County Healthcare Limited

Courtenay House Care Home

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Courtney House Care Home is registered to provide accommodation and personal and nursing care to up to 46 people. The people living at the home have physical disabilities and some also live with dementia.

At the time of this inspection care was provided to 39 people. This comprehensive inspection took place on 18 August 2016 and was unannounced.

The provider is required to have a registered manager as one of their conditions of registration. A registered manager was in post at the time of the inspection and had been registered with the Care Quality Commission (CQC) since 23 March 2016. A registered manager is a person who has registered with the CQC to manage the home. 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 were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were helped to take their medicines as prescribed by staff who were trained and had been assessed to be competent.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and care was provided in their best interests. Staff were trained and knowledgeable about the application of the MCA.

People were looked after by staff who were trained and supported to do their job.

People were treated by kind, respectful staff who enabled them to make choices about how they wanted to live. People and their relatives were given opportunities to be involved on a day-to-day basis about their planned care.

People were supported to be part of the community and they were helped to take part in recreational activities that were important to them. People's care records were reviewed but the frequency of this was variable. It was unclear how people or people important to them were actively involved in the reviewing of their planned care. In addition, although staff knew about people's individual needs, they had insufficient detailed recorded guidance to ensure this standard of care would be provided in a consistent way. Following our inspection the provider wrote and told us about the immediate action they intended to take

to rectify these deficiencies. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The registered manager was supported by a team of management staff and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

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.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which vetted prospective employees before they were deemed suitable to safely look after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual physical and mental health needs were met but the timing of when these were met was variable. People's

care records were not detailed and did not always provide staff with sufficient guidance to ensure that people would be provided with consistent, individualised care.

People were supported to take part in activities that were important to them.

The provider had a complaints procedure in place. This enabled people and their relatives to raise their concerns and these were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

The safety and quality of people's care was monitored and kept under review.

The management of staff ensured that people benefited from safe and appropriate care.

Courtenay House 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.

This inspection took place on 18 August 2016 and was unannounced. It was carried out by two 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.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

The provider completed a Provider Information Return (PIR) and sent this to us before the inspection. 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.

Prior to the inspection we made contact with a local authority quality assurance manager to help with the planning of the inspection and to gain their views about how people were being looked after.

During the inspection we spoke with 10 people, four relatives and three visiting health care professionals. We also spoke with a visiting registered manager [from another of the provider's homes]; a regional manager; a clinical lead nurse: an administrator; the activities co-ordinator; one registered nurse; one care home assistant practitioner; one team leader; one senior care assistant; two members of care staff; one cook; one member of house-keeping staff and one maintenance member of staff.

We looked at three people's care records, medicines administration records and records in relation to the management of staff and management of the service, including audits.

Due to their complex communication needs some people were unable to say to us about their experience of being looked after. Therefore, we observed care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

People told us that they felt safe because of how they were looked after. One person said, "I am safe and comfortable here. I've started to get to know the carers and they are friendly and chatty." One relative told us, "[Family member] is in a safe place and I can leave [family member] here after a visit, knowing [family member] is in safe hands." Another relative said, "[Family member] is well cared for and there are systems in place to make sure [family member] is safe and secure." A visiting health care professional told us that they had no concerns about the safety of people because staff treated them well.

We checked and found that staff were aware of their roles and responsibilities and knew how to keep people safe from the risk of harm. Staff were trained and were able to describe the types of harm that people might experience. They also told us about the actions they would take in response to such untoward events. This included reporting the concerns to the management team of the home and to external agencies, which included the local safeguarding team. Members of care staff were also able to demonstrate their knowledge regarding the signs to look out for that people might experience if they were being harmed. The team leader said, "There could be withdrawal. The person could stay in their room. Or be losing weight." The senior member of care staff gave a similar response and added that people may show unexplained bruising.

Procedures were in place to keep people safe from the risk of harm. Their risks were assessed and measures were in place to mitigate the risks. These included risks associated with choking; falls and development of pressure ulcers. The measures included ensuring people at risk of choking were given their food and drink that they were able to easily swallow. The cook told us that food with hard-to-swallow husks was not provided such as certain types of vegetables. People at risk of falls were provided with protective mats. In addition, their beds were lowered to reduce the physical impact in the event of them falling from their bed. People who were assessed to be at risk of developing pressure ulcers were provided with pressure-relieving equipment. They were also helped to change their position, when in bed, to relieve harmful pressure. Members of staff demonstrated their knowledge in relation to managing people's risks. The maintenance member of staff advised us that they checked that pressure-relieving mattresses were operating correctly. Members of care staff told us about how often people needed help with changing their positions. People's records confirmed that they were re-positioned in accordance to their assessed risk.

The provider had submitted notifications to us when there were occasions of people being placed at risk of harm. The information detailed in the notifications told us that appropriate actions had been taken to protect people from the risk of recurring harm. This included, for example, when a person acquired a pressure ulcer. This told us that there were systems in place to ensure that people were kept safe as practicably as possible.

We checked and found that there were recruitment systems in place to vet prospective staff before they were deemed suitable to work. One member of care staff described their experience of when they were applying for their job. They said, "I filled out an application form. I came in for an interview. There was a DBS [Disclosure and Barring Service] check. [A criminal record check]. I had two references and I had to bring in my passport [for the purpose of identification]." Another member of care staff also told us that they had

undergone a similar recruitment process. Both members of care staff said that all the checks were in place before they were allowed to start their job. Staff recruitment files contained the required information which had been obtained before the prospective staff member was contracted to work.

We found that people were looked after by sufficient numbers of staff although this varied at times. One health care professional told us that there was always enough staff. This had enabled them to have a member of staff to chaperone them, if they needed this level of support. One person said, "They [care staff] do take their time to get to you sometimes. There are not enough staff but they are very busy." One relative said, "I feel staff are pushed to keep up with demands. Every day seems to vary." The senior member of care staff advised us that, "A couple of months ago it [staffing numbers] was not so good. But it is picking up." Two members of care staff said that there were always two members of care staff to assist people with their moving and handling needs, by means of a hoist. They said, "One staff member to use the hoist and one member of staff to guide the hoist and person." The member of house-keeping staff told us that there had been an increase in numbers of staff to keep the home clean.

Measures were in place to cover staff vacancies or staff absences and to ensure that people received a continuity of care. The team leader said, "Sometimes we don't have enough staff but [other] staff do pick up extra shifts. We have used agency staff but not very often." On the day of our visit there were enough staff. We timed and found that staff responded to people's call bells in a timely manner and that people were looked after by unhurried staff. The senior member of care staff said, "We don't run around like headless chickens as it is not nice for the residents [people living at the home]."

People told us that they were satisfied with how their prescribed medicines were managed and got them when they needed them. We saw that people were asked if they wanted to take their medicines and were given a reason for them to do so. In addition, people were asked if they needed any of their prescribed medicines to ease any discomfort that they might be experiencing. We also saw the senior member of care staff offered a person an alternative choice of presentation of their medicine -which was in liquid form - which they preferred to take. People were helped to take their medicines safely by staff who were trained and assessed to be competent with this aspect of people's care. Medicines administration records were completed to signify that people had their medicines as prescribed. Medicines were kept secure so that only authorised staff had access to people's prescribed medicines. This showed that procedures were in place to keep people safe from the risk of unsafe management of their medicines.

Good

Is the service effective?

Our findings

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 registered services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had made applications to the local appropriate authority when they believed a person was being deprived of their liberty. The applications were based on assessments of people's capacity to make informed decisions. These included, for instance, decisions where they were to live and how they were to be looked after. The clinical lead nurse and team leader said that they were waiting for the outcome of the decisions made by the authorising local authority.

Members of care staff told us that they had attended training in the application of the MCA and demonstrated an awareness of the application of this piece of legislation. The clinical lead nurse said, "[The MCA] is to protect people who are deemed not to have [mental] capacity." The senior care assistant explained that some of the people were unable to make certain choices because they lacked capacity. However, they were aware that such people were looked after in their 'best interest.' This included, for example, having their medicines as prescribed.

People's mental capacity was assessed and recorded by hospital-based medical practitioners. The assessments were in relation to whether people were to be resuscitated. However, there was a lack of review of these, which included the appropriateness of the adoption of the hospital record. In addition, there was insufficient evidence to suggest that there had been a review of the clause that indicated that this decision was 'indefinite'. This method of recording was not necessarily in accordance with up-to-date practice and policy. The regional manager was aware of the recent changes and advised us that action would be taken to review people's do not attempt to resuscitate forms. This was to ensure that people were supported in making such sensitive decisions, based on the guidance and legislation of the MCA.

People were having their needs met by staff who were trained to do so. One relative said, "The staff know what they are doing." Staff told us that they had attended training in a range of topics. Two members of care staff described their induction training and this included observing more experienced staff members. One member of care staff said, "I had the induction. I was shown around the home and the residents [people who live at the home]. I watched the staff [at work]." Both members of care staff told us that their induction training included fire safety and moving and handling. They said that they were assessed to be competent to

ensure that people were kept safe when being helped with such needs. On-going training included that for caring for people living with dementia and health and safety training, such as moving and handing and infection control. The administrator was able to demonstrate that the staff training records indicated that almost all of the staff [97%] had attended the provider's required training.

People benefitted from being looked after by staff who were supported to do their job. One person told us, "They [staff] want to do their job they are doing which means they enjoy it." Members of care staff told us that they had the support to do their job, which they said they enjoyed doing. They told us that they worked well as a team and had support from the management team. This support included informal and one-to-one support. The one-to-one support included discussions about staff training needs and the standard of their work performance. The clinical lead nurse also told us that they were supporting registered nurses with the changes implemented by their governing body, the Nursing and Midwifery Council [NMC]. They said, "I'm in charge of the nurses. I support them with giving them guidance and getting them used to reflective practise." They also told us that they supervised the registered nurses on both an informal and formal basis. They said, "I observe their practice. Training needs are also picked up at supervisions. We have identified we need more training in syringe drivers [equipment to deliver monitored doses of prescribed medicines] and re-fresher training on female [urinary] catheterisations." We found that some of the care staff had a basic understanding of looking after people with diabetes and Parkinson's disease. Following our inspection the regional manager wrote to tell us action was being taken to improve staff's understanding of diabetes. They said, "…this will ensure that the staff team are better equipped and have a greater understanding and more measured approach."

We checked and found that people were helped to maintain their nutritional health. People told us that they had enough to eat and drink and we saw that they chose when and where they wanted to eat. People also had positive comments about the quality of the food. One person said, "The food is so good. I probably have a little too much. Which may account for my weight gain?" Another person said, "I love the food. It is varied and tasty. They do a great job. I look forward to every meal." People were helped with eating and drinking if they were not able to do this for themselves. When people were able to independently eat their food, plate guards were provided which enabled people to easily get their food on to their fork or spoon. People's individual dietary needs were catered for which included soft and pureed diets. Information about people's food and drink allergies was obtained and shared with the catering staff. This was so that they were able to prepare meals and snacks according to people's individual dietary needs. We saw that people were offered drinks and snacks, which included biscuits, crisps and a choice of fruit, during the day.

People's weights were monitored and the frequency of these was based on the outcome of their nutritional risk assessments. Information in respect of people at high risk of undernourishment was collated and reviewed by the management team. This was to ensure that appropriate actions were taken in response to any significant unintentional weight loss. Actions taken included involvement with dieticians and GPs. People were prescribed nutritional supplements to increase their weight and maintain their nutritional health. In the event that people were unable to maintain their nutritional health by mouth, they were helped to maintain their nutritional health by artificial means. Records of these demonstrated that people's nutritional regime was carried out in accordance with their planned care.

People's mental and physical health care needs were met by a range of health care professionals and by the home's staff. One visiting healthcare professional said, "Staff are very good at getting us when people's needs change." This was so that they would be able to provide additional health care advice. Another visiting healthcare professional told us that they frequently visited the home to treat people's feet. The clinical lead nurse told us how people, who were living with diabetes, were supported to reduce the risk of foot-related problems. They said, "The diabetic podiatrist team becomes involved." A third visiting

healthcare professional had positive comments about how nursing staff looked after people's pressure areas. They said, "The staff have been proactive in the last few months. I attend nursing patients [people who have nursing needs and live at the home]. When there has been a new patient the [nursing] staff have contacted me to make sure the [pressure-relieving] equipment is right." The team leader told us about the effective care provided to one person. This care had helped the healing of a pressure ulcer. They said, "[Name of person] had a grade three pressure ulcer and that is now healed with the help from the staff and district nurse."

Good

Is the service caring?

Our findings

We found that people were being looked after by kind and caring staff. People and their relatives had positive comments about their experience of the home. One person said, "I am very happy here indeed. It is homely and comfortable. I really do feel like it is home. [I have] very good treatment by staff." Another person told us, "I feel I belong here and I belong to them [staff]. It's a nice relationship." One relative said, "They [staff] definitely see [family member] as a person who they respect." Another relative told us, "The carers [staff] are friendly, kind and lovely." The senior member of care staff said, "If you don't care, you shouldn't be doing the job."

People's choices of how they wanted to be looked after were valued. This included choices in relation to their medicines and what they liked to eat and where to eat. Members of care staff were aware of people's rights in making choices. The senior care assistant said, "I always give people a choice. You do get to know them over a period of time." They expanded on this and explained how they helped a person, who was living with dementia, in making lunch time choices from the menu options.

People's rights to independence were promoted and maintained. One member of care staff described how they encouraged people to remain independent with washing and dressing. They said, "If they [people] can do it themselves, they then will wash their face [and elsewhere]. You just don't rush in and do it for them." People's independence with eating and drinking was maintained and promoted with the provision of eating equipment and encouragement from staff.

People's rights to privacy were generally upheld. There were lounge areas and people had the privacy of their own room. One person said, "I like it here. There's company when you need it and you can be on your own." All people's bedrooms were used for single occupancy only and communal bathrooms and toilets had overriding locks provided on the doors. However, we found that three doors of these communal bathing/toilet facilities could not be locked. We brought this to the attention of members of the management and maintenance team. We saw that the majority of people were helped to wear clothing that protected their privacy and dignity. However, we saw one person in a state of undress in a corridor and unattended. In addition, we found that when people had a urinary catheter, their catheter bag was in public view. Following our inspection the regional manager acknowledged that quality improvements were needed. They wrote and said, "I have contacted or (sic) resident experience team, and instructed them to complete a number of training sessions on dignity and respect, whilst I feel that the staff are respectful, you mention of position of catheter bags, lock on bathroom doors lead me to believe it is something we could improve on."

People were allowed to receive their guests when and where they wanted. This included communal rooms, private bedrooms or in the garden areas of the home.

The management team told us that general and independent mental advocacy services were not used. The administrator said that they would take our advice to get further information about such services. Advocacy services are organisations that have people working for them and who are independent and support people

to make and communicate their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

People's individual needs were assessed and met. Pre-admission assessments were carried out to ensure that the home was an appropriate place for the person to live. One relative told us that they were included in their family member's pre-admission process. People's on-going needs were also assessed. These included those associated with pressure area care; mobility needs and personal care. Staff were also aware of the communication needs of people living with dementia. We saw that they spoke with people in a way that they would understand. Furthermore, the staff did not correct people's sense of reality but engaged with them in their world.

However people's needs were not always met as they wanted these. One person said, "They [staff keep me waiting. I need help with dressing and waking. I have to wait a long time, sometimes beyond 10:30 in the morning. At night it's not so bad. After asking to go to bed I might wait for 10 minutes." One relative told us that when they arrived they found their family member was lying across their bed "with their feet dangling (over the edge)." They added that this was because their family member wanted "to get up" and was "still in their nightwear by 11:45." Another relative said, "It's now 10 o'clock and [family member] is waiting to be washed and dressed." This meant that people's needs were not consistently responded to albeit there was sufficient staffing numbers to look after people.

People were not fully protected from the risk of receiving inappropriate care as care plans and risk assessments were not always kept under review or were incomplete. One example of this was there was no detailed guidance for staff in the management of a person's diabetes. Another example was that a person's oral assessment was last recorded on 19 May 2016. They were treated by a GP during June 2016 for a mouth condition. However, the person's record for their oral assessment had not been updated since then. The clinical lead nurse told us that a random sample of people's care plans was audited each month. They believed this last care plan was yet to be audited. Moreover, we found insufficient recorded evidence that people, or their legal representatives, were actively involved in the reviews of people's planned care. Following our inspection the regional manager advised us that "Care plans: we are currently making a list of residents (sic) needs and full review of all care plans will take place to be completed by the end of the month to ensure they are both up to date and reflective. I have organised care plan session training, there will be a number of drop in sessions and this will be followed by practical observations and support for staff to build further confidence. I have also requested or (sic) dementia trainers to attend to discuss how my choices [a record of people's life histories and information about people want to be looked after] be incorporated into both the care plans and play a greater part of the residents daily lives."

People were treated as unique individuals and this was supported by people's detailed life histories held within their records. One relative said, "They [staff] see my [family member] as a real person." Members of care and nursing staff demonstrated their knowledge about people's individual health care needs and personalities. Our observations of staff interacting with people found that staff knew people as individuals and socially discussed their activities and interests with them.

There was a range of interests which mattered to people and they were supported in following these. One

person said, "I like the bingo and I can get out to the chapel in the village on a Wednesday." One relative told us, "[Family member] gets to go in the garden and last week [family member] was doing cooking which [family member] enjoyed. [Family member] helps plant flowers as well." Other social activities included, for instance, going to the sea-side to eat fish and chips; arts and crafts and doll therapy. We saw some people take part in making cakes in the morning and one of the people doing a jig-saw puzzle in their room.

There was a procedure in place to listen and respond to people's complaints. People told us that they would speak with members of care staff if they were unhappy about something. None of the people we spoke with had any concerns or complaints to make. Members of staff were aware of the provider's complain procedure and how to support people with this. The team leader said, "I would listen [to the complainant]. If you can sort it, you sort it. Document it and report it to the [registered] manager." The complaints log showed that one complaint was received and investigated. The investigation showed that the complaint was taken seriously and any issues were addressed.

Good

Is the service well-led?

Our findings

There was a registered manager in post although they were on leave when we inspected the home. People and relatives knew who the registered manager was and some told us that they had seen them walking around the home. One person said, "[Name of registered manager] speaks to me when [they] are around and [they] ask me if I'm alright. I'm comfortable with [them]." The local quality assurance manager also had positive comments about the registered manager. They described the registered manager to be approachable, co-operative and transparent with members of the local authority safeguarding team. We received other positive comments from members of staff about the leadership style of the registered manager. We often heard the descriptors of "approachable" and "supportive". Members of staff also added that the registered manager would help them provide people with care and this would also be supporting the staff team.

There was a management structure in place with the registered manager being accountable to the regional manager. The registered manager was also responsible for the management of nursing, care and ancillary staff. Individual members of staff were aware of who they were accountable to but were enabled to liaise directly with members of the management team,

The registered manager had made sure that that they had submitted notifications as required which demonstrated that they had an understanding of their legal responsibilities as a registered person.

People were provided with opportunities to tell the provider their views about their experience of the service. This included during meetings and by feedback using the information technology available in the home. Monthly reports of the feedback were reviewed. For July 2016 feedback the home was rated high according to the 44 responses received by this most recent monthly survey. The visiting registered manager advised that they were unable to locate any plans to say what any remedial actions had been taken in response to less than positive feedback. However, they said that any actions were taken by staff "there and then."

Members of staff were enabled to make suggestions and comments during staff meetings. This included upgrading people's wheelchairs. They said that this suggestion had not been actioned but confirmed that people's wheelchairs were safe and fit for purpose. Nevertheless, they said that they felt they were able to make such a suggestion. Minutes of the June 2016 staff meeting demonstrated that staff were reminded of their roles and responsibilities in providing people with safe care. This included, for example, responding promptly to people's call bells and maintaining accurate care records. However, the minutes reduced the management team's ability to show how staff were encouraged to contribute to the agenda items, and therefore the running of the home.

The provider information return [PIR] was submitted when we required this. The information held in the PIR showed that the provider aimed to continually improve the quality of people's care and experience of living at the home. This included, for example, continued training and management of staff and, "To continue to use a You Said, We did approach to improve the service."

Other quality assurance systems were in place This included the response time for responding to and resolving complaints according to the provider's complaints procedure. A 'trigger' alert system was in place to alert the registered manager should this quality action be delayed. We found that some areas of the home required some refurbishment. Both the visiting registered manager and regional manager advised us that audits had identified these areas for improvement. Action had been taken to order replacement furniture and proposed re-decoration and they were waiting for the provider to approve the orders. Care plans; medication and people's weights were audited and recorded. The clinical lead nurse told us, "That information goes to head office. They then send us any issues to correct." The regional manager told us that they would review this information when they next visited the home.

There was an open culture in the management of the home. Members of care staff were aware of the whistle blowing procedure and said that they would have no reservations in using this. The senior member of care staff said that they had previous experience of blowing the whistle to report poor staff practices and would have no reservation in doing so again. The team leader told us, "Whistle blowing is where you report it [concerns] secretly if you think someone is being harmed or neglected and you feel nothing is being done."

The aim of people's support and care was to value their rights to make choices, decisions and independence. In addition to this, people were effectively supported to be integrated into the community. This was by taking part in practising their religious beliefs and taking part in recreational activities.