A. Welcome House Limited

Kathryn's House

Inspection report

43-49 Farnham Road
Guildford
Surrey
GU2 4JN

Tel: 01483560070

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Kathryn's House provides accommodation and personal care for up to 29 older people, some of whom were living with dementia. The home is set over three floors with access to the upper floors via a small lift. At the time of our inspection there were 24 people living at Kathryn's House.

The inspection took place on 8 December 2016 and was unannounced.

At our inspection in April 2016, breaches of legal requirements were found and we took enforcement action against the provider. We issued warning notices in relation to safe care and treatment, person centred care and good governance. As a result of our concerns Kathryn's House was placed into special measures. The provider wrote to us to say what they would do to meet legal requirements. We undertook a further inspection in August 2016 to check the provider had taken action to meet the regulations. We found the provider had made some improvements in the quality of people received. However, these were not sufficient as the care people received was not always safe, staff were not able to demonstrate their understanding of safeguarding, people did not always receive care in line with their needs, there was a lack of activities which took into account people's interests and the provider had not ensured that quality assurance systems were in place. There were continued breaches because the provider had failed to take proper action. As a result of this Kathryn's House remained in special measures.

We undertook this inspection as a result of receiving concerns regarding people's care and to check that the provider had taken action to meet their responsibilities. We found that previous improvements made had not been sustained and that there were on-going concerns regarding the care and treatment people received.

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 is responsible for the day to day management of the home and was available throughout the inspection.

There was a continued lack of managerial oversight within the service. The provider and registered manager had not identified shortfalls with the care people received or poor practices in staff performance. There was a lack of understanding with regard to the responsibilities as registered persons. The provider had failed to ensure that the CQC had been notified of significant events at the service.

Risks to people's safety were not adequately identified and addressed. Accident and incident forms were not always completed in detail and were not analysed to minimise the risk of reoccurrence. Sufficient staff were not always deployed to meet people's needs and the minimum staffing levels determined by the provider were not always met. Staff had failed to identify safeguarding concerns and ensured that these were reported to the relevant authorities.

Staff had not received training in relation to people's specific needs including supporting people living with dementia and other mental health conditions. Staff had received some training to support them in their role but were unable to demonstrate their understanding in practice. The provider had failed to ensure staff received effective, on-going supervision which monitored their skills and practice. Staff told us they felt supported by the registered manager.

People's legal rights were not protected as the principles of the Mental Capacity Act 2005 were not followed. Capacity assessments had been completed in relation to a number of restrictions but had not been shared with staff. There were capacity assessments completed in relation to locked doors and DoLS applications had not been submitted to the local authority.

People's nutrition and hydration needs were not adequately met and action was not taken where people had experienced significant weight loss. People did not have sufficient choice about what they ate and specialist dietary needs were not fully catered for.

Staff did not always treat people with kindness and people's dignity was not respected. People did not always receive personal care in line with their needs and the provider had not ensured that checks were maintained to ensure people were not being woken at an unreasonably early time in the morning. We observed that on occasions some people's requests for support were ignored.

The care people received was not person centred and staff were unable to describe people's past lives, hobbies and interests. Care plans were not organised and contained contradictory information. Staff confirmed they had not read people's care plans which meant they were not fully aware of people's needs and preferences. There was a lack of activities provided to people and staff did not understand the importance of providing a stimulating environment. Staff did not interact positively with people.

Improvements had been made to the way people received their medicines and systems in place were found to be effective. When required people had access to healthcare professionals. Emergency plans were in place to ensure that people's needs would continue to be met in the event of an emergency and staff were aware of the support people required to leave the building safely.

There was a complaints policy displayed and where a complaint had been raised this had been addressed to the person's satisfaction.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

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.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Inadequate

The service was not safe.

Risks to people's safety were not being adequately identified and addressed.

Staff had not recognised and reported abuse.

Accidents and incidents were not effectively recorded and monitored to minimise on-going risks.

There were not enough staff to meet people's needs effectively at all times.

People's medicines were safely managed and administered as prescribed.

Is the service effective?

Inadequate

The service was not effective.

Staff had not all received training to meet the needs of the people and were unable to demonstrate that their learning in other areas had been effective.

Staff did not receive effective supervision.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not fully implemented which meant people's human rights were not protected.

People nutritional and hydration needs and choices were not always met.

People had access to healthcare professionals.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with respect and their dignity was not maintained.

Staff did not always respond to people's needs and were observed to ignore people's requests for support and communication.

Staff did not always respond to people in a kind manner.

Is the service responsive?

Inadequate

The service was not responsive.

Staff were not always aware and responsive to people's needs.

Care was not always planned and delivered in a person centred manner.

Social activities were limited and people spent much of their time without occupation or stimulation.

There was a complaints policy in place and displayed.

Is the service well-led?

Inadequate

The service was not well led.

Sufficient action had not been taken to address and maintain improvement in relation to the previous identified breaches of regulations.

Audits were not in place to monitor and assess the quality of the service and shortfalls in people's care had not been identified or addressed.

Records did not always up to date and did not contain consistent information.

Staff told us they felt supported by the manager.

Kathryn's House

Detailed findings

Background to this inspection

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

This inspection took place on 8 December 2016 and was unannounced. The inspection was completed by three inspectors.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the registered provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection we observed care in the home and spoke with the provider, registered manager, the deputy manager, compliance manager and three members of care staff. We spoke with four people who used the service.

We looked at five people's care plans and records relating to people's care including daily notes, food and fluid recording and behaviour monitoring charts. We reviewed a range of documents which related to how the home was managed including accident and incident forms, policies and procedures, training records and health and safety monitoring.

Inadequate

Is the service safe?

Our findings

At our inspection in April 2016 we found concerns regarding the safety of people's care. During our inspection in August 2016 we found that some improvements had been made. However, risks were not fully assessed and shared with staff, medicines were not managed safely, personal emergency evacuation plans were not completed and there were not sufficient staff were being deployed to meet people's needs.

At this inspection we found that improvements had been made to the way medicines were managed and personal emergency evacuation procedures were in place. However, there were on-going concerns regarding how risks to people's safety were managed, how staff were deployed and the failure of the provider and registered manager to identify, act upon and report safeguarding concerns.

Risks to people's safety continued not to be satisfactorily identified or addressed. One person's care file stated they were known to smoke in their room and cigarette smoke was smelt outside their bedroom. Legislation states that smoking in care homes is prohibited unless in designated areas which are clearly signed and meet with regulations. The provider's policy on people smoking in their rooms stated that people were permitted to smoke in their rooms. The registered manager told us they were shocked by this. They acknowledged it was out of date and not in line with current legislation. Despite this understanding, the registered manager and provider were both aware that the person regularly smoked in their room at night and had done so for over two years. The provider showed us the person smoked in the en-suite shower room and said that fire resistant flooring, curtains and bedding had been supplied to minimise the risks. The risk assessment in place for the person smoking in their room stated there was a medium to high risk of the person starting a fire. The control measures in place were that lighters should be removed from the person at night to prevent this and that the person had been made aware that smoking was only permitted in designated areas. These control measures were not effective as the person continued to smoke in their room. The registered manager said, "The risks are quite high." They added that the fire service had recommended fitting a portable sprinkler system but this had not been actioned. This meant that the person and others living at the service were being placed at risk. Following the inspection the provider informed us that the person had again been reminded that smoking was not permitted in their bedroom and their care manager had been contacted to plan a way forward.

One person's file stated they had a history of falls and used a walking frame when mobilising. There was no risk assessment relating to the prevention of falls within the persons care file. We observed the person try to stand up and fall backwards in their chair. The person was unable to use their frame for support as this had been moved out of their reach. We observed another person walking downstairs independently. The person negotiated the turn in the stairs in an unsafe manner which put them at risk of falling. The person's file said they were able to mobilise independently and this concern had not been identified. We spoke to the registered manager about this who assured us they would observe the person and assess the risks.

One person who was cared for in bed had bedrails in place to prevent falls. Their risk assessment stated that the district nurse had completed a full risk assessment for the use of bedrails although there was no copy of this on file. The registered manager informed us that during times of high anxiety the person had recently

started to try to get out of the bottom of the bed where there was a gap in the bedrails which could potentially cause the person injury. The registered manager said that another staff member had been asked to report this to the district nurse so they could reassess the person's needs. The service had not implemented any additional control measures themselves to keep the person safe. Following the inspection we were informed that the district nurse had made recommendations which the staff were following. Staff informed us that the person remained in bed most days due to their frailty although this was not recorded in their care plan. There was no skin integrity risk assessment or care plan in place. There was no guidance provided to staff as to whether the person required support to be repositioned and we observed the person remained in the same position throughout the day which put them at risk of developing pressure sores.

Where people required the use of a hoist to support them with moving and handling the size of sling required was not recorded within their care file. The deputy manager told us that they had identified staff had been using the wrong sling settings for one person which resulted in them being in a laying position rather than sitting when being hoisted. They had advised staff on the correct settings to use. Risks in relation to falls, malnutrition screening and skin integrity were not routinely assessed in order to ensure effective control measures were in place. The registered manager told us they were aware that not all risk assessments had been completed and they were continuing to update people's care files.

Accidents and incidents were not routinely completed and not analysed to ensure appropriate action had been taken to keep people safe. During the inspection we were informed that one person regularly kicked another person. There were no incident forms completed in relation to this and the person's behaviour monitoring chart was not completed in detail. One person had become anxious and tried to leave the service on three occasions within eight days by climbing the fence or trying to open the front door. On one of these occasions the person had climbed through a ground floor window and was found near to their previous home. The GP and the community psychiatric nurse were called for advice although there was no record of what additional guidance had been given to staff on how to support the person. An incident for another person showed they had begun choking during dinner. Staff had acted appropriately to support the person although there was no record of what further action had been taken to ensure the person continued to be supported safely with their food. We made the provider aware of our concerns and following the inspection the provider told us that instruction had been given to staff that the person's food should be cut into small pieces. A referral had also been made to the Speech and Language Therapy Team to request an assessment of the person's swallowing.

The failure to identify and assess risk and take action to mitigate known risks is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some risk assessment was taking place to mitigate risks to people's safety. For example, most people had fall sensor mats in their bedrooms to alert staff when they got up at night. This meant staff could go to the person's room promptly and offer support which minimised the risk of falls.

Sufficient staff were not deployed to support people safely and effectively. Following our last inspection we recommended that staff were deployed appropriately to ensure people's needs were met. During this inspection we found that the required changes were not made and the minimum staffing levels determined by the provider were not consistently met. The registered manager told us that there should be four care staff on duty during the day. We were informed that a staff member had called in sick which meant the service was short staffed. We observed that staff were rushed and didn't have time to spend with people. Staff spent time in the morning completing tasks such as making beds and doing laundry rather than leaving these tasks until additional staff were available in the afternoon. There were occasions when people had to wait for support as there was only one staff member covering communal areas. We observed one

person attempt to get up from their chair but was unable to do so. A staff member told the person they would find another staff member so they could help them up. The person had to wait for over 10 minutes before staff returned to support them. Another person was heard to ask twice for staff to support them to return to their room but had to wait for staff to be free. The registered manager said it was unusual for the service to be short staffed and that staffing levels rarely fell below the required numbers. However, we examined rotas for the previous six weeks and found that on ten occasions only three care staff were available. One staff member told us that staffing levels were not consistent. They said, "It's not unusual for there to be three rather than four, we just have to get on with it but it's not right."

The failure to ensure there were sufficient staff deployed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of abuse as staff had failed to identify and act upon safeguarding concerns. A staff member told us that one person was physically and verbally aggressive to others. They said, "(Name) can be physically aggressive pretty much every day and regularly kicks (name). We try and keep them away from each other. (Name) has bad dementia and doesn't flinch. We don't notice any bruises. (Name) tells residents to shut up. I say to them that it's not right or nice." A recent entry in the person's behaviour monitoring chart stated the person had been, 'kicking staff and residents'. There were no incident forms relating to this behaviour to show how people were supported or how staff had reacted and the incidents had not been reported to the local safeguarding authority. Following the inspection the provider informed us that the local safeguarding team had been informed of these concerns.

During our inspection in April 2016 we found that people were not supported safely with regard to their moving and handling needs. Staff were seen to be using unsafe techniques known as 'drag lifts' when supporting people to transfer or stand. At our inspection in August 2016 we found that improvements had been made and staff were using appropriate equipment when supporting people. Prior to this inspection we received two external concerns which highlighted that drag lifts were again being used by staff. The provider and registered manager had not identified that staff were again using unsafe moving and handling techniques and staff had not acted on their responsibility to report concerns.

The failure to identify, act upon and report safeguarding concerns is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in April and August 2016 we found that safe medicines management processes were not followed and that systems were not in place to ensure that people would be evacuated from the premises in the event of an emergency. At this inspection we found that improvements had been made in these areas.

People received their medicines safely, in line with their prescriptions. Each person had a Medicines administration record (MAR) which contained a recent photograph and known allergies. Medicines were stored securely in a locked drugs trolley. MAR charts were signed following the administration of medicines and no gaps in recording were seen. Where people were prescribed PRN (as required) medicines guidelines were available to ensure these were administered appropriately. Medicines not in blister packs were recorded and stocks counted on a daily basis. PRN protocols in place which included what the reason they were required needed and how people may indicate they needed them. Temperature checks were recorded for clinical room, medicines cupboard and medicine fridge to ensure that medicines were kept at a safe temperature. When supporting people with their medicines the registered manager was patient and encouraging, taking time to explain to people what they were doing.

Each person had a personal emergency evacuation plan in place to guide staff and emergency services on

the support they would require in the event of an emergency. A coding system had been developed on people's doors which identified the support people needed. Staff were aware of the meaning of the colour codes and had received training in supporting people to leave the building safely.

Inadequate

Is the service effective?

Our findings

People were supported by staff who did not have the skills to carry out their job role effectively. Following our inspections in April and August 2016 we found that staff did not have an understanding of their responsibilities with regards to safeguarding and the Mental Capacity Act 2005 (MCA).

At this inspection, staff still lacked knowledge in these areas and were unable to demonstrate how their learning impacted on their job role. Staff had not identified or reported safeguarding concerns regarding one person kicking another or some staff members continuing to use inappropriate moving and handling techniques when supporting people. This meant that although staff had completed safeguarding training they were not able to demonstrate their understanding in practice. Staff continued to lack understanding of the principles of the MCA and with the exception of one staff member were unable to explain how this impacted on their work. Following the last inspection the provider told us they had received guidance from the training provider in how to test staff members knowledge following training and were currently looking at how to implement this process. We found no evidence to show this had been completed. During the inspection the provider showed us a handwritten piece of paper which stated, 'MCA/PEEPS AND SAFEGUARDING. I have been explained and understood'. This was signed by all staff members. Despite having signed this, staff that we spoke to were not aware of their responsibilities in these areas.

Staff demonstrated a lack of understanding of the needs of people living with at the service. Staff had not received training in supporting people living with dementia or those with other mental health support needs. Staff did not offer people stimulation or engage in meaningful conversations or activities with people. Two people were repeatedly prompted to sit down when they attempted to leave their chair and were not offered alternative activities. This showed a lack of understanding from staff that people living with dementia may find comfort in walking around. We asked one staff member about their job role. They told us, "To look after the residents, keep them safe and maintained but we can't do this every day because our residents don't let us." This showed a lack of understanding and skill in meeting people's needs.

Staff did not receive effective supervision in order to monitor their performance and the support they provided to people. At the inspection in August 2016 we made a recommendation that plans were implemented to ensure that staff were supervised appropriately and regularly and their competence was checked as part of this process. At this inspection we found that this recommendation had not been implemented and effective supervisions were not taking place. We asked to see supervision records and were provided with a notebook which contained brief comments of when the provider had spoken to staff. These included, 'Spoke to (name) about the importance of cleaning up spillages on carpets asap' and 'At infection control training (name) showed 5 staff box for cleaning up spillages'. There was no evidence that staff had been given the opportunity to discuss their individual performance, any concerns or difficulties or training needs. The provider told us that these areas had been covered in staff appraisals which were conducted annually. At our previous inspection these documents had been presented as supervisions. The review of staff performance on an annual basis does not ensure that staff receive adequate supervision within their role.

Failing to ensure that staff receive effective training and supervision to carry out their role was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 (DoLS).

We observed that some improvements had been made in completing MCA and best interest decisions regarding specific decisions. However, the provider continued to fail to protect people's legal rights as the principles of the MCA were not consistently followed. MCA and best interest decisions had recently been completed for the use of bedrails and falls sensor mats although these had not been checked by the registered manager and had not been placed in people's care files or shared with staff.

During the inspection we observed a staff member prompt someone to sit down and say, "Your room is locked." We asked a staff member why the person's room was locked and were told this was because other people wandered into people's rooms and took things. Staff did not offer to unlock the person's door which meant this restricted the person's right to spend time in their room. There was no MCA or best interest decision regarding the decision to keep people's bedroom doors locked or to deprive people of their right to spend time in their room.

The external doors to the service were locked and the majority of people were unable to leave without support. However, there were no capacity assessments or best interest decisions regarding this restriction and no DoLS applications had been submitted for the majority of people living at Kathryn's House. As previously reported incident forms showed one person had made repeated attempts to leave the building. Following the inspection the provider sent evidence which confirmed a DoLS application had been submitted to the local authority in September 2016. However, this was a standard request for authorisation rather than an urgent request which would have been expected in these circumstances. There was no capacity assessment completed regarding this application and no evidence of a best interest decision having been made. One person had a DoLS authorisation regarding their need for constant supervision, locked external doors and the consistency of their food. The DoLS authorisation was out of date and there was no evidence available to show that an application had been submitted for these restrictions to legally continue. The registered manager said they were unsure if they had completed this. Following the inspection the provider told us this was being discussed with the local authority.

People's human rights were not protected because the requirements of the MCA were not always followed. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's food choices and preferences were not always met and records were not accurately maintained. There were no choices of meal offered to people and the option of spaghetti bolognese was the only choice. We asked one person if they were offered a choice of meal. They told us, "No, you just get what you're given. You can ask for something else if you want to." The majority of people living at Kathryn's House would be unable to ask for an alternative. One person required a gluten free diet. They told us, "I've got to be careful what I eat. They don't cater for me. I'm sick of yoghurts but they can't buy me special food, I always have something for breakfast but it's never cooked." We saw the person was given mashed potatoes with their

Bolognese sauce rather than pasta and was offered yoghurt for pudding. Another person required a vegetarian diet and was given pasta with tomatoe sauce which did not look appetising. One person's care records stated that they did not like pasta and should be offered a small portion of food. The person was given a large portion of spaghetti bolognese. We observed another person spent the majority of lunchtime asleep at the table and did not eat their lunch. The person's records stated they had eaten all of their meal. We observed that three people had not been offered lunch. There was some confusion between staff as to whether the people had eaten and we were then told they were all having lunch on the second sitting. As the three people concerned had eaten breakfast before 0730 this meant that they were waiting for six hours between their meals.

People did not always receive appropriate support to eat. We observed one person being supported by a staff member to eat their lunch. Large spoonful's of food were placed into their mouth and they were not given sufficient time to swallow between mouthfuls. Another person spent over 30 minutes with their lunch in front of them as they were falling asleep at the table. Staff approached the person on three occasions to give verbal prompts before going to sit with the person. The staff member encouraged the person to eat but did not check if their food was cold.

Failing to ensure that people had support to eat in line with their choices and needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported to ensure they had adequate levels of fluids. When people were asleep they were either not offered a drink or this was placed in front of them and removed later untouched. This meant that three of the people we observed did not have a drink during the inspection and others maintained only a limited fluid intake.

Weight records showed two people had lost 5 kgs of weight over the past two months. There were no records within people's files to show how this had been addressed or if the GP had been informed to ensure the people had no underlying health conditions leading to the weight loss.

Failing to identify risks to people's health and ensure that people received adequate hydration was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of the above we saw evidence within people's files that they had been supported with their healthcare needs appropriately. Records showed people had seen the GP, chiropodist and district nurse when required. One person had been referred to the hospital by the GP but had been discharged the same day. Staff had taken prompt action to ensure the person was readmitted to hospital and received the healthcare support they required.

Inadequate

Is the service caring?

Our findings

During our inspection in April 2016 we found that people were not always treated with dignity and respect. People were being woken at an unreasonable time in the morning, were not receiving appropriate support with their continence needs and were not being spoken to in a respectful manner.

At our inspection in August 2016 we found improvements had been made although there were on-going concerns regarding how people were spoken to by some staff members. During this inspection we found that improvements had not been sustained.

People were not always treated with dignity. Prior to the inspection we received information that people were not being supported to wash when receiving personal care. On arrival at the service and throughout the morning we checked the rooms and bathrooms of people who were dressed and having breakfast. Of the sixteen rooms checked we found that seven people's bathroom basins were completely dry. We checked the communal bathrooms which were also dry, indicating they had not been used that day. Staff told us that people were supported to wash in the morning, "We sit them on the toilet and help them to wash by the basin. We use two flannels, one or the bottom half and one for the face." Another staff member told us, "If people have been incontinent we give them a shower, otherwise they have a wash using flannels which go straight in the wash." We observed nine people's beds had been stripped during the morning and staff confirmed this was due to people's incontinence. However, only one person's shower was wet. We observed one staff member go into someone's room to support them with personal care. The person was in bed but awake when the staff member entered their room. Very little interaction could be heard with the person and they came out of their room fully dressed within twelve minutes. We observed that care was not taken over people's personal appearance. Several people did not look as though they had been supported to wash or have their hair washed or brushed and some people's clothes were stained. At lunchtime we noted one person's hand and fingers were engrained with dried faeces. We brought this to the attention of the registered manager who asked a staff member to support the person to wash their hands.

Staff told us that they supported people with their oral healthcare during personal care. We checked people's toothbrushes and found they were all dry, indicating they had not been used that day. We spoke to the registered manager about this who asked us if the people whose brushes we had checked had teeth. This demonstrated a lack understanding regarding the need for oral healthcare. People with their own teeth or dentures still required oral hygiene. People's care plans did not contain information regarding how staff should support them with their oral hygiene. We noted that a number of people's breath had a strong odour.

On arrival at the service at 0800, 13 people were sitting in the dining room or lounge having already had personal care. The staff member present told us that 11 people had eaten their breakfast by 0730. One person told us that staff woke them up at 0500 each day, they told us, "I'm so tired." One staff member told us, "The night staff get 8 or 9 people up to help us. They do personal care for people." Other staff members told us that night staff supported people with their personal care but only if they were awake. The registered manager told us it was unusual for this many people to be ready in the mornings. However, we checked

night care records for the previous six days and found that between 10 and 14 people were awake and had received their personal care before 0715 each morning. Although the registered manager and provider told us they started work early to check that people were not being woken at an unreasonable time there were no records to show how this was being monitored. A report conducted by a quality assurance manager from Surrey County Council in November 2016 had recommended that the 'senior management team carry out routine spot checks of the night shift (late night and early morning)'. The same recommendation had also been made in May 2016. The registered manager and provider had not acted on this advice and there was no evidence to show that they had investigated why people were awake so early.

People were not always treated with respect. We observed one staff member responded negatively to people and did not treat people with kindness or consideration. Throughout the inspection they were observed to give direction to people rather than encouragement and spoke to people in a derogatory manner. We heard one person ask if they could have a cup of coffee. The staff member responded by telling them they had drunk their coffee. The person then asked if they could have a cup of tea instead. The staff member told them, "No, you've had that. An hour ago you had that." Another person asked for a paper, the staff member responded by saying, "We've got no more. That's it, you've ripped it all." The person appeared anxious and said, "But I need something to keep me going." Another staff member intervened and reassured the person they would find a paper and did so. Whilst we were talking to one person the staff member approached them from behind and said, "I'm just going to put this on you." They placed a clothing protector over the person's head leaving it hanging on their chin. The staff member walked away without checking the person was comfortable. On a separate occasion we observed a gentleman wearing a very feminine, flowered clothing protector. When he had finished eating the staff member removed the protector and directly placed it on someone else. One person attempted to get up from their seat. The staff member said, "Sit down and I'll talk to you." The person sat down but the staff member did not go to speak to them. We had reported similar concerns regarding the staff member's behaviour following our inspection in August 2016. There were no records to demonstrate how this had been addressed and no monitoring of the staff members conduct. We discussed these concerns with the registered manager and provider who told us they had noted the staff member could be loud but said they were shocked by reports of how they spoke to people. Following the inspection the provider informed us that the staff member was no longer employed at the service. However, we observed the staff member had repeatedly treated people with a lack of respect which had not been identified by the registered manager or the provider and had not been reported by staff.

On other occasions we observed staff ignored people's requests for support and did not acknowledge people's communication. We asked one person how they were as they were being brought into the dining room in their wheelchair. The person said, "It's awful here. I need to go to the toilet. Please take me." The staff member supporting the person ignored this request and placed the person at the dining room table. The registered manager intervened and requested the staff member support the person to use the bathroom. Another person asked if they could have their medication as they wanted to have their breakfast. The registered manager did not look at the person but said, "Your breakfast is coming." The person did not appear to realise this comment was directed at them. When the person's porridge arrived they said, "This porridge isn't properly done, there's lots of bits in it." Staff did not acknowledge this or go to speak to the person. One person said that their back was aching from sitting in the dining chair. Staff ignored this and the person remained in the dining room chair until they had finished their breakfast. We did note the person was provided with a cushion when they were sat at the dining table during lunch. One person repeatedly tried to get up from their chair and on each occasion staff prompted them to sit back down. They did not offer the person reassurance or acknowledge their need for support.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of

observing care to help us understand the experience of people who could not talk with us. We observed the interaction with staff and mood of two people sitting in the lounge area. During the 90 minute observation people had little interaction or stimulation and both fell asleep for the majority of the time. Staff approached one person on two occasions, the first to put a blanket over their legs. On the second occasion the person had fallen asleep. Staff woke them and asked if they wanted some banana. The person was sleepy but indicated their agreement. The staff member proceeded to put a piece of banana directly into the person's mouth before moving onto to the next person. The second person also slept through the majority of our observation, the only interaction from staff was when they asked if the person wanted some fruit.

Not ensuring people were treated with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were occasions when staff treated people with kindness. We heard one staff member supporting someone who was anxious during personal care. The staff member was reassuring to the person, using their name and gently saying they were trying to help them. On another occasion we saw a staff member talking to someone sat at the dining table. The staff member was gently rubbing the person's back in a caring manner. One staff member who was offering people drinks was seen to be caring in their approach and spoke to people respectfully.

Inadequate

Is the service responsive?

Our findings

At out inspections in April and August 2016 we found that staff were not always aware of people's needs and preferences. Care plans were incomplete or out of date and staff did not access the information. At this inspection we found that although some improvement had been made to plans, people's needs and preferences were not always met.

Staff were not always responsive to people's needs. One person's care plan stated they should have their glasses with them at all times and were hard of hearing. The person had been supported to the lounge without their glasses and we observed they attempted to stand up several times and staff prompted them to sit down. The person eventually said that they couldn't see anything and needed their glasses. A staff member reassured the person they would go and get their glasses but did so in a quiet voice. When the person said they couldn't hear what had been said the staff member went to get the glasses but did not further reassure the person. They again started to get up as they were unaware the staff member had gone to bring their glasses and were prompted to sit down without further reassurance. We heard the person say, "I'm really miserable, absolutely miserable."

People did not receive person centred support and staff were not aware of the content of people's care plans or their life histories and interests. Staff meeting records showed that staff had been asked to read people's care files and a keyworker system had been implemented. We spoke to one staff member who told us, "I've read some of them but not all." Another staff member told us they had not read people's care plans and were unable to tell us the names of the people they held key working responsibilities for. We looked at two people's records who were cared for in their rooms. Both people's files stated they enjoyed particular types of music, one person enjoyed reading and another person enjoyed watching nature programmes. Staff we spoke to were unable to tell us what type of music or hobbies either person enjoyed. We observed both people spent their day in their rooms without music, television or staff company. At our last inspection we found that the care offered at the service did not always reflect people's individual needs. One person had told us they wanted to develop their independent living skills with a view to moving into their own flat in the future. During this inspection we found that there had been no changes in the way the person was supported and they continued to feel frustrated that they were not receiving support to move on.

At our inspection in April 2016 we found there was a lack of activities which suited people's individual needs. During our inspection in August 2016 some improvements had been made, although further work was required. At this inspection the improvements previously made had not been sustained and that there was a lack of stimulation for people.

People had little to do during the day and social activities were limited. One person told us, "I don't like living here, nothing much is going on and you just sit and sit. It would be nice if you had some exercise. It's a long day just sat here." The atmosphere in the lounge was very quiet throughout the day and a number of people slept for long periods. The television was on although the volume was quiet and could not be heard clearly from the back of the room. Interaction from staff was task orientated and mainly focussed on offering people support with meals or personal care. The only structured activity provided on the day of the

inspection was a quiz which lasted for 20 minutes. Three people joined in and appeared to enjoy this. Activity records kept mainly centred on when people's family members visited. There were some records of the PAT dog visiting and weekly music sessions taking place. We asked one person about their craft work which they had previously told us they enjoyed. They told us that they didn't do much of this as they had asked for some craft items but these had not been purchased. We spoke with the activities co-ordinator who told us they found it difficult to manage the activities alongside their other responsibilities as part of the care team. When asked about the skills they felt they had to undertake the role they told us, "I shouldn't be the activities coordinator, they only picked me because my English is better." Following the inspection the provider told us they had increased the number of activities provided by a visiting professional to facilitate an armchair exercise group.

Not ensuring that people received care in line with their needs, along with a lack of activities which suited people's individual needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place which detailed how a complaint could be made and how this would be dealt with. The manager maintained a complaints file and one complaint had been made since our last inspection. This was with regard to one person feeling that staff had made a derogatory comment to them. Records showed that the staff member had been spoken to and had said they did not intend to cause offence. They had been asked to apologise to the person and the person had accepted this.

Inadequate

Is the service well-led?

Our findings

At our previous inspections in April and August 2016 there was a lack of effective oversight and leadership systems within the service. There were continued breaches regarding people's safety, identifying and acting upon safeguarding concerns, MCA assessments and person centred care. Although some improvements in people's care was observed during our inspection in August 2016, due to the history of non-compliance with regulations we did not have confidence that the provider and registered manager would be able to sustain these improvements and ensure they were embedded into practice.

At this inspection we found that previous improvements with regards to how people were cared for had not been sustained and monitoring systems to identify shortfalls in the service provided had not been implemented.

There was a lack of management oversight of the service and we found significant shortfalls in the care that people received throughout our inspection. The provider and registered manager told us they had spent long hours at the service to ensure that staff practice was monitored. However, this had not led to significant improvements in the quality of life people living at Kathryn's House experienced. The provider and registered manager were unable to demonstrate how they had worked with staff to improve practice. They had not identified concerns regarding the times people were getting up in the morning, the way in which care staff were addressing people, the lack of attention to people's personal care, the lack of meaningful activities or stimulation provided or on-going concerns regarding people's safety. There were no records maintained of management observations and no action plans in place to ensure these shortfalls were addressed. The provider and registered manager had repeatedly stated their commitment to the people they support. However, the lack of sustained improvement within the service along with the failure to identify concerns did not demonstrate that they had the knowledge and skill to ensure people received safe and effective care in line with their needs and preferences.

Following our inspection in April 2016 the administrator for the service had been appointed as compliance manager. We spoke to them during the inspection about their role. The compliance manager told us they had undergone training alongside staff and had completed internet research regarding the regulations covering social care. However, they did not have any direct experience or qualifications in relation to providing care and were unaware of the responsibilities of their role. The lack of internal quality assurance systems meant the service was not proactively identifying or addressing concerns. A culture of reacting to external feedback from the Surrey quality assurance team and the CQC had developed and systems implemented as a result were not monitored to ensure they were embedded into practice. There had been no work completed with staff to ensure the culture of the service was aimed at providing person centred care. Staff worked in isolation to complete tasks rather than putting people at the centre of the service.

Quality assurance audits did not cover all aspects of the care provided. The compliance manager told us that audits completed covered response times to call bells, infection control and cleaning. We viewed records of these audits since our last inspection and found that no actions had been identified in any area. Audits of care plans, daily records, risk management, activities or observations were not completed and

systems had not been developed to implement any additional audits.

People's care records did not cover all aspects of their support and were not organised to ensure that information was current. Previous inspections had highlighted that not all people living at Kathryn's House had a care plan in place and that information was not always up to date. During this inspection we noted that some improvements had been made although care plans still lacked detail and files contained conflicting information as old care plans were incorporated alongside more up to date information. For example, one person's care plan stated they were able to walk short distances but later said the person required the assistance of two staff members and a hoist to transfer. Another person's records stated in one section the person required a pureed diet although in another section stated that following a review from the GP they were now able to eat a soft diet. People's night and daily care records did not reflect what support they received with their personal care and what time this was provided. The risks to people of this lack of accurate recording was that staff either did not read the care plans or if they did they did not have accurate guidance on the care people required to meet all of their needs.

Feedback on the quality of the service from family members and other agencies was not sought on a regular basis. A survey to gain views of the service provided had last been completed in 2015. The registered manager told us they were aware this was overdue and intended to send the forms out soon.

The lack of effective quality assurance systems and the failure to maintain accurate and organised records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events. As reported there had been a number of incidents related to safeguarding concerns and one incident where the police had been called when a person went missing from the service. Our records showed that the CQC had not been informed of these incidents to ensure that we were able to monitor the service provided effectively.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

Staff told us they felt supported by the registered manager. One staff member said, "I could go to her if I needed to." Another staff member told us, "She's a good manager, she's supported me." Regular staff meetings took place and developments within the service were discussed. However, not all staff followed the instructions provided. For example, staff had been directed to read care plans but had not done so. The registered manager had also asked that staff complete the first stage of a care plan so she could give feedback. The registered manager told us that only four staff had completed this.

At our inspections in April and August 2016 we identified that the registered manager worked long hours and was not supported by the provider. During this inspection the provider informed us that a deputy manager had been recruited to support the registered manager. They told us they were in the process of drawing up separate job descriptions to ensure that the roles and expectations were clear. We met with the deputy manager during the inspection and found that they had identified a number of areas which required improvement such as staff skills in supporting people living with dementia, moving and handling practices and the implementation of risk assessments. The registered manager told us they were pleased to have the additional support.