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Courthill Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 13 November 2018 and was unannounced. The last inspection was in January 2018 where we rated the service as Good. This inspection found the legal requirements were not fully met in relation to person-centred care planning. You can see what action we told the provider to take at the end of this report.

Courthill Care Home 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.

Courthill Care Home accommodates up to six people in one adapted building. Care is delivered across two floors and people have access to a garden and sensory room. At the time of our visit, there were four people living at the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. The service was not too large and met the principals outlined in Registering the Right Support. However, we did identify areas for improvement around how people's care and activities are planned. These are detailed within the Responsive domain.

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's care was not always planned in a personalised way. At the time of our visit, new care plans were being implemented in response to concerns raised by the safeguarding team. Whilst these records were detailed, there was a lack of evidence of people being involved in these. We also identified missed opportunities to support people to find new activities and express choices about their care. Care planning for end of life care was not taking place, although the registered manager told us they intended to introduce this following our visit.

People's dietary needs were met and people liked the food they were served. Some improvements to how people were involved in menu planning were underway at the time of our visit and put in place following the inspection. We identified the provider could improve the way they reached out to the local community to create a more holistic approach to people's care. We made a recommendation about community links.

People were supported by a consistent staff team who knew them well, which minimised the impact of some of the issues identified regarding care plans. Staff provided support that encouraged people to

develop skills and independence whilst maintaining a good understanding of any risks. Where risks were identified, plans were in place to guide staff about how to keep people safe. Staff understood their roles in safeguarding people from abuse and the provider had carried out checks on staff to ensure they were suitable for their roles.

People were supported to access healthcare services when required and we saw evidence of healthcare professionals input to care plans. There was a system in place to ensure people received an assessment of their needs before coming to live at the service. People's medicines were managed and administered in line with best practice, with detailed guidelines to inform staff about how and when to administer medicines to people.

Staff felt supported by management and there were a variety of checks and audits in place to monitor the quality of the care that people received. There was an ongoing plan to improve the service and this inspection found a number of improvements implemented, with some yet to be fully addressed. The registered manager knew when to notify CQC of important events such as deaths, injuries or allegations of abuse.

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

The service was safe.

Risks to people were assessed and there was guidance for staff on how to keep people safe. Staff maintained records of any incidents that took place as well as behaviour charts which were used to inform care planning.

Staff understood how to respond to suspected abuse and the provider had systems in place to ensure people's finances could be managed safely. Improvements had been implemented in response to concerns raised through safeguarding investigations.

People's medicines were managed and administered safely, by trained staff.

There were enough staff to meet people's needs and ensure activities took place. The provider carried out checks on staff to ensure they were suitable for their roles.

Is the service effective?

Requires Improvement

The service was not always effective.

People received food in line with their dietary needs and preferences. However, systems to involve people in this had only just been implemented.

Staff ensured people's healthcare needs were met and healthcare professionals had input into care planning.

Staff had received the right training and support for their roles. We made a recommendation about how training is monitored.

Consent was sought in line with relevant legislation. Where restrictions had been placed on people to keep them safe, the correct legal process had been carried out, as outlined in the Mental Capacity Act 2005. However, improvements in this area had not yet become embedded.

People received an assessment of their needs before they came

to live at the service.

Is the service caring?

Good

The service was caring.

People were supported by a consistent staff team who they had built a rapport with and we observed pleasant interactions between people and staff.

Staff provided care that encouraged people to develop skills and independence.

People were supported to maintain important relationships and relatives told us they benefitted from being made to feel welcome.

Staff provided support that promoted people's dignity and was respectful of people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People took part in a variety of activities but they were not always involved in choosing them.

Care plans were detailed but lacked evidence of people's involvement in them. There was not a system to provide people with regular meaningful input into choices about their lives.

People's wishes with regards to end of life care were not documented.

People and relatives knew how to complain and felt confident any issues raised would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Improvements to the service had been implemented but more work was required to ensure the legal requirements of the regulations were fully met.

Whilst we did see some links with the local community, these were limited. We made a recommendation about community links.

Staff felt supported by management and had opportunities to make suggestions about people's care.

There were a variety of checks and audits in place to monitor the quality of the care that people received.

The provider had met their statutory obligation to notify CQC of important incidents and events.

Courthill Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was prompted in part by notification of an incident following which a person using the service was admitted to hospital. This prompted a safeguarding investigation by the local authority which was in progress at the time of our visit. However, the information shared with CQC by the safeguarding team raised concerns about healthcare appointments, person-centred planning and responses to incidents. This inspection followed up on those concerns.

This inspection took place on 13 November 2018 and was unannounced.

The inspection was carried out by two inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We asked for feedback from the local authority.

Due to the inspection being brought forward, we did not ask the provider to submit a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with four people and two relatives. We spoke with the registered manager, the deputy manager and two care staff. We looked at care plans for two people including risk assessments, medicines records, person centred care plans and daily notes. We looked at a variety of checks and audits as well as records of meetings of staff, people and relatives. We looked at two staff files and checked records of staff training and supervision.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the service. We observed people being given freedom to move around the service and to go on outings, with measures in place to reduce risk. A relative told us, "[Person] has settled very well and the behaviours we saw before he came to live at the service have been eliminated." Another relative said, "It is safe. If [person] gets cross about something they always find a way around it."

Risks to people were routinely assessed and plans were drawn up to keep people safe. Care plans contained risk assessments with plans for staff to mitigate risks identified. For example, one person had epilepsy and their care records showed the person had a planned review by healthcare professionals because they had not suffered a seizure for over ten years. In the meantime, the person's epilepsy was documented with guidelines outlining how staff should respond in the event of a seizure. Staff were able to tell us how they would respond in the event of this person having a seizure, by calling an ambulance and keeping the person safe until it arrived. Other risk plans seen covered areas such as behaviour, choking and accessing the community safely.

When incidents occurred, staff took action to prevent them occurring again. The provider kept a record of accidents and incidents and records showed there had only been one incident since our last visit, where a person had become anxious and hit staff. In response staff made sure the person was safe and a review of their risk assessment took place, resulting in their care plan being updated. The person was also referred to healthcare professionals and records showed there had been an improvement to the person's wellbeing and no further incidents. Where people had needs relating to their behaviour, charts were completed and these contained information about what caused the behaviour, the approach staff took and what happened after the behaviour took place. Records showed these charts had been used to inform the decision of healthcare professionals for one person at a recent appointment.

People were kept safe from potential abuse. Staff had been trained in safeguarding adults and were knowledgeable about how to escalate their concerns if they suspected abuse had occurred. Before the inspection, the local authority safeguarding team had raised concerns that incidents were not always being shared with them. Records showed this was now taking place and the registered manager demonstrated a good understanding of what information to share with agencies.

People's financial records were kept accurate and up to date. Where staff supported people to purchase items and handle their money, detailed accounts were kept with receipts for purchases. The accounts seen were accurate and clearly recorded which made them easy to audit. Following an inspection at another of the provider's services where we identified shortfalls in this area, the provider had made changes to their policy and one person was in the process of applying to the local authority deputies for their finances. The provider had learnt from these issues and was working with the local authority to improve the safety of their systems, which showed a culture of learning lessons where things had gone wrong.

People's medicines were managed and administered safely. Medicines were administered by trained staff who had their competency assessed. We observed staff administering medicines and they did so

competently and in line with best practice. The staff member ensured they washed their hands, administered tablets in line with the person's medicines plan and completed the medicine administration record (MAR) once the dose had been administered.

We checked MARs and they were up to date with no gaps. Medicines were regularly audited and checked to ensure best practice was sustained. The pharmacy had visited recently and carried out an audit. Where people were prescribed medicines on an 'as required' basis, there were protocols in place to guide staff on when to administer them. At the time of our inspection, the provider had introduced new protocols which provided more detail, this was in response to feedback from the local authority quality assurance team. Staff were knowledgeable about one person's medicine for pain, they were able to describe how the person may express pain and interventions to take. Another person had 'as required' medicine for behaviour and we noted a recent letter from the prescribing professional stated more detail was required in the person's protocol for this medicine. This had been addressed and there was detailed guidance in place.

There were enough staff present to support people safely. The provider calculated staffing numbers based on people's needs and any activities they took part in each day. We observed that there were enough staff at the home to keep people safe and people were able to go on planned outings with staff as planned. Staff told us that they had enough time to spend with people and we observed staff as able to spend time with people on a one to one basis, responding to any requests as and when people made them.

Recruitment checks were undertaken to ensure staff were suitable for their roles. Staff files contained evidence of checks of references, work histories, proof of right to work in the UK and a check with the Disclosure and Barring Service (DBS). The DBS carries out criminal records checks and holds a database of potential staff who would not be suitable to work in health and social care.

Requires Improvement

Is the service effective?

Our findings

People received foods that they liked. One person said, "I had a pasty [today], the foods always nice." A relative said, "The meals are lovely, they're all home cooked on the premises."

People's care plans contained some information about specific foods they enjoyed. For example, one person liked pies and eating out and this was in their care plan with records showing they regularly ate these foods. At the time of our visit, there were not tools such as pictures in place to support people to express wishes and make choices about foods. The registered manager told us there was a plan to introduce pictures to enable people to make choices. This was implemented immediately after the inspection and we received evidence to show this. Minutes of house meetings also showed effort was being made to get feedback on food and when we observed people eating, they expressed that they liked the meals and finished their food.

People received food in line with their dietary needs. Where people had specific nutritional needs or risks, care was planned around these. For example, one person was assessed as at risk of choking due to the fact that they often ate too fast. Their care plan documented that they were to have their food cut up and staff were to provide verbal prompts if they ate too fast. Staff were knowledgeable about this risk and we observed them providing this person with prompts and discreet supervision when they ate.

People's healthcare needs were met. Where people had ongoing treatment from healthcare professionals, this was used to inform care planning. For example, one person could become anxious and they were supported by a community nurse. A recent letter showed the registered manager had discussed this person's behaviour with the nurse and changes to the persons care plan had been made after this appointment. People's records contained trackers for healthcare appointments and these showed people had recently seen optician, dentists and their GP.

Staff had received appropriate training for their roles. One staff member said, "We do training and refresher courses, I did a full induction." Records showed staff had completed training in areas such as autism, behaviour and epilepsy which was suited to the needs of the people that they supported. Staff demonstrated a good understanding of how to respond to epileptic seizures and changes in people's behaviour. The provider kept a training matrix to record which staff had attended training and this showed staff had attended all courses. However, the matrix did not show the date of training in order to enable the provider to keep track of when each training course was last attended to enable them to plan refresher training. Staff told us they had received regular training throughout the year and certificates seen supported this. However, the training matrix did not accurately evidence how regularly training was refreshed.

We recommend that the provider reviews their systems for documenting training to ensure it can be easily tracked.

Staff had regular one to one supervision meetings and they told us they found these useful. One staff member said, "I have supervision regularly with [registered manager], I can ask whatever I need." Records

were kept of supervision and there was a tracker in place for this, which did document dates when these had taken place. Records showed all staff had received supervision within the last two months.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether staff were following the MCA and found that the correct legal process was being followed, apart from in one instance. Whilst we found that the process had been followed, in some cases this was only in response to recent feedback from the local authority. Mental capacity assessments covered a variety of decisions such as consenting to care and supervision from staff. Where people were unable to make decisions, best interest decisions were documented. As the examples seen showed only a recent improvement in this area, time will be required to allow best practice to become embedded.

We also identified one restriction which was not recorded in DoLS applications. Due to a specific risk for one person, the kitchen door was locked which meant people could not freely access the kitchen. Documentation did not have record of this specific restriction, but we did note applications covered a variety of other restrictions. We raised this with the registered manager and they spoke with the DoLS Team immediately. The registered manager made changes to how people accessed the kitchen, with supervision from staff where there were risks, to reduce the impact of this restriction on the whole service. There was already a plan to refurbish the kitchen within the next month and after the inspection the provider shared their plan with us. They planned to change the method of locking the door which would remove this restriction for people who did not require it. We will follow up on the impact of this improvement at the next inspection.

People had received an assessment before moving into the service. There had not been any new admissions since our last visit but paperwork in files showed a thorough assessment of people's needs, involving people, relatives and healthcare professionals, had taken place. Information from assessments had been added to care plans. A relative said, "We gave staff a very detailed briefing when [person] moved in."

Good

Is the service caring?

Our findings

People expressed to us that they liked the staff who supported them and we observed pleasant interactions throughout our visit. Relatives said that the service was caring. One relative said, "[Person] is very content there and happy." Another relative told us, "There's some lovely staff there, [person] gets on well with all the other residents too."

People were supported by caring staff that knew them well. During the inspection, we observed people interacting with staff. People shared jokes with staff and looked comfortable in their company. In the morning, a person was recalling places they had lived with staff. Staff provided prompts to the person, demonstrating a good understanding of their background and allowing the person time to recollect. Later, staff reassured someone who could become anxious, responding to signs they were worried by talking them through their concern and supporting them to go on an outing.

Staff had worked with people for a long time and built up a rapport. There was not a high turnover of staff at the service and the staff team in place was the same as at our last inspections. People were regularly supported by the same staff which enabled positive working relationships to develop with them. Staff were able to tell us about people's needs and what was important to them. We observed an inclusive atmosphere in the home in which staff and people chatted and enjoyed each other's company. A relative told us, "It's very homely and there's a really nice community atmosphere there."

People were supported to develop independence. People's care plans contained information about tasks they liked to do themselves as well as support they liked to provide around the home. For example, one person liked to clean and we observed them being supported to do this during our inspection. Daily records showed they supported with this most days and this person's relatives told us how this was something that was important to them. Another person was being supported to go out to develop independence in the community. Staff told us the person required less support when going on outings as they had developed more understanding of risks through this support. The person told us about how they stayed safe when they went out and this showed they had developed knowledge in this area.

People were supported to maintain important relationships. Relatives told us that they were made to feel welcome when they visited and people's files contained information about family members who were important to them. During the inspection, we observed staff talking to one person about their relatives and they showed a good knowledge of their background. We received feedback that communication with the home was good and during our inspection we observed the registered manager discussing people's needs with relatives on the phone. Records showed people were regularly supported to go on outings or holidays with friends from other services. Relatives told us they could always contact the home and they felt peace of mind due to this. One relative said, "We're always made to feel welcome and [person] is very laid back on our visits."

People's dignity was respected by staff. People were wearing clean clothes of their choosing and they looked well kept. Staff had been trained in how to provide care in a dignified manner and they

demonstrated a good understanding of how to do this. A staff member described how they provided people with choice of clothes each day and spent time supporting a person to dress themselves. They reported how through patience and repetition, the person had become able to complete more personal care tasks themselves.

Staff respected people's privacy and knocked on doors to gain permission before entering people's rooms. Personal care took place in private and staff had a good knowledge of steps to take to maintain people's privacy, such as closing curtains and ensuring doors were shut.

Requires Improvement

Is the service responsive?

Our findings

People told us that they liked the activities they took part in. One person said, "I like going to the [local day centre], we play games sometimes." A relative said, "[Person] goes swimming, cycling and to the park. It's a really lovely community there." Another relative said, "[Person] likes anything to do with water and they're good at involving him in things."

People attended a variety of activities but evidence of their involvement in choices was not always clear. People had individual activity timetables and staff kept a record of activities attended. These showed people took part in hobbies, outings, shopping and visited day clubs. However, people's activity timetables were similar and we found more work could be undertaken to involve people in identifying meaningful activities in line with their interests. People regularly attended a local day centre which they enjoyed, but there was sometimes a lack of alternative choice for people.

People received personalised care, however care plans lacked evidence of involvement from people. Care plans contained detail about what was important to people and what they needed support with. For example, one person's routine was very important to them. There was detailed information about the order in which they liked to complete tasks to start their day, alongside guidance for staff on the correct approach to take. However, the care plans lacked evidence of involvement of people in creating them. Staff also gave us examples of how they supported another person in a way that had caused them to require less support from them. Whilst this was a positive approach, it had not been documented in the person's care plan.

There was a lot of text guidance for staff but these did not always include pictures. People living at the service had learning disabilities and some used pictures or Makaton [communication sign language for people with learning disabilities]. The care plans were written and required a good level of reading ability to understand.

There was not always a person-centred approach to care planning. The wording between two care plans was similar in parts. For example, two people's care plans both described how people had a nice smile and 'liked to wear nice clothes', but did not expand on these areas to provide this information to staff. This showed more work was required to ensure the information was relevant to the person and reflected what was important to them.

We also noted that care plans lacked information about people's protected characteristics as outlined in the Equalities Act 2010; with a lack of information documented about people's sexuality and gender identity. At the time of our inspection, the registered manager was in the process of updating care plans to a new template. After we gave feedback on these issues, the registered manager shared an example of a new care plan that contained pictures and more information about people. However, this did not yet provide information on people's sexuality and gender identity. This meant there was a risk that people's sexual needs, and the impact of their sexuality and gender identity on care preferences were not considered.

People's needs were being reviewed regularly, but the records of this were not always available. During the

inspection, we did not see evidence of any recent reviews carried out by the provider. However, after our visit the registered manager sent us examples of six-monthly reviews that had taken place earlier in the year. These review documents showed people's needs, healthcare, medicines and activities were discussed twice a year, but we did not see any record of more frequent opportunities to identify changes to care. One person's review showed they had expressed a wish to stop going to church as they watched church services on TV now, which had prompted a change to their activity schedule. Whilst these documents were detailed, the evidence of involvement of people was limited. Reviews did document the views of the person, but did not provide their input on every aspect of their care. Whilst we saw evidence of six monthly reviews, we did not see evidence of more frequent or informal opportunities for people to express their wishes.

End of life care had not been planned for. At the time of our visit, there was a lack of information in people's care plans about end of life care. We did see evidence of end of life care planning for people who had moved from the service, but at the time of our visit there was a lack of information about end of life care for the people currently living there. People at the service were not on an end of life care pathway, however initial information about people's needs and wishes in this area had not yet been gathered. The registered manager told us that this was something they were working on, we will follow up on the impact of these improvements at our next inspection.

The shortfalls in person-centred planning were a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were informed of how to complain. There was a complaints policy in place and relatives told us they knew how to complain and felt confident any issues would be addressed. The complaints policy contained pictures and was accessible to people. There had not been any complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us that the service was well-led. Two people told us they liked the registered manager and we observed them interacting warmly with her during the inspection. One relative said, "The service is well managed, its fine and I've never had any complaints." Another relative told us, "[Registered manager] is very hands-on, she knows everything about all the residents."

The provider had responded positively to recent issues raised by the safeguarding team and these had prompted improvements to care plans and record keeping. Whilst we saw these improvements had been implemented, more work was required to ensure care plans were person-centred and people were routinely involved in decisions about their care. The feedback from people and relatives was all positive and the registered manager took immediate action when we gave feedback after the inspection. However, some improvements were yet to be made and we will require evidence of sustained and embedded good practice in order for the service to meet the characteristics of a 'Good' rating in Well-led.

There was room for improvement around how the service linked with the local community. Records contained evidence of regular contact with agencies involved in people's care as well as day centres people attended. We found staff could be more creative with planning activities and we identified there could be more done to link with the local community. For example, all people visited the same local day centre. Whilst they told us they enjoyed this, we did not see evidence of alternative ideas being explored for people. There was still room for improvement in how the provider linked with the local community in a way that could impact positively on people's care by identifying more choice.

We recommend that the provider looks to the wider community to develop links that will benefit people.

Staff felt supported by the registered manager. Staff told us that the registered manager was always available and they could raise any issues they had with confidence that they would be addressed. There was a deputy manager in post who provided staff with line management when the registered manager was not there and took the lead on some duties such as audits and planning. During the inspection, we observed the registered manager working alongside staff to support people. People were familiar with the registered manager who had worked with them for a long time.

The provider had shared lessons learnt from issues at their other services. Following an inspection of another of the provider's services, improvements had been made to the way finances were recorded and changes to policy had been communicated to people, relatives and staff. At the time of our inspection, the new fees policy had not been written but we saw evidence of the changes having been communicated to relevant stakeholders. We will follow up on the progress of this improvement at our next inspection.

There had been recent improvements to record keeping. The registered manager showed us how daily records, records of activities and healthcare appointments had been improved. These records were easy to audit and track that people's care had been delivered as planned. This showed a culture of learning and a vision to improve the service in response to feedback.

There were a variety of checks and audits in place to monitor the quality of care that people received. Despite them not having yet addressed the issues around involvement of people in care plans, there was ongoing auditing of care plans taking place which had caused improvements to the detail within care plans. Audits also covered checks of the environment, fire safety, medicines and cleanliness. The provider kept a record of audits with a tracker and this showed checks were up to date.

The registered manager understood their requirement to notify CQC of important events. Providers are required by law to notify CQC of incidents such as deaths, serious injuries or allegations of abuse. The registered manager showed a good understanding of when to notify CQC. Where there had been a recent incident, the provider had notified CQC as appropriate.

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 People were not always involved in planning their care and activities. People's wishes with regards to end of life care had not been documented.