St Catherine Care Home Ltd

St Catherine Rest Home

Inspection report

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13 May 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

St Catherine Rest Home is a care home that provides residential care for older people and people living with dementia. It is registered for 19 people and at the time of this inspection there were 17 people using the service.

At our last inspection on 15 and 16 December 2015, we found two breaches of the legal requirements and asked the service to make improvements to ensure there were effective arrangements in place for the proper and safe management of medicines, and that persons employed at the service received appropriate support and supervision as is necessary to enable them to carry out the duties they are employed to perform.

This inspection took place following concerns raised by the London Ambulance Service about the service on 12 May 2016. We carried out a responsive inspection on 13 May 2016 which was unannounced to look at concerns relating to the safety of the service.

We found that the service was not always safe. Risk assessments were not robust or updated according to people's changing needs. People's daily records were not updated in a timely manner and accidents and incidents were not recorded consistently.

People requiring covert medicine administration did not have Mental Capacity Assessments or authorisation from their GP's within in their care plans.

We found the systems in place to ensure the safe management and administration of medicines were not always effective, which was also the case when we inspected the service in December 2015.

Records showed not all staff had completed essential training for their role. Criminal record update checks had not been completed for all staff to ensure they remained safe to work with people which was also the case when we inspected in December 2015. In addition staff references were not in date.

There was no registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The management structure of the service had recently changed and staff told us that this was having an impact on the home.

Audits were being carried out but were not effective in monitoring the changes in people's needs.

We found 3 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can

see what action we told the provider at the back of the full version of the report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risk assessments were not robust or updated according to people's changing needs. People's daily records were not updated in a timely manner and accidents and incidents were not recorded consistently.

We found the systems in place to ensure the safe management and administration of medicines were not always effective.

Is the service effective?

Requires Improvement

People requiring covert medicine administration did not have Mental Capacity Assessments or authorisation from their GP's within in their care plans.

Not all staff had received training in First Aid or Dementia Care. Criminal record update checks had not been completed for all staff and staff references were not in date.

Referrals to relevant healthcare professionals were not always made.

Supervision was taking place and we saw records of this.

Is the service well-led?

Requires Improvement

The service was not always well led. The management structure of the service had recently changed and staff told us that this was having an impact on the home.

Audits were being carried out but were not effective in monitoring the changes in people's needs.

St Catherine Rest 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 team consisted of two inspectors and a specialist advisor. Before the inspection we looked at the concerns raised by the London Ambulance Service and information we already held about this service. This included details of its registration, previous inspection reports and information the provider had sent us. We contacted the host local authority to gain their views about the service.

During the inspection we looked at five care plans, including risk assessments and medicines. We looked at staff files and the staff training matrix. We also looked at policies and procedures such as safeguarding adults and whistleblowing. We spoke with five people using the service and five members of staff including the current person in charge.

Requires Improvement

Is the service safe?

Our findings

Risk assessments were not robust and identified risks were not followed through with referrals or risk management plans. For example, one care plan stated that a person had a significant weight loss of 10kgs, but no action was taken for this to be followed up by a GP or a referral to a dietician or other relevant health professionals. A report produced by a community matron, who visited the service on 12 May 2016 in response to concerns raised by the London Ambulance Service also stated that actions were not taken around people at risk being referred to health professionals.

Records showed a person was assessed as being at risk of refusing their medicine. Even though this risk was identified in their care plan, mitigation of this risk was not explored leaving the person vulnerable, without a clear plan in place on what to do when they refused medicines. Another person's care plan, a health condition was identified that could potentially be infectious. There was no risk assessment in place to manage the risk. Also, another person was identified as being at risk of falls. However a fall management plan was not in place within their care plan, meaning that the risk's management was not mitigated.

During our inspection we saw inconsistent record keeping for the repositioning of a person who was documented as requiring "two hourly repositioning", but this was not being adhered to and records were not being updated accurately. The report from the community matron also highlighted how record keeping was not robust, stating that documentation was, "Incomplete, lack of patients names on documentation, rarely writing the time on data entry, improper use of fluid and repositioning charts". This meant that accurate record keeping practices were not in place and put people at risk when essential details were not being recorded.

Accidents and incidents were not always recorded. We saw that an incident had been documented in a person's daily notes but it was not recorded in an incident report.

During the inspection we saw that medicines were not being stored safely. We saw that the medication fridge was unlocked and the temperature of the medicines storage room was at a high temperature due to being adjacent to the kitchen. The backdoor was opened to cool the room following our feedback that the room was too hot for safe storage of medicines. However, this meant the room was accessible from the garden, creating a risk that people could enter the storage room and access medicines which were not securely stored.. The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager of the service at the inspection told us they would purchase a lock for the fridge and that they would reconsider the location of medicine storage. We received evidence after our inspection that the location of medicine storage has been changed and was now stored appropriately and a fridge with a lock has been purchased

A number of people using the service had their medicine administered covertly; however there was no mental capacity assessment or GP authorisation in their care plans. This is a breach of Regulation 11 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Following our inspection, the provider sent us evidence of the relevant authorisation.

On the day of inspection, a heavy smell of urine was present in a number of bedrooms. We saw stained curtains and an en-suite toilet was in a poor state and peeling. There were sharp edges to the tiles of the stairs. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The manager told us they would rectify these issues above and since our inspection, the service has removed the sharp objects

Staff recruitment processes were not always safe. Some staff did not have criminal record checks carried out when they commenced employment at the service. The service was using criminal record checks from previous employers. This meant that the service were potentially unaware of concerns or convictions upon the commencement of employment. In addition, references were not in date and there were no records of staff interviews. These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt safe. One person said, "I do feel safe". Another person told us, "Oh yes, I feel safe. I haven't had no problems".

Staff told us and records confirmed they had received training in safeguarding adults. One member of staff told us that if they suspected any type of abuse, they would, "Report it to my line manager, then they investigate it." Another member of staff told us, "I'd do a body chart, speak with the manager for them to investigate and do an incident form."

Requires Improvement

Is the service effective?

Our findings

Not all staff were given the appropriate training. For example the service had a training matrix that showed a number of staff had not had training in First Aid, putting service users at risk of improper care in case of emergency. This was corroborated in the community matron's report whereby it stated there was a "lack of staff knowledge over what to do in certain emergencies". The training matrix also reflected that a number of staff had not received training in dementia care. The lack of training in these areas meant people using the service may have been exposed to the risk of harm in that some staff did not have the appropriate knowledge and skill to ensure people using the service were protected. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection, we have received evidence that all current staff have received training in First Aid and Dementia Care.

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 to 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 found documentation for one person using the service showing that their Deprivation of Liberty Safeguards authorisation had expired and that a new application had not been made. The manager was unaware of the expiration. This meant that the person using the service may be have been unlawfully deprived of their liberty during the expiration period.

People were supported to have sufficient food at drink at the service. One person using the service told us the food was, "Quite nice." Another person using the service said, "The food is very good, and if there is something I don't like to eat they will always put me an egg on."

During our inspection we observed people eating lunch and two food options were offered. People who required assistance with eating were supported and encouraged accordingly. People with dietary requirements, for example those who had softened or pureed diets were given the same food options as the other residents. We observed people using the service helping out with the preparation of dinner, for example a group of people sat around a table peeling potatoes. They told us they enjoyed helping out with meal preparation.

We saw that people had nutritional assessments within their care plans, however where weight loss had been recorded, a referral to a health professional had not been made. This meant that although people's weights were being recorded, any potential health issues arising from a weight gain or loss were not being addressed, putting people at risk of not receiving the appropriate care. Since our inspection, we have seen evidence that district nurses are visiting the service every day and that they are monitoring the health needs of all residents.

We saw records that showed staff were having regular supervision, the most recent in April 2016. At the last inspection staff were not receiving regular supervision. One member of staff told us how they felt about their supervision sessions stating, "I'm not going to say it's not supportive, it's ok."

Requires Improvement

Is the service well-led?

Our findings

Prior to our inspection, we were informed that the previous registered manager no longer worked at the service, having left in March 2016. The proprietor of the service was currently in charge and in the process of becoming registered.

Staff told us the change in management had an impact on the service. One member of staff said, "They are trying their best. They are trying to make changes and improvements. But there are staff who have been here a long time who aren't willing to be doing the change. The staff are divided in two. The change was not done well." Another staff member said, "I'm not complaining but, [previous registered manager] was giving me all the training and support I needed".

Another member of staff told us, "It takes a while to work out what to do. I don't think [manager] can manage it all by herself. She's here late, she's trying I'm sure."

Another member of staff told us, "Since I started I can see they are trying to change a lot of things like introducing keyworker sessions. They do listen and they are trying to change things. But they need resources to change things."

We asked staff if the new management were approachable. One member of staff told us, "I'm probably a bit more wary of trying to approach [manager]. I've not needed to but I've not tried. I'm sure she would be supportive. I hope so anyway. I've not needed to ask her for anything."

Policies and procedures were updated in February 2016 and included policies on recruitment, safeguarding adults and whistleblowing. The manager told us they ensured staff understood and read through policies by asking them in their supervision meetings.

The manager told us they carried out audits. We were shown records of these and they included care file, risk assessment and medication audits. The audit records for care plans and medicines were undated which made it unclear as to when these audits were actually carried out. The audit records for risks assessments were dated, the most recent being May 2016 and were documented as "Up to date", however we saw that risk assessments were not being updated in accordance with people's changing needs.

At our last inspection, the service had systems in place to obtain the views of people who used the service and family members. Regular meetings were held with people and their family members, however at this inspection, there were no records of resident's meetings in 2016. The manager told us residents meetings used to take place but that there hadn't been any recently.

We saw records of surveys completed by families of people using the service. A recent survey from April 2016 asked, "Are staff polite and welcoming when you visit?" One family member answered "Yes", and said, "The home is wonderful, staff are brilliant".

The manager told us they had plans to introduce staff surveys to monitor staff morale and suggestions made by the workforce. They told us, "Since the registered manager left, I've had no one to help me. I am putting a deputy manager in place to help me". Following on from the inspection, we have been informed that the service has now recruited a deputy manager.

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 11 HSCA RA Regulations 2014 Need for consent A number of people using the service had their medicine administered covertly; however there was no mental capacity assessment or GP authorisation in their care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment During the inspection we saw that medicines were not being stored safely. We saw that the medication fridge was unlocked and the temperature of the medicines storage room was at a high temperature due to being adjacent to the kitchen.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff were given the appropriate training. For example the service had a training matrix that showed a number of staff had not had training in First Aid, putting service users at risk of improper care in case of emergency. The training matrix also reflected that a number of staff had not received training in dementia care.