Community Integrated Care

St Catherines Care Home

Inspection report

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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 23 January 2017 and was unannounced. At our last inspection in November 2015 we found that the service required improvement in relation to providing a safe, effective and well led service.

St Catherine's Care Home provides support and care for up to 40 people, some of whom may be living with dementia. At the time of this inspection 39 people used the service.

The service had a registered manager. 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.

Risks to people's health and wellbeing were assessed but not always managed to keep them safe from harm. Staff did not always follow the plans put in place to reduce and mitigate risks for people. Accidents and incidents were not thoroughly reviewed to try to avoid repetition. Staffing levels were not reviewed when there were changes in people's level of need.

Medicines were not managed safely. People did not always receive their medicines as prescribed and the systems in place to manage the risks associated with them were not always followed.

The principles of The Mental Capacity Act (MCA) 2005 were not consistently followed. The provider was not ensuring that people were consenting to, or when they lacked mental capacity were being supported to, consent to their care.

People offered positive and negative comments in regard to the food. Where people were at risk of malnutrition care plans were in place to ensure people were eating sufficient amounts to keep them healthy.

People were supported to access other healthcare professionals to maintain their health and wellbeing. However not all concerns were followed up in a timely way.

People's privacy, dignity, preferences and views were not always respected and upheld. Leisure and social activities were provided, but not all people received the support they needed to engage in meaningful activity.

There was a complaints procedure but not all people were aware of it.

Audits and quality monitoring systems were completed but did not always record all relevant information so they were not effective in driving improvements. Improvements were needed to ensure the systems in place

adequately assess, monitor and improve the quality of care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe. Risks to people's health and wellbeing were identified and reviewed but not always managed in a safe or consistent way. Staffing levels were not determined or reviewed when people's needs changed. People's medicines were not managed safely. Staff were aware of the safeguarding procedures and knew the action to take when there were suspicions of abusive situations.

Is the service effective?

Requires Improvement

The service was not consistently effective. The principles of the MCA and DoLS were not consistently followed to ensure that people's rights were respected.
People had their nutritional needs assessed and monitored where concerns were identified. Staff felt supported with their training needs so felt able to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People's privacy, dignity and preferences were not always upheld by staff. People were not always given the opportunity to make choices and decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Some people were not supported to be involved in meaningful hobbies and interests within the service to promote their emotional wellbeing. Staff knew people who used the service well and knew their likes and dislikes but were not always responsive to their individual care needs.
The provider had a complaints policy available but some people were unaware of the procedures.

Is the service well-led?

Inadequate

The service was not well led. Systems were in place to assess and monitor the quality of care provided but these were not as effective as they should be. The provider did not always respond to feedback about the quality of the service to ensure that improvements were made.

St Catherines 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 23 January 2017 and was unannounced.

The inspection team consisted of 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.

Prior to the inspection we looked at the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We used a range of different methods to help us understand people's experiences. We spoke with 14 people who used the service about their care and support and to six relatives and visitors to gain their views. Some people were less able to express their views and so we observed the care and support they received throughout the day.

We spoke with the registered manager, the deputy manager, two registered nurses, three care staff and a member of the ancillary team. We looked at care records for nine people to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

Requires Improvement

Is the service safe?

Our findings

People's risks had been assessed, but we found that they were not consistently managed to protect people from the risk of harm. For example staff told us, and the risk assessment identified, a person was at high risk of falls and needed staff supervision and support at all times. This person had recently fallen whilst they were unsupervised and sustained an injury. We were told that the person was left alone whilst they were on the commode and had fallen off. The registered manager and the deputy manager confirmed the person had been left alone and unsupervised but could not give a reasonable explanation of why staff did this and why they did not follow the person's plan of action. Staff were not adhering to the actions recorded in the risk assessment and care plan to lower the person's risk of further falls.

Some people were at risk of developing sore skin due to their inability to move independently. In these circumstances staff were required to regularly support some people with repositioning and pressure relief. Staff told us and we saw that it was recorded that one person had previously developed a pressure ulcer which had been successfully treated by the nurse. This person was not being repositioned as per the recommendations and was at risk of further developing sore skin.

We found that improvements were needed to the way medicines were monitored and managed. We saw that where people needed 'as required' medicines there were no protocols in place to give staff the guidance as to when people may need these medicines. For example, one person who often became distressed and agitated was prescribed medicine to reduce their anxieties. However, there were no protocols in place to guide staff on how to recognise the level of anxiety the person exhibited. We saw a nurse administered this anxiety reducing medicine to the person when they were not displaying any signs of anxiety. The nurse told us they were aware of this 'as required' medicine but administered it to pre-empt the person experiencing anxiety. This meant the person received their medicine when there was no clinical need and not as the medicine was prescribed.

One person was prescribed daily medicine for a specific health condition. We saw this person had not received this medicine for a four week period. The registered manager and the deputy manager told us this was an oversight and had not been identified by the nurses responsible for the administration and auditing of the medicines. The doctor had been informed but no action had been taken by the nurses or the provider to follow this up to ensure the medicine was available. We did not see that the person had received any monitoring for this specific health condition during this four week period. This meant the person was at risk of a deteriorating health condition because no action had been taken to ensure the prescribed medicine was available.

Some people were prescribed cream and lotions to support them with maintaining good skin. The nurse told us that the care staff applied these creams and lotions when they provided personal care support. The nurse confirmed the care staff applied the creams at the point of the delivery of care but told us they did not observe the cream being administered. However we saw the nurse signed the medication administration record to record it had been administered. This meant that we, the nurses or the provider could not be sure that people had their medicines when needed, or that they were always administered and applied in a safe

way.

Some medicines required cool storage to ensure they were safe to use and a medicines refrigerator had been provided. Staff told us the temperature of the medicine refrigerator should be monitored daily when it is in use, and recorded. A maximum/minimum thermometer is recommended for this. We saw the recording chart had been completed but there was no record of the minimum/maximum temperature. This meant there was no guarantee that the medicines in the refrigerator had been stored safely within the required temperature range.

Staff told us and we saw they began the morning medicine round at 8.15am and finished at 1.45pm. The nurse told us they had been exceptionally busy and that was the reason for the length of time to complete the medication rounds. We saw the lunch time medication round was administered immediately after the morning round. Some people were prescribed medicines for a specific health condition. These prescribed medicines had to be given at set times during the day to be the most effective for people. We saw these medicines were not given as they had been prescribed, there was no guarantee or record made to indicate the time the medicine was administered which meant that some people may not receive their medicines at the prescribed times. The lack of adherence to the prescribing instructions meant people may be at risk of not fully benefitting from the effectiveness of the medicines.

On one unit we saw the medicine trolley was in a communal area and was left unlocked and unattended. People accessed this area; there was a high risk that medicines could be removed from the trolley without the knowledge of staff. We were not assured that medicines were stored safely or securely to protect people from possible harm.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave varied experiences of staff availability within the service. One person said: "There are lots of staff. They do come very quickly if I press the buzzer". Another person told us there were times when they had to wait for staff when they required support. A member of staff told us: "We were very behind today, we're late getting people up and dressed". We observed staff were busy attending to the personal care and support needs of people in their bedrooms, no staff member had been allocated to supervise other people who used the communal areas. People were left to their own devices and we saw some people walked without direction around the units.

We observed one person walked into another person's bedroom and lay on the bed. Staff told us this person had high support needs in relation to their personal hygiene and so compromised the cleanliness of the other person's bed on which they lay. Care staff told us this was a regular occurrence, and were unsure of the action they could take. We saw another person wandered into another person's room and started to remove items. We informed a care staff who guided and supported the person to their own bedroom. Action had not been taken or considered to ensure these two people were supported with any structured meaningful activity to reduce their restlessness. There were not enough staff available to supervise people who used the communal areas as they were attending to other people's care and support needs.

Staff we spoke with felt there were not always enough staff available to fully meet people's needs. They told us there were 'a lot' of people who required the assistance of two care staff to meet their care and support needs. The registered manager told us the staffing levels were not based on the dependency needs of people but were maintained at specific levels during the morning, reducing during the afternoon and again at night. They told us the reason for the reduction in the staffing levels was because people did not require

so much personal care support as they did in the mornings when most people needed a level of support with their preparations for the day. We heard the call bells rang constantly during the morning as people needed support from staff. We did not observe any undue delays when staff needed to answer the call bells; but people were left unsupervised when they accessed the communal areas as staff were busy providing support to people in their bedrooms. This meant some people in the communal areas were at risk of falls and accessing areas of the service where they disturbed other people.

We saw records that showed the provider had safe recruitment procedures in place. Staff who were employed at the service had undergone checks to ensure that they were of a good character and suitable to provide support to people who used the service.

People who used the service told us they felt safe. One visitor told us: "My relative is unable to use the buzzer system but I still feel that they are safe here. Staff keep looking in to see that [relative] is okay. I've never seen anything to concern me". A person who used the service told us: "I feel safe here". Staff we spoke with knew the signs of abuse and who they needed to report it to if they suspected someone had been abused. One staff member said they would report any concerns straight away to the managers and if they were not available then they would contact the local authority safeguarding team. The registered manager understood their responsibilities to report alleged abuse and confirmed referrals would be made to the local authority when concerns were identified.

Requires Improvement

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 or 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). The registered manager told us and we saw that referrals had been made in relation to the DoLS for people who lacked capacity to consent to the restrictions in place.

We saw that capacity assessments had been completed to ascertain the decision making abilities of people. Where people lacked capacity to make specific decisions we saw other people, including the person's representatives, were involved in making decisions in the best interests of some people. For example; we saw best interest decisions had been made in relation to a person's end of life care. However not all best interest decisions had been discussed or recorded. For example we saw one person had received foot care against their will and needed three staff to restrain them when they needed and received this treatment. This meant this person was placed at risk of harm, injury and discomfort because they were restrained against their will. The registered manager explained the person was mobile and walked around the service continually and as such required foot care. However the registered manager confirmed this had not been discussed and agreed as being in the best interests of the person. There had been no discussion, assessment or records of the least restrictive options that may have been possible or the type, level and extent of the restraint this person experienced. We could not be assured that decisions were being made in people's best interests when they were unable to make decisions for themselves.

This issue in relation to the use of unauthorised restraint was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us varied views of their mealtime experiences. Some people were happy with the quality of the food and said: "The food is satisfactory but not necessarily what I'd pick to have". Other people did not like the food provided, one person told us: "The food is so bad, I've asked my family to take me out for some meals". Another person commented: "The food is inedible. Some people are on a no salt diet, so it's easier for them if we all don't get it. My family have brought me some salt". The registered manager told us of the changes made to the food provided where an established food supplier provided food to the service each week. The meals were frozen and then cooked and served at each mealtime by the catering staff from a heated trolley.

On the day of the inspection we observed breakfast and lunch and saw people were provided with the type of meal that had been identified as required to meet their needs. One visitor told us: "[My relative] can't have certain items such as cow's milk so all her food stuff is labelled in the kitchen". We saw support plans and risk assessments were in place that detailed people's individual nutritional support needs and the action

needed to reduce the risk was recorded. We saw people's weight was monitored on a regular basis and food and fluid charts were completed each day. People received additional prescribed food supplements to support them with ensuring they received adequate daily nourishment.

Staff supported people to access health care services should they become unwell or require specialist interventions. Referrals to external health professionals had been made when needed, for example, speech and language therapists, tissue viability specialists and dieticians. The registered manager told us a GP visited the service each week to support people's health care needs. Concerns regarding people's health care needs were discussed with the GP but not always followed up in a timely way by the provider or the nurses. For example a person with a specific health care need had not received their medicine for a period of four weeks because the nurse and the GP had not followed this up.

Staff commented they received sufficient training for them to meet the needs of people who used the service. They told us they felt well supported with their training needs. One staff member discussed the recent dementia awareness training they had received. They commented that the training gave them an insight into how people living with dementia may feel when people had difficulty verbalising their needs. We saw staff were patient and understanding when interacting with people who were living with dementia; although these interactions occurred mainly during care and support interventions.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always upheld, for example we saw people entered other people's bedrooms. A person who used the service told us this was a regular occurrence with another person entering their bedroom very frequently. They told us they worry about this especially when they are not in their bedroom because of their personal items sometimes being moved or removed. They told us: "I shoo [the person] away if I'm here or buzz for the staff but it still happens, nothing's been done about it". Staff were unable to offer any solution for the intrusion and were unaware of any action that they could take. The registered manager and the deputy manager were both aware of this occurrence but had not issued any guidance to care staff to ensure the person was not being disturbed. This meant that this person's human right to privacy was not upheld.

People's preferences and views were not always respected. A person who used the service told us how they were cajoled into attending a social occasion when they did not wish to do so. They told us they participated but did not enjoy the experience. Another person sat alone in their bedroom for the majority of the day, they were obviously distressed as they were shouting and calling out. Although staff visited them on occasions throughout the day, the person's preferences for not being alone were not upheld. The person had a specific care plan which referred to the person's mental health needs. This recorded the person enjoyed the company of others and listening to music as this helped to reduce their anxiety levels. We saw the person was not supported to be with other people, staff did not put on the radio or a CD to support the person with their preferences. Consequently we saw the person remained in an anxious state for most of the day. We spoke with the nurse regarding the person's circumstances, they told us this was 'very unusual as staff usually put on some music'. The nurse could offer no reasonable explanation why the person had not been supported with their preferences. People's comfort, preferences and wellbeing was at times compromised.

This evidence represents a breach of Regulation 10 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Most people told us the staff were kind and caring. A visitor told us: "Staff are very, very caring and very helpful". Another visited commented: "[My relative] came here with very bad ulcers and the staff were marvellous". A person who used the service told us: "I'm being looked after very well". However two other people did not comment so positively and said: "On the whole staff are very good. Some are better than others but that's the same in any organisation", and "Staff don't talk to you, they shout at you and I'm not deaf". We saw staff were kind and caring when they interacted with people however, contact was limited and brief and the necessary support was provided. Staff were busy and had very little time to spend with people.

Requires Improvement

Is the service responsive?

Our findings

People told us the provider was not always responsive to their individual needs. For example, two visitors spoke with us and raised the issue of the lack of post-operative chairs which completely stopped their relative from being able to get out of bed or out of their own room. One person who used the service told us: "When I first came they [the staff] wheeled me round to see the place. It would be good if I could get a wheelchair and get out into the conservatory or the garden". They went on to say they spent most of their time in their bedroom as suitable chairs were not always available or they had to wait for a chair to become available. The registered manager told us that the provider had been informed that new chairs were needed and had agreed to this request. The registered manager was unable to tell us when the new chairs would be available.

All people who used the service had a plan of care based on an assessment of their needs. People's life and social histories had been obtained from the family and friends of people who used the service. This gave staff the information regarding people's backgrounds and significant life events when people were unable to verbalise these themselves. Care staff were aware of people's individual needs and told us about the care and support they provided to people each day. However not all people received the level of support they required or had been assessed as requiring. For example, people at risk of developing sore skin did not always receive support with repositioning at the required times. Some people did not always receive their time critical medicines at the times they had been prescribed and some people were not always supported with their personal preferences to reduce their levels of anxiety. We saw staff focussed on the support interventions and the task rather than the individual needs of people.

A person who used the service told us: "It's okay here but there's not much to do". Another person said: "I like to read and I ask my family to bring books in". Most people spent time in their rooms, some people used the communal areas and some people wandered around the units. There was no structured recreational activity arranged for the morning of the inspection. Staff were available to support people with their care needs but had very little time to spend quality time with people or to stay and chat. The provider employed an activity staff member who arranged a group activity during the afternoon. We saw a small group of people participated in this activity they appeared to enjoy this there was much conversation and laughter.

Some improvements had been made to the environment and the units were more dementia friendly. However further improvements were needed to ensure people living with dementia were able to orientate and find their way around. Not all bedroom doors were provided with information regarding the person who was accommodated in the room. This led to some people entering the bedrooms of other people.

The provider had a complaints procedure and this was displayed on the notice boards in various areas around the service. Not all people were aware of the procedures to follow if they had concerns. One person who used the service told us they had spoken with the management: "I complained about the length of the buzzer cord. It was too short and wouldn't reach my chair but now they've gone mad with it, it's now far too long". This meant complaints were not always satisfactorily addressed and action was not taken to improve people's experiences.

Inadequate

Is the service well-led?

Our findings

There was a registered manager who had been at the service for 14 years. One person told us: "The manager is lovely, very nice lady". Another person commented: "The manager is very helpful and very kind but we don't have much contact with her. You don't see her much on this side [the person referred to one of the units]". An additional comment by a person was: "The higher management team are so remote; they might as well be in outer space". We saw the registered manager was compassionate when in discussion about people and the service but told us of the plans to change the internal management structure.

There were some systems in place to assess and monitor the quality of care provided but they were not as effective as they should be. Quality assurance checks, monitoring records and audits were completed, but were not effective to ensure people's health, welfare and safety were upheld. This meant the fundamental standards of care were low and people were not provided with a safe, effective, responsive or well led service.

When we spoke with the registered manager and deputy manager about the number of falls that people had they were unable to demonstrate that these had been analysed effectively. They were unable to identify or consider any trends and themes in relation to the falls. This meant that although there were audits in place they were not always completed effectively to reduce people's risks and drive improvement within the service. People continued to be at risk of falling because they were left unsupervised; contrary to their individual assessments of need.

The medication systems were checked at regular intervals throughout each month, but did not identify the concerns we found with the management of medicines. We found protocols were not readily available for the use of 'as required' medicines. The lack of this information to ensure 'as required' medicines were administered when people required them had not been identified within the audits. Some people with specific health conditions did not receive their prescribed medicines as they needed them because they were out of stock. Stock control measures were ineffective, the lack of and availability of prescribed medicines was not identified during the audits. The nurses were signing the medication administration records when they did not observe or administer certain topical medicines. This was poor practice as the nurses could be signing for the safe administration of creams and medicines when they were not administered. This meant that there was not an effective system in place to monitor the safe management of medicines.

A pharmacy audit was completed in September 2016 where it was recommended that for the safe storage of medicines a minimum/maximum thermometer should be used to monitor the temperature of the medicine fridge. We saw the recording chart had been completed but there was no record of the minimum/maximum temperature. The findings and recommendations of the pharmacy audit had not been actioned, therefore effective action was not taken to ensure medicines were stored correctly.

Staff told us they had spoken with the managers regarding the staffing levels and that at times additional staff would be beneficial. In the Provider Information Return (PIR) the provider told us: 'Staffing levels are

maintained and increased as required'. The registered manager told us the dependency needs of people who used the service were not a basis for determining the staffing levels. We saw people who were at risk of harm because staff were unavailable to adequately supervise and observe people. People were becoming anxious and concerned because other people entered their bedrooms without being invited in. We saw one person had to wait for a period of 20 minutes to receive the support from a nurse after they had fallen. The provider and the registered manager were not monitoring people's changing needs, not reviewing the staffing levels, therefore action was not taken and people were at risk of harm to their health, safety and wellbeing.

Some staff did not show an understanding of the Mental Capacity Act 2005 (MCA), and the lawful and safe use of restraint practices. We saw one person was physically restrained and received treatment against their will. The registered manager and the deputy manager told us the reason for this level of support but confirmed this had not been discussed and agreed as being in the best interests of the person. There had been no multi agency assessment or discussion regarding the least restrictive options that may have benefitted the person more appropriately. There was no understanding that the person may have been unlawfully restrained as the provider may not have acted in the best interests of the person. The provider did not follow the principles of the MCA it was not consistently and effectively followed to ensure people who lacked capacity to consent were provided with care that was in their best interests and in the least restrictive way. This meant the provider and the registered manager did not understand their responsibilities associated with the Act.

People were not asked their views, opinions or experiences on the service they received. Some people told us they did not like the food but had not had the opportunity to discuss this. One visitor spoke on behalf of their relative and said: "Their idea of consulting with people is to not speak to them at all". The registered manager confirmed that satisfaction surveys were not distributed to people who used the service. This showed us people did not have the opportunity to feedback about the quality of the home; therefore action was not taken to improve people's quality of life.

Relatives meetings were held periodically which offered people the opportunity to discuss issues regarding the service on behalf of their loved ones. One relative told us: "They have relative meetings and I've raised the lack of suitable chairs several times. Just before Christmas, they said that Head Office had approved two chairs but we've heard nothing since". The registered manager confirmed this issue had been raised with head office and approval given for two new chairs. However they were unable to tell us when the chairs would be available. This showed us that when people gave feedback about the quality of the home action was not always taken in a timely to improve people's quality of life.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service was failing to ensure people using the service are treated with respect and dignity at all times while they are receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was failing to ensure people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service was failing to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).