

Miss Alison Thorne

# Catherine House

## Inspection report

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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 

### Overall summary

This inspection took place on 12 November 2014 and was unannounced.

The service provides accommodation and personal care for up to five people with a learning disability or autistic spectrum disorder. At the time of the inspection there were four people living in the home with mild to moderate learning disabilities. One person stayed there on a regular respite care basis.

People were able to carry out most of their own personal care routines but sometimes needed prompting or assistance from staff. They could all communicate verbally although some people had more limited

language skills than others. Staff supported people when they went out to most events and activities. Staff sometimes dropped people off and collected them later when people wanted to go out with family or friends.

During the inspection we met the registered provider and the manager of the home. Registered providers are 'registered persons' who have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered provider was in day to day charge of the home and therefore was not required to have a registered manager as a condition of their registration.

# Summary of findings

People had choice and control over their daily routines. One person said “I have a shower every day. I get up at seven and go to bed at 10. That’s my decision”. Care plans contained records of people’s preferences including their personal likes and dislikes. This helped staff to provide care and support in a way that suited each person’s individual preferences.

Staff respected and acted on the decisions people made. We heard staff consulting people about their daily routines and activities and no one was made to do anything they did not want to. Staff adapted the way they communicated with people according to each person’s needs. Where people lacked the mental capacity to make certain decisions about their care and welfare the provider knew how to protect people’s rights.

People were supported to be as independent as they were able to be. They helped staff with daily living tasks such as meal preparation and washing up. People were supported to visit relatives, access the community and participate in social or leisure activities on a regular basis.

During our inspection we heard a lot of friendly banter between people and staff. One person said “I get on well with all the staff. They are really nice”. The provider employed a small team of staff to support the people

living in the home. This ensured consistency and meant staff and people got to know each other well. One person told us “I’ve never had any problems or needed to make a complaint”.

People felt safe and staff knew how to protect them from abuse. One person said “No one ever treats me badly”. Care plans included individual risk assessments to minimise the risk of avoidable harm.

People had contact with their relatives on a weekly basis which helped maintain family relationships. Relatives were encouraged to visit the home as often as they wished and did not have to make prior appointments.

Staff received appropriate training and were assessed by senior staff to ensure they supported and cared for people properly. Staff said they all worked together as a supportive team and a senior person was always available if they needed additional advice. Staff told us the management were very approachable and supportive.

The provider had established close links with local colleges of further education, private and local authority run resource and day centres and Mencap. These links provided opportunities for people to integrate better within the local community.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to make choices and participate in activities they enjoyed. People were supported to be as independent as they were able to be.

There were sufficient numbers of suitable staff to keep people safe and meet their individual needs.

Good



### Is the service effective?

The service was effective.

People were supported to live their lives in ways that best suited them and helped ensure they experienced a good quality of life.

Staff were trained and received personal development to ensure they had the skills and knowledge to provide effective care for the people they supported. People also had access to relevant health and social care professionals.

The provider acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

Good



### Is the service caring?

The service was caring.

People were treated with dignity and kindness. People told us they got on well with the staff and described them as their friends.

Staff had a good understanding of each individual's needs and preferences. They consulted people about their daily routines and activities and respected their choices.

People were encouraged and supported to maintain regular contact with their families. People living in the home had some form of contact with a relative on a weekly basis.

Good



### Is the service responsive?

The service was responsive.

People told us they were able to make decisions about their daily routines and activities. People had a significant say in the care and support they received.

Each person had two key workers with responsibility for ensuring the person's wishes were heard and acted on.

People and their relatives were encouraged to feedback any issues or concerns directly to any member of staff.

Good



### Is the service well-led?

The service was well led.

Good



## Summary of findings

The provider and manager promoted an open culture and a caring ethos centred on the people living in the home. They were visible and accessible to people in the home, their relatives and the staff.

Staff we spoke with appeared motivated and praised both the provider and the manager for their caring, open and supportive approach.

There were effective quality assurance systems in place to monitor people's experience of the service and to identify areas for improvement. The provider used this information to continually review and improve the quality of care.

# Catherine 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 12 November 2014 and was unannounced. It was carried out by an adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection

reports and the Provider's Information Record (PIR). The PIR is a return completed by providers giving key information about the service, what the service does well and improvements they plan to make. At the last inspection on 25 October 2013 we did not identify any concerns with the care provided for people at Catherine House.

We talked with three of the people who lived in the home, interviewed four care staff, the manager and the registered provider. We observed how people were supported by staff, reviewed three people's care records, two staff recruitment records and other records relevant to the management of the service.

# Is the service safe?

## Our findings

People told us they felt safe and the care staff were good to them. One person said “No one ever treats me badly”. Another person said “Staff are nice to me, course they are”. People looked relaxed and at ease with all of the staff and with each other.

Due to people’s learning disabilities they had different levels of understanding and verbal communication skills. This made them potentially vulnerable to abuse and the provider had systems in place to help protect them. All of the staff we spoke with knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff training records showed staff received annual refresher training in safeguarding adults. Safeguarding and whistle blowing policies were in place. Whistle blowing is a way in which staff can report misconduct or concerns within their workplace. Staff were able to refer to these policies if they needed more information about the different forms of abuse and how to report it.

People’s risks were well managed through good assessments that identified the risks and provided information to help staff understand how to reduce the risks. People were involved in risk assessments and were helped to understand the ways in which risks could be minimised. Staff spoke to people in ways each person could understand. People’s verbal communication skills varied but all were able to speak with staff. Staff used pictures and symbols to help some people with their understanding when this was appropriate.

Risk assessments included plans for assisting people who needed intense support when they became distressed or anxious. Individual plans described the circumstances that may trigger the distress or anxiety and ways to avoid these triggers. Distraction, support or calming techniques were used if people became agitated and to avoid the use of any kind of restraint. Other risk assessments included arrangements for keeping people safe when accessing the community and for safeguarding people’s money. People told us staff discussed with them situations that may present risks in order to help keep them safe. For example, staff discussed with one person the risks of carrying a lot of cash in public. The person decided they would keep their money in a cash tin with a lock rather than carrying it around with them.

Staff knew what to do in emergency situations. For example, protocols had been agreed with hospital specialists for responding to people who had seizures. Staff told us they had been trained in providing medication for people who had prolonged seizures. They knew what to do and who to notify if a person’s seizure did not end within a prescribed time period. Staff said they would call the emergency services or speak with the person’s GP if they had any other concerns about a person’s health.

The manager said they had very few accidents or significant incidents at the home. This was confirmed by the incident records. Staff completed an incident form which was signed off by the manager with any comments or learning from reflective practice. The manager said they reviewed all incidents to see if any improvements could be made. For example, due to previous medicine errors they had arranged with a local pharmacy to switch over to a monitored dosage system. This is where tablets are supplied in a colour coded blister pack to ensure people received the correct dose at the right time of day.

To ensure people’s environment was safe a specialist external contractor was used to carry out an annual health and safety risk assessment of the home. There was also a comprehensive range of health and safety policies and procedures to guide staff in helping to keep people safe. For example, there was an up to date assessment of the home’s fire safety arrangements and current test certificates for gas safety checks.

There were enough staff to meet the needs of people and to keep them safe. On most shifts there was usually one member of staff on duty for each person. The provider regularly assessed the staffing levels to ensure people were kept safe and their needs were met. We observed when people requested assistance someone was always on hand to support them. If staff were engaged in other tasks they stopped what they were doing to speak to or support people when requested.

Staff told us the provider was good at getting additional support to cover short notice absences. The provider employed a small team of 12 staff which ensured consistency and meant staff and people in the home got to know each other well. There was a clear staffing structure in place to ensure senior staff were always available to provide staff supervision and support.

## Is the service safe?

There were effective recruitment and selection processes in place to reduce the potential risks to people living in the home. Appropriate checks were undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references were obtained.

People had prescribed medicines to help with their physical and/or emotional health needs. People took their medicines when prompted by the staff. Staff said they always checked to ensure the correct prescription and dose

was given to the right person. Staff told us they received medicines training from the local pharmacy and through an E-learning module. Staff training records confirmed this. The manager or the senior support worker assessed staff's competency before they were allowed to support people with their medicines.

Medicines were kept in a secure and suitable storage area and medicine administration records were accurate and up to date. Unused medicines were returned to the local pharmacy for safe disposal when no longer needed.

# Is the service effective?

## Our findings

People were happy with the support provided by the care staff. One person said “I’m very happy here. I get on well with all the staff”. Another person said “My keyworker helps me with lots of things”. We observed people being supported with a variety of activities from making puzzles to preparing meals and heard lots of friendly conversations.

Staff received training to ensure they knew how to effectively support and care for people. The training included guidance on mental capacity considerations, choice, dignity and best interest decision making. These areas were particularly relevant for a learning disability service.

The manager said all the care staff had completed the diploma in health and social care qualifications to level 2. Two care staff were currently completing level 3 diplomas and two more staff were being enrolled for next year. This external training helped ensure people received effective care based on the best available practice. One support worker said “We receive lots of training and can request more specialised training, like epilepsy, as well”.

One of the care staff we spoke with had been recruited this year. They told us they received induction training when they first started based on the health and social care common induction standards. They said they shadowed a senior member of care staff until they were assessed as competent to provide an effective level of care.

Staff adapted the way they communicated with people according to each person's needs. This helped people to understand the care and treatment choices available to them. People had mild to moderate learning disabilities and all were able to communicate verbally with staff. Staff were trained to use symbols and pictures to help with people's understanding when this was needed.

Staff told us they had one to one supervision sessions with the manager every six to eight weeks and an annual performance and development appraisal meeting. Staff said they all worked well together as a good supportive team. Team working helped them provide effective care and support for people in the home.

The provider sought consent from people for providing care or treatment. Staff respected and acted on the decisions people made. For example, one person chose to

remain in their room and did not shower or come down for a meal until lunchtime on the day of our inspection. There were consent forms in people's care plans signed by those people who had the mental capacity to give their consent. This included consent to treatment and to sharing their personal information with healthcare professionals.

Where people lacked the mental capacity to take particular decisions the provider followed the Mental Capacity Act 2005 (MCA) code of practice to protect people's human rights. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals where relevant. Care records showed the provider followed the assessment and best interests decision-making approaches described in the MCA code of practice.

We saw records of multi-disciplinary meetings to make decisions about specific aspects of some people's care. This included best interest discussions with the person's family and the health and social care professionals involved with their care and treatment. For example, it had been agreed to observe a person who was prone to seizures during the night to help keep them safe. This was subject to review with health and social care professionals to examine whether other less restrictive methods could be used in future.

A Deprivation of Liberty Safeguards (DoLS) application was in progress to determine whether authority was needed from the Council to continue with this restrictive practice. This showed the provider was ready to follow the DoLS requirements. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The provider had trained and prepared staff in understanding the requirements of the MCA and the DoLS.

The manager told us they did not use any form of physical or medical restraint. When people became anxious or distressed staff supported them through non-physical intervention such as distraction, support and calming techniques.

People were supported to have sufficient to eat and drink and maintain a balanced diet. People had choice over meal



## Is the service effective?

times and menus. The manager said people could eat whenever they wanted to and wherever they preferred. Generally people had their main cooked meal together but had breakfast and lunch when they liked. Staff sat down with people each week to agree the weekly menu. Individual alternatives were provided if people decided they did not want the weekly menu choice. People told us they enjoyed mealtimes. One person said “We get nice food and drink and I get a choice”. Another person said “My favourite meals are cottage pie, roast dinners and dumplings”. One person had special dietary needs. Their care plan stated they were on a gluten free diet and needed their food cut into small portions to help them swallow. They were not at the home on the day we inspected but staff said they always supervised this person during mealtimes to avoid the risk of choking.

People were able to access healthcare services to help them maintain good health. One person said “I can talk

with my doctor if I have any worries. They give me medicines which help”. People’s care plans contained records of hospital and other health care appointments. There were health action plans to meet people’s health needs. People had ‘hospital passports’ which are documents containing important information to help support people with a learning disability when they are admitted to hospital. Staff told us they supported people when they needed to attend hospital or other appointments to make sure they received the treatment they needed.

People had their own single occupancy bedrooms. These were individualised and were well furnished and decorated to each person’s preferences. People had their own belongings such as posters, toys, DVD and music equipment. These personal belongings helped to make their rooms more homely.

# Is the service caring?

## Our findings

We heard a lot of friendly banter between people and staff. This was always respectful and appropriate to the person's level of learning disability. People told us they were fond of the staff and considered them to be friends. One person said their key worker "Teases me in a good way and makes me laugh a lot. Once I laughed so much it made me cry". Another person said "I get on well with all the staff. They are really nice". One member of staff said "It doesn't feel like work. The people living here are lovely and it is a lovely home".

Staff showed compassion and kindness towards people. For example, one member of staff was visibly upset when describing how one person had struggled coping with a long term health condition. Another member of staff was annoyed with the way some members of the public were disrespectful toward people with a learning disability.

We heard staff consulting people about their daily routines and activities and no one was made to do anything they did not want to. People were given their own space but the staff were always on hand when people wanted assistance or company. We were told each person was assigned two key workers. The key workers had particular responsibility for ensuring the person's needs and preferences were identified and respected by all staff. People discussed their needs and preferences at monthly care plan reviews with their key worker. Some people were able to write their own comments in the care plan whereas others relied on their care worker to record the discussion for them. The key workers spent a lot of individual time with people and took them out each week. One person said they "like their key worker a lot" and another person said "they help me with so many things". One member of staff said "The nice thing is we get a lot of one to one time with people. This means we really get to know them".

People were supported to access external advocates to support them in making important decisions about their care and treatment. Records showed one person had been supported by an advocate from a local advocacy service prior to going into hospital. Although the person had sufficient mental capacity to make their own decisions, the advocate provided additional support and ensured they were properly informed.

People were treated with dignity and respect. We observed staff spoke to people in a polite and caring manner and respected their decisions. When people needed support staff assisted them in a discrete and respectful manner. Personal care was always provided in the privacy of people's bedrooms or bathrooms. Each person had their own bedroom where they could spend time in private when they wished.

Staff understood the need to respect people's confidentiality and to develop trusting relationships. Care plans contained confidential information about people and were kept in a secure place when not in use. When staff needed to refer to a person's care plan they made sure it was not left unattended for other people to read. Staff treated personal information in confidence and did not discuss personal matters with people in front of others.

Staff supported people to maintain their independence, as much as they were able. We saw people helping staff with a range of daily living tasks. One person told us "I like helping out with meals and washing up". People were able to decide when to get up and go to bed, when and where to have meals, and whether they wished to spend time on their own.

Relatives and friends were able to visit people as often as they wished. Some people said their relatives visited several times a week. Every person we spoke with said they had some form of contact with a relative on a weekly basis.

# Is the service responsive?

## Our findings

People contributed to the assessment and planning of their care. Each person had structured one to one sessions with their key worker at least once a month to discuss their care plans and preferences. We saw records of these monthly review discussions in people's care plans. One member of staff said "There is a really homely atmosphere here and care planning is very person centred".

Each person had an individualised easy to read contract of service describing the service they could expect to receive. The contracts of service were written in short easy to understand sentences in large print with related pictures. This helped people with limited reading abilities to understand the content. Care plans contained records of people's preferences including their personal likes and dislikes. For example, one person was very keen on pop music and had several posters of their favourite pop group on their bedroom wall. They showed us a photograph of themselves surrounded by their favourite band members taken at a recent concert staff had supported them to attend. People also had choice and control over their daily living routines. One person said "I have a shower every day. I get up at seven and go to bed at 10. That's my decision".

Care records were up to date and accurate. There were detailed care plans, quick reference guides providing an overview of each person's care needs and preferences, separate daily records of the care and support provided and weight monitoring records. The manager planned to integrate the separate records to ensure information about a person's care was readily accessible when needed.

People could express a preference for the care worker they wished to support them. Staff members of the same gender were available to assist people with intimate personal care if this was their preference. One member of staff said "We try to match people with the staff they like most, but we don't have set individuals to support".

People told us staff supported them to spend time in the community and participate in a range of social and leisure activities on a regular basis. This included holidays, trips out, visits to relatives, attendance at activity centres, college courses, and some voluntary work. One person said "Staff take me out for rides and that. I like going to the pub, I've got friends down there". Another person said "I go out a lot. I've just got back from the supermarket where I bought some arts and crafts. I go out to different centres most days". A member of staff said "Everyone goes out pretty much every day".

People said they had regular contact with their relatives and friends. One person's relatives lived a long distance from the home but they had regular contact on the telephone. Staff supported this person to visit their relatives two or three times a year. This helped people maintain family relationships and avoid social isolation.

The manager said they believed in an open door policy. People and their relatives were encouraged to feedback any issues or concerns to them directly or to any member of staff. The individual telephone numbers and email addresses of senior staff were shared with relatives to facilitate good communication.

We were told the service had not received any formal complaints in the last 12 months. If there were any issues these were resolved quickly through informal discussions. The provider had an appropriate complaints policy and procedure in place. The manager said this was accessible to people and their relatives but they planned to produce an easy to read version as well. One person who lived in the home said "I've never had any problems or needed to make a complaint. If I did I would talk to my key worker, she is a lovely lady". Another person said "I see my family every week. I would tell them if I ever had a complaint".

# Is the service well-led?

## Our findings

Staff told us that management operated an “open door” culture and they were very supportive of people and staff. One staff member said “The management are lovely people. They always make a real effort to support the people in the home and we can call them anytime if there is a problem”. Another member of staff said “We work really well as a team. They are very good employers and we have a really good manager. There is an open door policy and things get dealt with straight away”.

The service’s Philosophy of Care was stated as “We aim to provide guidance and support to encourage each individual to develop to their fullest capacity ensuring good communication skills, personal choice and self-esteem, enabling individuals to integrate in the local community and work towards independent living”. The manager said it was a family run business and the provider took a personal interest in people and staff. They aimed to provide high quality care for people with a learning disability centred around the individual needs of each person. To support this they encouraged an open and inclusive culture for people, their relatives and staff. To ensure staff understood and delivered this philosophy of care, the service provided comprehensive induction and training, held monthly staff meetings, and carried out individual staff supervision sessions every six weeks. They used all of these events to highlight and reinforce the service vision.

The provider had systems in place to monitor implementation of their service vision. They regularly visited the home and also participated in shifts as and when needed. There were monthly management meetings and they received all staff meeting minutes for information. Staff and relatives were able to contact the provider directly if they wished. We were told relatives were welcome to visit the home when they wished and did not have to make a prior appointment.

Staff were encouraged to raise issues, concerns or put forward suggestions at monthly staff meetings. Discussions covered issues like health and safety matters or strategies for supporting people who needed intensive support when they were anxious or distressed. For example, a ‘bum bag’ containing all of a person’s rescue medicines had been introduced following a suggestion from a member of staff. This enabled the person’s medicines to be grabbed quickly when they experienced a seizure at night.

People and their relatives were actively involved in developing the service. Care plans contained records of meetings, telephone discussions, emails and letters from people’s family members and other representatives. Records showed there was regular contact and involvement with family members and other representatives. The manager said they did not carry out formal satisfaction surveys but they were in regular personal contact with people, their relatives and the health and social care professionals involved in their care. People told us they were in daily contact with the staff, the manager and the provider and they could speak with whoever they wished. The manager said they also held monthly service user meetings but described them as very informal. One person said “We sit down together to talk about things we want to do and places we want to go”.

The provider had a quality assurance system to check their policies and procedures were effective and to identify areas for improvement. For example, there were weekly medicines audits, care plans were reviewed on a monthly basis and were also checked by the manager every quarter, in-house weekly and monthly health and safety checks were carried out to ensure a safe and homely environment. Any accidents or incidents were reviewed to identify whether there were any trends or lessons for improving the service. An external human resources contractor reviewed the provider’s policies to ensure they were appropriate and in line with the latest legislation. Staff questionnaires were circulated every six months and suggestions or issues identified were incorporated into an improvement plan. One idea currently being considered is an online electronic system for policies and procedures to make it easier for staff to access the most up to date policy.

The provider participated in a number of forums for exchanging information and ideas and fostering best practice. They were affiliated to the Registered Care Providers Association Ltd (RCPA), received regular E-updates from the Epilepsy and Autistic Society, Mencap, Care Focus, Skills for Care and other relevant training providers. They also used the CQC website as a source of current information. The provider and manager attended regular seminar days hosted by the RCPA and other relevant organisations. Any new ideas or points of interest were cascaded to the staff team.

## Is the service well-led?

The provider said they were passionate about integrating people with learning disabilities within the local community. They had established close links with local colleges of further education, private and local authority run resource and day centres and Mencap.