Pharos Care Limited

Katherine House

Inspection report

91-93 Sutton Road
Erdington
Birmingham
West Midlands
B23 5XA

Tel: 01213509578

Date of inspection visit:
17 August 2020

Date of publication:
06 January 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Katherine House is a care home providing personal care and accommodates nine people in one adapted building. On the day of the inspection, the service was providing care and support for eight people who have a learning disability and behaviours that challenge others.

People's experience of using this service and what we found
Care and treatment was not always provided in a safe way. The providers systems failed to identify risks to people or if risks were identified they were not managed effectively.

Systems in place failed to safeguard people from the risk of abuse. Support for staff to carry out their role was not effective.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes. Systems in place to manage the control of infection were not robust and did not always follow current government guidance in relation to COVID19.

People received their medicines when needed.

There was a lack of provider oversight which meant risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service were ineffective and placed people at the risk of harm. The systems in place failed to identify the areas for improvement found at this inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was Good (Published February 2018).

Why we inspected
The inspection was prompted due to whistleblowing concerns raised with us. These concerns related to people's care and their safety. A decision was made for us to inspect and examine those risks.

We reviewed the information we held about the service. We only looked at safe and well led during this inspection. We did not look at the key questions of effective, caring and responsive. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Katherine House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified three breaches in relation to safe care and treatment, safeguarding and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Katherine House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors. Two inspectors visited the home on the 17 August 2020, whilst the third inspector undertook telephone calls to staff and relatives on the 13 August 2020.

Service and service type
Katherine House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission (CQC) at the time of this inspection.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with Covid-19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We did not ask for a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

We carried out telephone interviews with four staff members and two relatives on 13 August 2020.

During the inspection
We met all the people living at Katherine House. We spoke with eight staff members including, care staff and senior care staff and the providers representative.

We reviewed a range of records. This included four people's care records and three people's medication records. We looked at three staff files in relation to recruitment. We also looked at records that related to the management and quality assurance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and sought assurance and written confirmation about action taken regarding's people's immediate safety.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Systems in place for assessing risks to people were not robust. For example, restrictions had been imposed in people's bedrooms including the locking of an en-suite bathroom and toiletries kept in a locked cupboard. There was no risk assessment in place to guide staff on how these restrictions should be managed and kept under review and therefore no consideration had been given to the least restriction imposed on people's choice, freedom and control.
- Potential risks to people's safety in the environment had not been identified and responded to proactively to mitigate any risks to people. For example, the laundry room was left unlocked and the COSHH (Control of substances hazardous to health) cupboard within this room was not secured and had no locking facility on it and the cupboard contained a number of hazardous items. Action had not been taken to mitigate the risk from a hanging looped blind cord in a person's en suite, which posed a risk of strangulation.
- Two people's beds had their mattress's left in the delivery packaging and sheeting placed on top. Staff told us the packaging was left on to protect the mattress from becoming soiled. The plastic covering not only posed a health and safety risk to the person but also by leaving the plastic covering on, people may sweat more with the potential to cause them sore skin.
- One person used a wheelchair to access the community and staff told us this was difficult at times as the person would slide down in the wheelchair. There was no risk assessment in place to ensure that any risks to the person had been considered and to guide and inform staff on how the person should be supported safely.
- The physical health assessment for one person did not include information about the person's complex health condition.
- Behaviour incident reports lacked information about the duration of the incident and when there was an injury, there was a lack of information about this. For example, Incident form dated 31 July 2020 recorded the person had hit their head on the wall and dropped to the floor. The injury section, medical attention section was not completed. The body map section showed possible bruising to back, arm, legs and head. The follow up sections and managers sections were not completed. There was insufficient oversight and monitoring of such incidents, resulting in these concerns not being evaluated and addressed to minimise the risk of re occurrence.
- Arrangements in place to protect people by the prevention and control of infection were not always effective which placed people at risk of harm.
- There was a generic risk assessment in place for the non wearing of masks by staff in relation to the management and prevention of Covid 19. Staff told us that some people did not like to see staff or visitors to the home wearing masks. Some staff wore masks, some staff did not, and some staff wore their masks around their chin. There was no person centred approach based on an individual risk assessment to guide and inform staff practice and there was no system in place to ensure staff complied with infection control

guidance.
●There was no risk assessment in place for people or staff who were at higher risk of Covid 19, for example, who were shielding or who were at higher risk because of their ethnicity. There were no protocols in place for the putting on and taking off of personal protective equipment (PPE).
●Some staff raised concerns about no eye protection available to them in situations where this would be assessed as needed. For example, if a person was to spit when the staff member was in close proximity.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
●The safeguarding systems in place were not effective.
●We received two whistleblowing concerns in June 2020 and referred these to the local authority. The local authority requested the provider carried out their own investigations. The provider shared the outcome of their investigations with us, the allegations of physical and psychological abuse were not upheld.
●Following our inspection of the service, we received further whistle blowing concerns in relation to poor care and the safety and well being of people. Investigations into these concerns were still ongoing when we produced this report.
●The provider told us in response to the whistle blowing investigations in June 2020, they carried out their own benchmarking assessment of the service in July 2020. One of their findings was staff were not aware of what needed to be reported to the local authority as a safeguarding. The provider told us they were planning to do some work with the staff team in relation to this, but this had not taken place when we inspected.
●A behaviour incident report we looked at recorded an incident where one person living at the home hit another person. This was not identified as a safeguarding incident and was not reported to us or the local authority as legally required.
●There was no system in place for the overseeing of safeguarding incidents and to show what lessons had been learnt following an incident and how staff were informed about lessons learnt from safeguarding incidents.
●A relative we spoke with told us they had been informed about a safeguarding investigation involving their family member. They were informed the investigation had been closed but had not been told any details or offered any reassurance about the incident.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
●Some staff told us they had not received supervision at all or not received it for several months. Supervision is an opportunity for staff to receive support to carry out their duties effectively. A staff member told us, "I can't remember the last supervision I had." We asked to see evidence and or reassurance that staff were receiving supervision for example, records of staff supervision dates. However, this reassurance could not be provided.
●Staff told us they were due training updates and some staff told us they had received no training since they had been employed. The training matrix shared with us showed significant gaps in staff training.
●Staff were available to support people and respond to people's request for care, in a timely way.
●Recruitment checks were completed before staff commenced at the service. We saw no records of staff

induction.

Using medicines safely

●Only one of the four staff members who administered medicines had their practice observed to ensure they remained competent in the safe administration of medicines.

●Prescribed creams were not dated when opened. The dating of creams when opened ensures that the cream is only used when it is effective.

●Medicine records we checked showed people had received their prescribed medicines.

.

.

.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person- centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a governance system in place, but this had not been operated effectively and had failed to identify the concerns we found during the inspection.
- The provider had some systems in place to monitor health and safety and carry out audits on the environment. However, these were ineffective. Where the audits had identified issues, the provider had failed to take action on the issues identified or had failed to identify potential risks to people safety. For example, the providers own health and safety audit identified that COSHH items should be stored in a locked cupboard. However, COSHH items were stored in a cupboard with no locking facility and therefore presented a risk of harm. The providers' infection control and mattress check's identified in October 2019 that a person's specialist mattress was damaged and required replacing. However, this had not been replaced at the time of our inspection nine months later and the mattress was seen to be in a poor condition.
- Systems in place failed to ensure the provider had a robust and effective system for the reporting and recording of incidents. For example, behaviour incidents lacked detail about duration, any intervention used, lacked detail about injuries and any follow up actions taken following the incident including any medical attention. The provider failed to have an effective system that had oversight of such incidents ensuring they were regularly monitored, reviewed and with recorded actions taken to minimise reoccurrence.
- Systems in place failed to ensure the provider operated a robust pre- admission process and transition process. For example, we asked to see the pre-admission information for a person who had recently moved to the service from one of the providers other services. There was no pre assessment completed and no transition plan.
- Systems in place to audit people's care records and risk assessment failed to identify that measures had not been put in place to reduce some risks to people. The system in place failed to ensure that care plans were kept up to date with people's specified needs and routines.
- Systems in place for the management of effective infection control had failed to ensure clear guidelines were in place for staff to follow and failed to ensure the guidelines were implemented effectively to protect people and staff.
- Systems in place for the oversight of safeguarding and complaints management were not robust.
- Systems in place failed to identify that staff were not receiving the support and knowledge to carry out their role effectively. For example, staff had not received the required training to carry out their role.

Supervision sessions and staff meetings were infrequent and there was no system in place to assess staff competency.
●The service had failed to have a registered manager for nine months.

The lack of governance systems and poor oversight meant people were receiving poor quality care and were placed at risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
●Systems in place to ensure the provider operated an effective complaints procedure were not effective. We had referred a complaint to the provider in February 2020 and asked for it to be recorded in their records and a relative told us they had raised a complaint in September 2019. There were no records of these concerns and the actions taken by the provider to demonstrate they are open and honest when things go wrong.
●Following our inspection we spoke with the provider representative and the nominated individual (who had been on a period of leave for several months) They told us proactive action had been taken following the inspection and measures were already in place to address the concerns identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us there had been lots of management changes. Some staff did not feel supported and told us communication needed to be improved. A staff member told us, "We feel like we have been abandoned."
●There was no staff support system implemented to ensure that regular supervision and staff meetings took place so staff were kept informed about their role and responsibilities and to gather staff views about the service.
●There had been no recent relative or staff surveys completed to gain feedback and views about the service.
● A relative told us they were satisfied with their family members care. They said, "I know (person's name) is well looked after." Another relative told us, "Communication is a problem, there has been lots of managers, very inconsistent and things not followed through."
● Staff were helpful and we saw some kind and caring interactions with people. However, there was a lack of direction.

Working in partnership with others;
●The service worked in partnership with other professionals and agencies, such as health care professionals and social workers.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks to service users were managed effectively

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that systems in place for safeguarding service users from the risk of abuse, were effective.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that governance systems in place were managed effectively.

The enforcement action we took:

Impose a condition