits from the police and local councillors. The administrator explained these would be shared with people for their expressions of interest.

The registered manager and provider promoted an ethos of honesty, learned from mistakes and admitted when things had gone wrong. 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. For example following a significant incident at the home, the registered manager had worked in partnership with other authorities and had implemented systems to reduce the risk of the incident happening again.

The registered manager worked effectively with other health and social care organisations to achieve better outcomes for people and improve quality and safety. These included tissue viability nurses, GPs, dieticians, commissioners and the local authority safeguarding team. The professionals we contacted did not express any concerns at the time of our inspection.

In accordance with their legal responsibilities, the provider had conspicuously displayed their previous inspection rating in the home and on their website. The provider had informed us of significant events which had occurred in the home.