Courtyard Continuing Care Limited

Head Office

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 16 May 2018 and was announced. This was the first inspection of this service using our revised inspection methodology. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of our inspection it provided a service to children and young adults in the Greater Manchester and Merseyside area. At the time of our inspection 22 people were using the service.

People we spoke with told us they felt their relatives using the service were kept safe. The service conducted appropriate checks on people before they were offered employment and tried to recruit people who they believed would fit in with the families they would be supporting.

Once recruited, staff underwent comprehensive training including training in the use of medical equipment that people they were supporting would use. Care workers told us they did not feel rushed during the training and felt they would not be signed off as competent until they were ready. All staff were signed off by the clinical lead once they had completed their induction and staff had their competency reassessed at least annually to ensure they were maintaining good practice.

People we spoke with told us they had the same team of care workers most of the time and that these were usually sufficient. Some people we spoke with commented that because of the in-depth training new care workers underwent it sometimes took a while for care workers to be replaced when they left.

The service had good oversight of the use of medicines by care workers and medicine administration records were regularly audited to ensure care workers were following good practice.

People were involved in the support planning process. The operations manager of the service told us the transition process from when a person was referred to the service to them starting with the service would take between six and twelve weeks during which time the person's support plan could be drawn up and agreed with family members and other healthcare professionals.

People's cultural and religious needs and choices were included when support plans were agreed.

The service worked well with other organisations to try and ensure a smooth transition between healthcare settings. This included people being visited in hospital by care staff so they could get to know each other and where people were already receiving support, care workers visited them in hospital to provide social support for them.

People we spoke with told us they felt their relatives were treated with compassion and respect. People felt confident in the care workers' abilities to look after their relatives.

Many of the people they were supporting were not able to communicate verbally but as the care workers

knew the people they were supporting well they were able to understand the non-verbal communication of the people.

Relatives of people using the service told us they were involved in regular reviews of the support their relative was receiving and felt their views were listened to and included in any revised support plans.

The service encouraged people to share their views with them and where people had complained they told us they had received a prompt reply and an apology. People told us their complaints had been listened to and things had improved as a result.

The management team had a clear vision of the service they wanted to deliver. Care workers we spoke with largely shared their vision although some people we spoke with felt they didn't hear from senior management frequently enough.

Care workers we spoke with told us they felt able to speak up when things weren't right and felt confident the management of the service would listen to their concerns. The managers of the service told us they were always looking to improve and welcomed feedback. We saw records where suggestions had been investigated and changes made as a result.

The service had a registered manager in place. 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 showed a clear understanding of their responsibilities and recognised where the skills of the other members of the management team complimented their own. The management team held regular meetings to review the service and other members of the management team told us their strengths were recognised and their views were listened to.

The service demonstrated good working relationships with other agencies such as commissioners of care, specialist hospitals and other healthcare professionals to try to ensure good outcomes for people using the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People told us they felt their relatives were safe. The service had a clear safeguarding and whistleblowing process. Care workers were aware of their responsibilities and felt able to raise concerns.

Checks were made on applicants before they were offered employment. Once they were employed care workers underwent a comprehensive training programme before being signed off as competent to work.

Risks to people were assessed and appropriate measures were put in place where risks had been identified.

Is the service effective?

Good

People's needs were assessed in conjunction with their relatives and other healthcare professionals and the support plan was agreed between them.

People's care records contained detailed information about their needs allowing care workers to support them effectively.

Care workers told us they felt they were well trained and well supported. They received regular competency checks and supervisions.

Is the service caring?

Good

People told us they felt the care workers were very caring and treated their relatives with respect.

Care workers knew the people they supported well allowing them to understand their communication and how they were feeling.

People told us they felt like part of a team with the same group of care workers and families.

Is the service responsive?

Good

Relatives of people using the service were encouraged to be

involved in reviewing the support their relative was receiving. Relatives told us they felt listened to.

Where a change in people's needs was identified, support plans were updated promptly.

The service viewed complaints as an opportunity to improve and we saw records showing thorough investigations into complaints and any lessons learned.

Is the service well-led?

Good

People told us the managers of the service were approachable and people felt able to contact them if the need arose.

A number of audits and reviews were undertaken to identify areas that could be improved and these were discussed during regular management meetings.

Where improvements had been identified, these changes had been implemented.

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Detailed findings

Background to this inspection

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

This inspection took place on 16 May 2018 and was announced. The inspection team consisted of two adult social care inspectors. During the inspection we spoke with the Registered Manager, the operations manager and the clinical lead. We spoke with the parents or guardians of four people using the service and four members of care staff.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to children and young adults across the North West of England.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was completed and returned by the provider in line with the requested timescales.

We also considered information we held about the service, such as notifications in relation to safeguarding and incidents which the provider had told us about and contacted the local authority, the local Safeguarding team and Healthwatch to seek their views about the service. The feedback from these people was positive.
We reviewed three people's medicine records, four care files, four staff recruitment records, staff training and development records, records relating to how the service was being managed such as records for safety audits and a sample of the services operational policies and procedures. We also saw feedback from people given directly to the service.

Good

Is the service safe?

Our findings

Safe recruitment practices were in place. There was a clear process from application for employment to the induction process. We looked at the checks made on four applicants and found appropriate checks were made including Disclosure and Barring Service (DBS) checks. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks help to ensure only suitable applicants are offered work.

People using the service who we spoke with told us they felt they had an excellent team of care workers. One person told us; "We're very lucky with the team we've got. I absolutely adore them." The operations manager explained that staff were recruited specifically to meet the needs of the individual person. They told us; "All the families are very different, we want someone who will fit in [with them]. We speak to the applicants and find out what drives them? What are they interested in? If they share our ethos then we invite them in for an interview. We want the right person with the right attitude. When we accept a referral for a person needing support we recruit a team of four or five care staff. We train the staff so they are able to cover a couple of packages of care."

Care staff received induction training tailored according to the needs of the people they would be supporting. This included a thorough competency assessment to ensure they could safely meet the needs of people with complex needs. The assessment covered medication and equipment people may be using such as oxygen saturation monitors and suction machines. Staff were not signed off as competent until the clinical lead of the service was satisfied the worker could demonstrate safe practice. One care worker we spoke with told us; "You aren't signed off induction until you definitely feel confident" Another care worker said; "We aren't left until we are completely confident. You can go at your own pace and not made to feel rushed."

People were protected from the risk of infection by staff undergoing regular infection control training and spot checks from senior staff ensured their practice met infection control standards. Care staff we spoke with demonstrated a good understanding of infection control and relatives of people they were supporting told us they felt staff worked to protect their relatives from infection.

The service had a medication policy in place and at the time of the inspection it was being reviewed. The clinical lead told us they wanted to incorporate evidence based practice guidelines and include any learning from any medication related incidents. People's care records contained a medication risk assessment and a clear explanation of who was responsible for which tasks so the person could be supported with their medication safely.

Any support with the person's medication was recorded on a Medication Administration Record (MAR) and these were audited by nursing staff to ensure they were accurate and correct. Where the forms had not been completed correctly, this was documented in the person's care records along with what action had been taken and what learning had been identified.

People told us they felt their relatives were safe. One person we spoke with told us; "My [relative] is particularly vulnerable and needs a lot of care and monitoring but I trust the care workers entirely." The service had a safeguarding policy in place. Care staff we spoke with told us they were encouraged to raise concerns and when they did they were supported. One care worker we spoke with told us; "Of course, [the person's] safety comes first." Another care worker we spoke with told us; "I had to raise a concern and the office were brilliant supporting me." Records were kept of alerts made to the local authority and any actions taken recorded.

Risks to people were assessed and where risks were identified measures had been put in place to try to minimise the impact of the risk. People's care plans contained a variety of risk assessments with detailed plans of how tasks can be managed to keep the person safe. Where people needed specialised equipment, their care plan explained how staff should check the equipment was safe and what to do if they had any concerns.

Relatives of people using the service had been involved in deciding how their relative would receive support and people's care records included a service user agreement explaining different people's responsibilities and expectations which was signed by the relatives and a representative of the service.

The service had processes in place to investigate complaints and instances where things went wrong. We saw records detailing investigations into incidents and actions taken as a result to try to prevent a recurrence. Learning from incidents was shared to staff throughout the service.

Good

Is the service effective?

Our findings

We found people's care records centred around the person and contained detailed information to allow the care staff to support the person in their chosen way. Where measurements needed to be taken, for example people's blood pressure or pulse, guidance was in the care plan about what the normal range was for that person and what care staff should do if the measurement wasn't in the range. An example we saw was; "[Person's] pulse is monitored overnight, limits are 55-135. Pulse must be recorded hourly and during any events (seizures/unsettled periods)"

Support people needed to make sure they received enough nutrition and fluids was also well documented. It was clearly recorded whether the care worker or parent was responsible for particular tasks and how the person would be supported. The records we saw contained guidance for staff explaining how a person might appear if they weren't receiving enough nutrition and fluids. An example of this was; "[Person] can become pale and have sunken eyes if they are dehydrated."

People's care records also contained information sheets on health conditions the person had. Care staff we spoke with told us they were very useful for getting to know how the person's health conditions could affect the person and allowed them to better support the person.

Care staff told us they felt well supported and had the training they needed to perform their role. There was a clear process in place to identify when people were due to have their competency reassessed and the assessment was planned around the staff's shift pattern so their practical competency could be observed. As with the induction training for staff, the ongoing competency assessments were signed off by the clinical lead once they were happy the member of staff was demonstrating safe practices. A care worker we spoke to told us; "If you aren't sure of anything you can phone the nurse and they will come and help you. They have come out in the middle of the night to help me." One member of care staff commented they had requested additional training to help them support people better but they had yet to receive it.

Care staff received regular themed supervisions and at the time of our inspection an appraisal system was being introduced. Care staff told us they found these very useful and they felt supported. One care worker we spoke with told us; "My manager does supervisions every few months which is plenty. They are always at the end of the phone and if there were any issues I would speak up rather than waiting. My manager is very supportive and will do anything for you." Another care worker told us; "My manager is lovely, I can phone them if I need them." One care worker we spoke with felt that more meetings between care workers would be beneficial.

At the time of our inspection staff training records were being transferred onto a rostering system to provide greater oversight of when staff were due for reassessment or training.

The service worked closely with other organisations to ensure there was a smooth transition for the person when they moved between different care settings. The operations manager told us the transition from a hospital setting to the person's home could take between six to twelve weeks during which time staff could

be recruited and trained. The care team would then start to get to know the person on the ward and learn how they could best support them once they moved home. They told us; "We have to make sure it is right from day one. We can't do clinical things in hospital but we can do social and emotional things. We have an agreement signed off by the ward staff and family about what our staff can do there and what the hospital staff have to do. We have had meetings with staff from Alder Hey Hospital and the Royal Manchester Children's Hospital to see how we can improve our staff's access to the wards and improve discharge planning so people have as seamless a move as possible."

The operations manager told us they had regular meetings with both social care commissioners and the Clinical Commissioning Groups (CCGs) to update them on where they were up to with the transition process and also to ensure that as people moved from children's services to adult care services the commissioning would continue and the person would receive the support they needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making a particular decision 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 a particular decision, any made on their behalf must be in their best interests and as least restrictive as possible.

Where adults were unable to give consent for care then decisions were based on the person's best interests involving the people who knew the person best and their clinicians. Staff understood their roles and responsibilities under the Mental Capacity Act and the Children's Acts and the decision making process for people was documented in the person's care records. This meant where people could not make decisions for themselves appropriate people were making the decision on the person's behalf and the service was working within the principles of the Mental Capacity Act.

Good

Is the service caring?

Our findings

People we spoke with told us they felt the care workers were very caring and supportive. One relative of a person using the service told us; "The carers we've got are amazing. Having people in your home isn't easy but they are great." Another person told us; "I absolutely adore the [care workers] they feel like part of the family." One care worker we spoke with told us; "I love it. I wouldn't want to do anything else."

Relatives of people using the service told us they felt involved in the care. One person we spoke with told us; "It's all about teamwork. We need to know the care workers can speak to us if there's a problem and we can speak to them too. We have a good relationship." Care workers we spoke with confirmed they felt they had good relationships with people using the service and their families. One member of staff we spoke with told us; "It's great to get them involved and see how happy they are. You can see you're making a difference and it's lovely to see. I want to make sure it's right." Care workers also told us they felt there were good relationships between the care team.

People we spoke with gave examples of how the care workers helped their relatives be as independent as possible and be part of family life. One person we spoke with told us; "We want [my relative] to be involved and they absolutely are. It's wonderful."

Care workers knew the people they supported well. Care workers we spoke with explained they had regular shifts with the same people and so got to know how they liked things to be done. A relative of a person using the service gave us an example where a care worker had identified that their relative needed extra support which they may not have identified if they didn't know the person so well. Another relative we spoke with told us; "[My relative] needs continuity and the care workers know them inside out." Care workers told us getting to know the people using the service was rewarding. One care worker commented; "It's the little things like seeing them get more skills and developing."

Many of the people being supported by the service were not able to communicate verbally but relatives we spoke with told us they felt because the care workers knew their relatives well they understood the non-verbal communication of the people they were supporting. One person we spoke with said; "They have really got to know [my relative] and they understand what they are trying to tell them."

Relatives we spoke with told us they also felt supported by the service. One person we spoke with said; "I coordinate all my relative's care and they are a massive help to me." Another person said; "We couldn't do without them."

Good

Is the service responsive?

Our findings

People told us they felt they were very involved in the planning of the care for their relative. One person we spoke with said; "They don't just come in and say this is what we're doing, it's more we tell them what to do." The registered manager explained that as the majority of people start using their service when they are discharged from hospital, their care plans were written in conjunction with the family, the hospital staff and the lead clinician involved in their care in the hospital. Once the plan had been agreed by them it was sent to the authority who were purchasing the care.

The way people were receiving support was regularly reviewed and people we spoke with told us they were encouraged to participate in the reviews. We saw where reviews had been completed, they were signed on behalf of the service and also by a relative on behalf of the person receiving support. Where changes to the support plan had been identified during the reviews we saw people's care plans had been updated accordingly and additional training needs for staff had been identified.

People's care records contained details of the person's background, preferences and any cultural or spiritual needs they had. They also contained information about the person's preferred social activities and any attendance at college or school. Staff were knowledgeable about how they would support people to maintain their cultural identity.

People's communication needs were identified and recorded and when people received support from other organisations this information was shared with them. People's care records recorded how they could communicate. One example we saw read; "[Person] can communicate using facial expressions, sounds and movements. Their eyes are expressive of how they are feeling." Care workers we spoke with told us that as they supported the same person most of the time they got to know them and understand how they could communicate.

Where people needed information in more accessible ways, the service sought to provide these on an individual basis to best suit that person for example in large print or reading through documents for people.

The service had a rostering system that was available for staff to access remotely so if there was an issue out of office hours, management had access to the same information relating to people using the service and their care workers as they would in normal office hours

People we spoke with told us they felt comfortable raising any concerns they had either with staff providing care or the office staff.

The service treated both verbal and written complains as an opportunity to review the service they were providing and make improvements. Staff we spoke with told us they received updates during team meetings and supervisions about learning from issues that had arisen.

At the time of our inspection the service did not provide end of life care.

Good

Is the service well-led?

Our findings

The management team had a good oversight of the culture of their organisation. The operations manager told us; The culture starts at recruitment. We look for people who have our values and understand how we can support people to make things positive experiences for people." The registered manager met all new staff on their induction and reinforced how important the values of the company were. Staff we spoke with told us; "I absolutely love working here. [The management] really care about the staff as well as the people we look after."

At the time of our inspection the management team consisted of a registered manager, an operations manager and a clinical lead. The management team were able to explain their roles and how they worked together to ensure good management oversight of the business. They explained they felt comfortable challenging each other and felt they were listened to and treated with respect.

The management team met regularly to discuss priorities for the business and how the service could be developed. The clinical lead explained; "We've all got different skills and experiences so we all bring something to the team." The operations manager told us; "We've got different skills, [the registered manager] has the care background, [the clinical lead] has the clinical background and I have the IT skills. We work together closely to put processes in place. We discuss the impact any changes will have on the different areas."

Staff told us the management team were very approachable and open and encouraged people to be open and feel able to share their views. A care worker commented; "They're really nice and approachable. They really are nice people."
Another care worker told us; "They have been really accommodating when I've asked things." Some people we spoke with felt they didn't hear from the management team in the office often enough although they did hear from the nursing team frequently.

In addition to people sharing their views on how the service could be improved the service used a variety of audits and reviews to identify learning and where improvements could be made to the service they were providing to people. The clinical lead explained; "We wanted to make changes more evidence based. We bring the nurses together as a team to discuss what is working and discuss things professionally. We also ask families how they think the audits and changes are working and review it." They added; "If people are able to be honest and tell us what's going on we can do something about it."

The service kept a cause for concern folder which contained details of complaints, safeguarding referrals, near misses, medication errors and other health and safety issues along with a policy and process of how the incidents should be investigated. We saw incidents had been thoroughly investigated and actions taken. Where the service needed to inform other organisations such as the Care Quality Commission (CQC) of events these notifications were appropriately made.

The service had a registered manager in place and they had a clear understanding of their obligations and

responsibilities. 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.