Bitterne Care Homes Ltd

St Catherine Care Home

Inspection report

19-21 St Catherines Road
Southampton
Hampshire
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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook this unannounced comprehensive inspection on 26 October 2017. This was the first inspection of St Catherine Care Home since it was registered with a new provider, Bitterne Care Homes Ltd.

St Catherine Care Home is registered as a "care home". People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and we looked at both during this inspection.

St Catherine Care Home accommodates up to 14 older people who may also be living with dementia. It is located in a residential area of Southampton, close to the provider's other home, St Katherine Care Home. At the time of this inspection there were 11 people living at the home.

The provider had a single registered manager responsible for both homes. 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.

Staff were aware of processes to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. There were enough staff to support people safely. The provider made appropriate recruitment checks to make sure all workers were suitable to work in a care setting. There were arrangements in place to store medicines safely and administer them safely and in accordance with people's preferences.

Staff training and supervision supported them to maintain and develop their skills and knowledge to support people according to their needs. There was sound knowledge and appreciation of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were able to eat and drink enough to maintain their health and welfare. People were supported to access healthcare services, such as GPs and specialist nurses.

There was a caring ethos, and interactions between staff and people were friendly and positive. People were able to take part in decisions about their care and support and their views were listened to. Staff respected people's independence, privacy, and dignity.

Care and support were based on assessments and plans which took into account people's abilities, needs and preferences. People were able to take part in leisure activities of their choosing. People were kept aware of the provider's complaints procedure, but there had been no formal complaints

The home had a homely, welcoming atmosphere. Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided.

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 were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient, suitable staff to keep people safe.

People received their medicines as prescribed and according to their preferences.

Is the service effective?

Good

The service was effective.

People were supported by staff whose training and supervision kept their skills and knowledge up to date.

People's human rights were respected by an awareness of legal requirements where people lacked capacity to make decisions.

People could maintain a healthy diet and had access to healthcare services when required.

Is the service caring?

Good

The service was caring.

People had developed caring relationships with staff.

People and their families were involved in decisions affecting their care and support.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care and support met their needs and took account of their preferences.

There was a complaints procedure in place, but it had not been used recently.

Is the service well-led?

Good

The service was well led.

There was a homely, supportive atmosphere based on clearly stated values.

A management system and processes to monitor and assess the quality of service provided were in place.

St Catherine Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 26 October 2017. We did not formally announce this inspection, but the provider knew we were coming because we inspected their other nearby home on 25 October. A single inspector carried out this inspection.

Before the inspection we reviewed information we had about the service, including notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return. 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. We also looked at reports of inspections carried out when the previous provider owned the service.

We spoke with three people living at St Catherine Care Home. We observed care and support people received in the shared areas of the home.

We spoke with the registered manager, the two owners and three members of staff. Other members of staff helped us with answers to individual questions about people's care and support. We also spoke with three health and social care professionals who visited the home on the same day.

We looked at the care plans and associated records of four people, including their medicines records. We reviewed other records, including the provider's policies and procedures, checks and audits, quality assurance survey returns, training, appraisal and supervision records, and three staff recruitment records.

Good

Is the service safe?

Our findings

People who lived at St Catherine Care Home were satisfied they were kept safe. One person said, "(Staff) know what they are doing." Visiting professionals had no concerns about people's safety or safeguarding.

There were effective processes in place to protect people from the risk of avoidable harm and abuse. Staff we spoke with knew about the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. They had contact telephone numbers for external organisations, such as the local authority, where they could report concerns if necessary. Staff had not seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the registered manager.

Suitable procedures and policies were in place for staff to refer to, including a whistle blowing policy. This had recently been the "policy of the week" which meant it had been the subject of specific discussions between the registered manager and staff to keep their knowledge up to date. The registered manager was aware of processes to follow if there was a suspicion or allegation of abuse. They had notified the local authority of an incident which could have been a safeguarding concern and had carried out their own investigation. The local authority had been satisfied there was no evidence of abuse on this occasion.

The provider had identified and assessed risks to people's safety and wellbeing. These included risks associated with falls, hallucinations and bruising. There were risk assessments for people living with dementia who walked about a lot. Risk assessments included actions for staff to reduce and manage risks. Where people were at risk of falls there were fall prevention plans in place, and where people were at risk of bruising or pressure injuries, body maps were in use to record any areas of concern. Staff were aware of people's risks and what actions to take to reduce and manage their risks.

Procedures were in place to keep people safe in an emergency and reduce risks to their health. Personal emergency evacuation plans were in place which showed support individual people would need in an emergency. There were contingency plans in place for risks which might disrupt critical areas of the service such as catering and electricity supplies, flooding and other extreme weather. There was a regular health and safety checklist, and records showed any issued identified were followed up. The provider had taken steps to make sure people were supported in a safe environment.

Equipment used in people's care and support was inspected and maintained regularly. There were records on file to show checks had been made on equipment including fire safety equipment, emergency lighting and alarms.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff, and staff told us their workload was manageable and they had time to engage with people while supporting them. The registered manager told us staffing levels were based on people's needs and dependency. Dependency profiles were included in people's care records. We saw staff were able to carry out their duties in a calm, professional manner.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people. The registered manager told us where they used agency staff they made sure the same checks had been made.

Medicines were stored and handled safely by staff who were trained and had undergone a competency check before they administered medicines to people. Staff had suitable instructions on how to administer people's medicines. These included detailed instructions where people were prescribed medicines to be taken "as required", and information about relevant allergies. The same standards were applied to creams and ointments. Medicine care plans were personalised. In one case, it was noted that it might take the person a long time to take larger pills.

Staff maintained accurate records of medicines administered. In the case of "as required" medicines, the records included the dose administered and the effect of the medicine. There were regular internal checks and audits to make sure people benefited from correct processes in the administration of medicines.

Good

Is the service effective?

Our findings

People living at St Catherine Care Home were confident staff had the skills and knowledge to support them according to their needs. A visiting healthcare professional told us they found staff to be "knowledgeable". Staff we spoke with told us the training they received prepared them to support people according to their needs.

Staff were satisfied they received appropriate and timely training and had regular supervision meetings with a senior staff member. They told us they had induction training which prepared them to support people according to their needs. There was regular refresher training in subjects the provider considered mandatory.

The registered manager had introduced the Care Certificate for new staff undergoing induction and was in the process of introducing it for existing staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The registered manager had an effective system for monitoring staff training. Their records showed clearly where staff had completed training, where it was due and where it was overdue. Staff had annual appraisals and four to six supervisions a year. The registered manager had delegated staff supervisions to a senior staff member.

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

Records relating to mental capacity assessments and best interests decisions were of a high standard. They showed that the provider followed the correct process. In some cases, the assessments had concluded that the person did not lack capacity, and in other cases, they lacked capacity for some decisions, but were able to make decisions about their day to day care. Assessments related to specific decisions, such as whether to take medicines disguised in food, and showed how people were given opportunities to take part in the process. Where best interests decisions were made, these were done in consultation with connected parties, such as family members or the person's GP.

Where people were at risk of being deprived of their liberty the registered manager had made applications under the Deprivation of Liberty Safeguards. The authorisations we saw did not impose any conditions. Where people had appointed lasting power of attorney for decisions about their finances or care, copies of the relevant records were in their file. It was clear to staff who had been authorised to make decisions on the person's behalf.

Where people had capacity and could communicate their wishes, we saw that staff were mindful of their responsibility to obtain consent to people's care. People had signed consent records in their care plans.

The provider supported people to eat and drink enough and to maintain a healthy diet taking into account their preferences and wishes. Where people were at risk of swallowing difficulties, their drinks were thickened with a prescribed thickener. Staff made mealtimes an enjoyable experience. Meals were appetising, and people were offered choices of menu. One person told us, "The food is lovely."

There was a good relationship with local healthcare providers. Records showed people had access to other healthcare services when needed. There were records of visits by GPs, district nurses, opticians and other specialists, such as community psychiatric nurses. Health and social care professionals told us the standard of care was "always consistent". They said staff contacted them appropriately and when they gave advice it was passed on and acted on. One professional told us staff knew the people well, and said, "I like coming here." Records showed staff worked closely with a visiting speech and language therapist, which meant the therapist could take into account how the person was likely to react to their visit and achieve more effective outcomes.

Good

Is the service caring?

Our findings

There were caring relationships between people and staff who supported them. A low turnover of staff meant staff had been able to develop long term relationships with people. There was a homely, friendly atmosphere in the home. Interactions between staff and people were always positive. People enjoyed contact with staff. When the registered manager told a person which member of staff was going to help them, the person said, "He's nice." Where a person did not communicate verbally, we saw staff supporting them with smiles and laughter.

Staff addressed people in a kind, respectful way, offered them choices and respected their choice if they declined help. Staff spoke clearly, made eye contact with the person they were talking with, and gave people time to understand and reply. Staff made sure people understood what they were saying by explaining and repeating themselves. One person was anxious about something that was going to happen on the day of our visit. All members of staff made sure they tried to reassure the person each time they passed or the person spoke to them.

Where other people might be worried by a person's reaction to events, staff made sure everybody understood what was happening and reassured them. Staff checked frequently that people were comfortable and that they were supported in the right way. For example they asked, "Do you want to sit a bit further back?", "Are you ready?", and "Shall we go upstairs now?"

Records showed people were involved in planning and reviewing their care and support. Where people had individual communication care plans, these contained guidance for staff on how to support the person to be involved in decisions about their care. Where a person had English as their second language, their care plan was developed with the help of a member of staff who spoke the same first language. Staff involved the person's family to make sure they were happy with the service they received.

The provider had a strong focus on respecting people's privacy and dignity. People had dignity care plans which covered aspects of care and support including choice, control, communication and privacy. Staff used a dignity in care assessment tool to review all aspects of people's individual care in the light of respecting their dignity. There was a "dignity tree" on display in the home. This was a picture of a tree used to capture people's ideas about dignity on the leaves. People's care plans included areas where they were able to be independent. When a person's GP visited, they were supported by staff to go to their own room so they could talk to the GP in privacy.

One person's family member had made an entry in the comments book which read, "[Name] is always turned out well and smartly dressed in fresh clothes that help her wellbeing." We saw staff supporting people to move about the home independently.

Good

Is the service responsive?

Our findings

People received assistance with their personal care that met their needs and took into account their preferences and wishes. Written comments by people's relations included: "[Name]'s stay at St Catherines has been wonderful and her day to day care is the best she could have." and "Homely and comfortable. Excellent care and lovely staff."

Care plans were detailed and individual to the person, with clear guidance for staff about how to meet the person's care needs. Care plans covered topics such as communication, mobility, eating and drinking, medicines, sleeping and recreation. Where people's needs or preferences changed, this was noted in their care plans. One person's mobility had worsened and this was reflected both in their mobility care plan, and how they were supported to take part in recreational activities. Another person's preferences about which staff members should support them had changed as they got to know the staff. This was reflected in their care plan.

Temporary care plans were in place for specific individual conditions, such as if the person was receiving treatment for an infection or was at increased risk of pressure injuries. One person's records showed that their pressure areas had improved and they were no longer at risk. A social care professional told us that another person had been discharged from the community mental health team following the care and support they received at St Catherine Care Home. There was a track record of positive outcomes for people.

Where people lived with a disability or sensory impairment, they had a communication care plan which identified their communication needs and included guidance on how to make information accessible for them. People had care plans which covered their cultural and spiritual needs. There was information about people's life history, important dates, hobbies, beliefs and interests.

The provider involved people and their families in the care planning process and in regular reviews of their care plans. People were satisfied their care and support met their needs and reflected their choices. They were able to follow their own routines. We saw one person who had chosen to stay in bed that morning received their personal care and had breakfast later.

Staff supported people's wellbeing with a variety of organised and individual leisure activities and events. Shared events included Christmas and New Year parties, a strawberry tea and a barbecue. People took part in organised games such as bingo and skittles as well as individual pursuits such as jigsaws, puzzles and reading. People played dominos and cards with each other. Staff made use of memory boxes and pictures to encourage people to reminisce and talk about the past.

People were aware of how to complain if they were not satisfied with the service they received. However, they told us they had not needed to do so. There was a process in place to review and action formal complaints, but it had not been used in the months before our inspection.

Good

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had a clear vision to deliver personal and individual care in a home-like atmosphere. This was supported by the provider's mission statement which listed the values of the service. These included "compassion, empathy, dignity and respect, safety and security, and person centred framework". The mission statement was displayed on the notice board.

Feedback from staff was that the registered manager was supportive, and there was a strong ethos of teamwork. Staff described the registered manager as "brilliant" and the atmosphere in the home as "wonderful". There was a comments book for visitors to record their impressions of the home. Comments were positive and included, "Staff really helpful – quiet and very clean". Another comment referred to a "commitment to high quality care".

The provider worked to continually improve the service. There was an ongoing improvement plan which was delivering improvements to the fabric of the building and making the service more "dementia friendly".

There was an effective management system in place. Staff felt supported by the registered manager to do a good job, and were aware they could talk to the owners at any time. The owners were available to support the registered manager at any time. There were weekly management meetings, regular staff team meetings and residents meetings. Staff told us the registered manager always started team meetings by asking them if they had any concerns, ideas or suggestions. There was a strong sense of teamwork amongst the staff. The registered manager had established a number of "champions" to be the focus of expertise in certain areas. These included dementia, dignity, infection control, health and safety, moving and positioning, activities and falls.

The provider had a quality assurance system to monitor and improve the quality of service people received. This was based on monitoring visits which took place every two months. These were recorded and actions from previous visits followed up. They covered 14 areas including feedback from people using the service, visitors and staff. A sample of care plans and other records were monitored and checked monthly. Other areas covered by the quality audits were refrigerator temperatures, medicines records, food hygiene checks, bath lift check, water temperatures, incidents and outbreaks, and health and safety.

People using the service, visitors and staff were invited to complete quality questionnaires. The questionnaires for people using the service used "happy" and "not happy" symbols, and reflected that people were "happy" with the service. The registered manager was aware of suggestions made in the questionnaires. They told us they were considering a request for staff to wear name badges. Visitor questionnaires were all positive, and described the service as "good" or "excellent". One comment read,

"[Name] is always clean, comfortable, happy and well fed – wonderful staff."