GCH (St Katharine's) Limited

St Katharine's House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected St Katharine's House on 13 December 2017. The inspection was unannounced. St Katharine's House is 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 both were looked at during this inspection.

St Katharine's House is a care home providing care for up to 76 people. At the time of the inspection there were 59 people using the service.

At the time of the inspection there was no 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 home manager told us they would be applying to register with the CQC.

People's care records were not always kept up to date and did not always reflect changes in their care needs. Records relating to assessed risks were not always kept up to date and care plans did not always contain up to date plans relating to how risks were managed.

There were sufficient staff deployed to meet people's needs. People commented on the number of agency staff working in the service and the provider was proactive in looking for ways to recruit permanent staff. Changes had been made to the rota for permanent staff to ensure there was an appropriate skill mix to meet people's needs.

People received their medicines as prescribed by staff who were trained and competent to do so. Infection control measures were in place to protect people from the risk of cross infection.

We saw people enjoying their meals and they were positive about recent improvements made to the food and drink. Where people had specific dietary requirements these were provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were supported through regular supervision and had access to training and development to ensure they had the skills and knowledge to meet people's needs. Staff felt valued and were involved in the development of the service.

People were treated with dignity and respect by staff who were kind and compassionate. People were complimentary about staff and had developed positive relationships with staff and others. We observed many kind and caring interactions where staff displayed their understanding of people's needs and

knowledge of them as individuals.

There were a range of activities taking place during the inspection and we saw people enjoying them. People were positive about the activities team and the effort made to ensure people were able to access activities that interested them.

The manager was passionate about the service and was committed to making improvements. Staff felt valued and listened to and were complimentary about the manager and the changes they had made.

There was an open culture which was promoted through the provider's vision and values. People were seen as unique individuals and the service promoted a culture of inclusiveness that valued everyone as individuals.

There were systems in place to monitor and improve the service and we saw that where issues were identified action was taken to improve. However, the systems had not identified the issues we found during the inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Care plans were not always updated to reflect changes identified through reviews of risk assessments.

Medicines were managed safely. People received their medicines as prescribed to ensure health conditions were managed.

There were effective systems in place to monitor accidents and incidents. Systems identified patterns and trends to enable prevention of further occurrences.

Is the service effective?

Good

The service was effective.

People's rights were protected and they were supported in line with the principles of the MCA.

Staff had access to training and development to ensure they had the skills and knowledge to meet people's needs.

People were positive about the food and drink. Peoples' nutritional needs were met.

Is the service caring?

Good

The service was caring

Staff were kind and compassionate.

People were treated with dignity and respect.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always up to date and did not always

reflect people's changing needs.

People enjoyed a range of activities that took account of their personal preferences.

Complaints were responded to in line with the provider's policy and to the satisfaction of the complainant.

Is the service well-led?

Requires Improvement

The service was not always well-led

Systems to monitor and improve the service were not always effective.

There was a clear vision that valued and respected people, relatives and staff.

There were systems in place to seek feedback about the service and improvements were made as a result.

St Katharine'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 13 December 2017 and was unannounced.

The inspection was carried out by three inspectors, a CQC observer and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

St Katharine's House accommodates up to 76 people in one adapted building. One area of the home specialises in providing care to people living with dementia.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

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 spoke with 22 people and five relatives. We also spoke with the registered manager, a nurse, two unit managers, five care staff and a housekeeper.

We looked at eight people's care records, five staff files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I feel safe and cared for". However, inconsistencies found in records meant we could not be sure people were always safe.

People's care plans contained risk assessments and where risks were identified there were plans in place to manage the risks. Risks included those associated with falls, mobility, pressure damage and choking. Risks were regularly reviewed and any changes identified. However, care plans were not always updated to reflect the changes in people's condition and information relating to risk was not always consistent through the care plan. For example, one person's monthly review of their handling assessment stated, "[Person] requires assistance from staff when mobilising". The person's falls risk assessment stated, "Have walking frame within arm's reach should [person] wish to walk". However, staff told us the person was no longer able to mobilise and was being cared for in bed.

Risks associated with behaviour that may be seen as challenging were identified. However, care plans did not always reflect best practice and guidance provided by health professionals. For example, one person could present with behaviour that challenged themselves and others. The person had been seen by a mental health professional. A record of the visit identified that staff should use "friendly body language" as person responded to "friendly people". The professional guidance also advised that making the person wait for support would antagonise them. The person's care plan did not contain this information and guidance for staff. During the inspection we saw the person did respond positively to staff who approached them in a friendly manner.

This was a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not feel there were always enough staff to meet their needs. Comments included: "There are not enough staff"; "The staff are absolutely stretched"; "The carers all try their very best but there just aren't enough of them" and "Sometimes there are not enough, sometimes there are enough".

Relatives told us the service used a high number of agency staff and this impacted on the time staff had to spend with people. Relative's comments included: "Often they (permanent staff) have to spend a lot of time talking to them and telling the agency staff what to do"; "There are too many agency staff here now" and "They don't always know the residents' needs".

We spoke with the home manager about the staffing levels. The manager told us that recruiting permanent staff continued to be a challenge and was an area they were trying to address.The provider employed a recruitment officer who was based at the service and was supporting the home manager with staff recruitment.

The home manager told us they made sure staffing numbers were sufficient to meet people's needs and agency staff were used to ensure these numbers were achieved. The home manager worked closely with the

agency to ensure consistent agency staff were sent to the service to minimise the impact on people. The home manager had also changed the staffing rotas to ensure an effective skill mix of permanent staff and agency staff.

We looked at staffing rotas for a six week period and we saw that agency staff were booked to ensure staffing levels were maintained.

Staff told us they felt there were enough staff. Staff comments included; "We have better staff now and manager reviews staffing levels often" and "We have enough staff to meet people's needs. We have time to engage with residents".

Through the inspection we saw people's requests for support were responded to promptly and staff had time to spend talking with people. Call bells were answered in a timely manner. People told us they were confident to use their call bells and that staff responded promptly. One person said, "If you want anything they come".

Medicines were managed safely. Medicines were stored securely and temperatures of rooms where medicines were stored were checked daily and were within safe limits.

Medicine administration records (MAR) were fully completed and included photographs of people and information relating to any identified allergies that impacted on people's medicines. Where people were prescribed 'as required' medicines (PRN) there were protocols in place identifying when the person may require the medicine.

We observed staff administering medicines. People were supported to take their medicines as prescribed. People were offered PRN medicines appropriately.

Staff who were responsible for administering medicines had completed medicines training and had their competency checked regularly to ensure they had the skills and knowledge to administer people's medicines safely.

People felt confident to raise any concerns and were comfortable to talk to staff about any worries they had. One person told us, "I can have one to one talks to the Nurse and we can talk about my anxiety".

Staff had completed safeguarding training and understood their responsibility to identify and report any concerns related to abuse. Staff comments included: "I would report abuse to senior member of staff or manager. Can also report to social services, CQC or police"; "I can whistle blow to CQC, safeguarding or doctors" and "I would report abuse to safeguarding team, CQC and manager".

Safeguarding concerns had been reported to the appropriate authority. Records showed that all concerns had been fully investigated and appropriate action taken to keep people safe from abuse.

The provider had effective systems in place to monitor accidents and incidents to identify trends and patterns. These were reviewed by the manager and the provider. Accident and incident reports identified what action had been taken at the time and on-going. Staff understood their responsibilities to report all accidents, incidents and near misses.

Staff were clear about their responsibilities to follow infection control procedures to minimise the risk of infection. One member of staff told us, "We wash hands after attending to people". Staff used personal

protective equipment when required. For example, we saw staff using disposable gloves and aprons when managing bodily fluids.

There were some areas of the home that were malodourous. However, we saw that housekeepers immediately addressed these issues by cleaning carpets and floors.

The environment was not always in a good state of repair. For example, one person's room clearly required redecoration. We spoke with the home manager who told us there was a rolling programme of redecoration. Following the inspection the home manager provided a schedule of works from the estate manager which identified when redecoration and building works were to be completed.

Equipment was regularly monitored and serviced to ensure it was safe to use. For example, hoists and weighing scales.

Good

Is the service effective?

Our findings

People's needs were assessed prior to them accessing the service. Assessments were used to develop care plans to guide staff in how to support people to achieve effective outcomes for people. Staff we spoke with knew people well and were guided by the information in people's care plans to ensure people were supported to achieve those outcomes. For example, one person's communication care plan identified the need to ensure the person had their glasses on and hearing aids in to enable effective communication for the person.

People felt that permanent staff knew them well and were well trained. One person said, "The full time carers are very good".

Staff completed training to ensure they had the skills and knowledge to carry out their roles effectively. Staff comments included; "Training is made available. I requested diabetes training and it was provided" and "I did dementia training last week on Friday. It helped me to understand a lot of things". New staff completed an induction programme that was linked to The Care Certificate. The Care Certificate is a set of standards that identifies the knowledge, skills and behaviours expected of care workers. One member of staff told us, "Induction is good. Manager is very supportive. I still have got another three weeks on my induction".

Following the inspection the manager provided training records that showed the training staff had completed and dates for planned training to ensure staff kept their knowledge up to date.

Staff felt well supported. Staff had access to regular supervisions and had an annual appraisal. Staff were confident to ask for support when needed. Staff comments included: "I feel supported. We have supervisions every three months"; "Appraisals are yearly and we discuss what has gone well and any future development" and "If I'm not sure about something I ask my senior. Sometimes, you're not sure. I tend to ask a lot of questions".

People were complimentary about the food they received and acknowledged recent improvements in the quality of the food. One person told us, "There are two good chefs now. One on, one off and they now come round and ask if we like the food".

People were involved in decisions about the menu choices. One person said, "The chefs come round and see us now and talk about what food we would like". One person told us, "I have pre-ordered my Christmas morning requirements; scrambled egg and salmon and a glass of champagne".

Care plans identified people's dietary needs on a nutrition and hydration care plan. During mealtimes we saw people supported in line with their care plans. For example, one person who required a pureed diet and full support to eat and drink was supported appropriately.

People were supported to enjoy a pleasant dining experience which encouraged social interaction between staff and people. There was a relaxed, cheerful environment and people commented on how this had

recently improved. It was clear that improvements in the food had contributed to the improved atmosphere.

Care records showed that people were supported to access additional health professionals when required. This included access to G.P's, district nurses, care home support services and speech and language therapy (SALT). One member of staff told us they were working closely with the district nurse and "sharing care with podiatry" to support a person who had a lesion on their foot.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA) which ensured their rights were upheld. 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.

Care plans identified where people lacked capacity to make decisions and where they had appointed a legal representative to act on their behalf. We saw that best interest processes had been followed to make decisions on people's behalf where they lacked capacity to make a decision.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that the home manager had made applications to the supervisory body for people who were assessed as lacking capacity to consent where restrictions were in place to ensure their care needs were met.

Staff had completed training in MCA and understood their responsibilities to support people and protect their rights. Staff comments included: "We always assume capacity in the first instance. We give them choices to make decisions even wrong ones"; "We support people in their best interest"; "We ask for consent before we do anything" and "The idea is to protect people. Never assume that they can't consent. If they can't any decision taken should be done in their best interests".

The home manager told us they were looking for ways to improve the environment for people living with dementia. During the inspection a manager from another location was present at the service and was working to improve the environment and skills of staff supporting people on the unit that supported people living with dementia. One member of staff told us, "[Manager] has given some really good guidance. It's amazing what he has achieved in a day". The home manager told us the visiting manager had rearranged the dining room which had resulted in a "more cheerful environment", added tactile items in the unit to encourage people to walk and touch the items and was developing themed corridors to provide a more dementia friendly environment.

The service had an outdoor area that people were able to enjoy when the weather was warm. One person told us, "The lovely gardens here. In the summer, us ladies sit outside, they put up a table for us and on a nice day we have our meal and supper out there".

Good

Is the service caring?

Our findings

People told us staff were kind and caring. People's comments included: "The staff here are very dedicated and very kind"; "I'm very lucky to live here"; "[Care worker] is a very good carer here. He is a regular carer here and I like him very much" and "Staff do their utmost for us".

The home manager promoted a caring culture that demonstrated the provider mission statement of "Enhance the lives of residents in our care by bringing them joy, happiness and fulfilment". For example, the home manager approached a person and welcomed them with an embrace. The home manager waved and spoke to people and staff as they walked through the service.

Staff were passionate about their roles and showed kindness and compassion when speaking about the people they supported. Staff comments included: "It's a friendly environment I would say. I feel like I'm home. You feel that warmth"; "You've got to care to be here" and "It's the small things that give me the most satisfaction".

We saw many kind and caring interactions between people and staff. For example, one person was concerned about a relative's upcoming birthday. The member of staff touched the person gently on the arm and reassured them that they had a birthday card for their relative and reminded them that they had written it together the previous day. The person was clearly reassured and smiled in response.

Staff reassured and listened to people when they showed signs of distress. For example, one person was being supported by two staff to transfer using a hoist. Staff explained what was going to happen prior to supporting the person. During the transfer the person began to call out, showing signs of distress. One member of staff immediately reassured the person in a calm voice.

People were supported to remain as independent as possible. One member of staff told us, "We encourage people who can walk to walk and support them". Staff prompted and encouraged people in a supportive manner and stepped into help where it was clear people were having difficulty. For example, one person had fallen asleep whilst eating their meal. A member of staff gently rubbed their arm to wake and encourage them to carry on eating. The member of staff supported the person to take a few mouthfuls of food and left the person when they were eating independently.

People told us they were treated with dignity and respect. We saw staff knock on doors before entering people's rooms and speaking discreetly with people when speaking with them about personal care needs. Staff understood the importance of respecting people and treating them with dignity. Staff comments included; "We respect everyone, if they request male or female carer we respect and support that" and "We respect people despite their diagnosis". People were addressed by their chosen name.

Throughout the inspection we saw that relatives were welcomed into the home and had clearly developed relationships with staff.

People's confidential information was stored securely. Care plans were kept in offices which were protected by a coded lock.

Requires Improvement

Is the service responsive?

Our findings

People's care plans included guidance for staff on how people's needs should be met. However, information in care plans was not always updated to reflect people's changing needs. For example, one person's care plan identified they had a pressure sore. There was a wound assessment chart in relation to the pressure sore. The person had a pressure mattress in place. The wound assessment chart indicated the wound had not been assessed since October 2017. Daily records showed the wound was improving. However, the assessment and care plan had not been updated to reflect the change.

Records were not always fully completed. For example, the service used a 'resident of the day' system. This meant that each day one person was identified and activities completed which included reviewing the person's care plan, deep cleaning their room and identifying any actions needed relating to their care needs and their immediate environment. However, we found that resident of the day forms were not always completed and actions not identified.

Care plans included information relating to people's social preferences. However, these were not always fully completed.

This was a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people's care plans included a document named "Knowing Me". Where these documents were completed they contained detailed information about people's social interests and how they enjoyed spending their time. This information was used to develop an activity programme that

People were positive about the activities arranged at the service. People's comments included: "There is the most wonderful team on the social side"; "We do quizzes, bingo and have sing-alongs" and "I think there are five activities people and they all work pretty hard". People were able to enjoy trips out. One person told us, "The trip to (garden centre) was enjoyed, we went last Tuesday".

During the inspection we saw people decorating a Christmas tree. People were engaged in the activity and were encouraged and supported to participate in the activity. In the afternoon there was a carol service in the on-site chapel. The service was well attended by people and relatives.

Some people's care plans included a document named "Knowing Me". Where these documents were completed they contained detailed information about people's social interests and how they enjoyed spending their time. This information was used to develop an activity programme that met people's social needs. There were detailed records of all activities people had attended and whether they had participated in and enjoyed the activity. Where people preferred one to one company they were supported in their rooms by activities staff. Records showed people enjoyed reminiscing, talking about their interests and participating in activities which included arts and crafts.

People's personal preferences were identified and respected. For example, one person did not enjoy Christmas and did not want a Christmas tree in their room; another person loved Christmas and asked for two Christmas trees. Both people's requests had been respected.

People were encouraged to be involved in running events organised in the home. One person told us, "We were allowed to run a tombola stall at the Home's Summer Fete/Bazaar. We took £235. (Activities Lady) was so on the ball to allow us".

People were supported to maintain and develop meaningful relationships. One small group of people enjoyed eating lunch together and the service had arranged for them to eat together in a small dining area. During the inspection we saw them spending time together and clearly enjoying their conversation and the whole dining experience.

Staff had completed training in equality and diversity and understood their responsibilities to treat people as individuals and protect their rights. Staff comment's included: "We do what's right by the individual person"; "We accept people from different cultures and of different genders. We treat them equally with respect" and "We treat people equally despite their gender, nationality or religion". One member of staff told us how they supported a person to meet their religious needs by ensuring they were ready for church on a Sunday when their friend came to collect them.

Staff knew people well and had developed caring relationships with them. One member of staff told us, "We get to know people and their likes and dislikes". Staff understood people's communication needs and took time to explain to people in a way they understood. For example, one person could become anxious about their family visiting. The person had a calendar with the days of their relatives visits identified. Staff sat with the person looking at the calendar and explaining what day it was and when they family member would be visiting. This reassured the person.

People felt confident to raise concerns and felt any issues were dealt with in a timely manner. One person told us, "If I'm not happy they'll always do something for me". Staff understood how to support people to make a complaint. One member of staff told us, "I can help a resident to make of complaint if they need me to".

The provider had a complaint policy in place and this was displayed in the home. Complaints records showed that the manager had investigated all complaints and resolved them to the satisfaction of the complainants.

Care records included people's end of life wishes where they wished to discuss this area of their care. For example, one person's care plan identified the person was "approaching the end of his life". The person's end of life care plan stated the aim was "To maintain the person's comfort and safety during the final stages of his life". We spoke with the person who told us they were comfortable.

The person had been seen recently by the GP and records showed the outcome of the GP visit. The person had anticipatory medicine for pain relief available but this had not yet been needed.

The person's family were involved in developing the plan which included the person's end of life wishes. A funeral plan was in place.

Staff showed compassion and understanding when speaking about supporting people at the end of their life. One member of staff said, "During end of life we support the person and the family. We respect the

person's end of life wishes".

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager in post. The home manager told us they would be submitting an application to register with Care Quality Commission (CQC). The home manager was supported by an operations manager. The service did not have a deputy manager in post. However, the home manager told us a deputy manager had been recruited and was due to commence employment in early 2018. The home manager recognised the absence of a deputy manager had an impact on the management of the service and had meant they had not made as much progress in implementing the improvements they wanted to make.

There was a range of audit systems in place which included audits completed by the home manager, the operations manager and an external consultancy service. Audits showed that where issues had been identified action had been taken to address the issues. For example, the home manager had completed a hand hygiene audit and identified that not all staff were following the provider's policy in relation to the wearing of jewellery. This was discussed with staff and the guidance was now being followed. However, the audits had not identified the issues we found during the inspection in relation to the accuracy of care records.

The provider had an effective system in place to monitor incidents, accidents, safeguarding and complaints. This ensured learning was used to improve the service at a local level and as an organisation.

The home manager spoke passionately about the service and the improvements they had made and those they planned to make. This included the on-going improvements to the unit supporting people living with dementia. The home manager had made positive changes to the staff rota system to ensure there was a suitable skill mix that took account of the high use of agency staff.

The home manager had recognised there were not always clear lines of leadership and accountability in relation to the day to day management of some units where there was no qualified nurse on duty. With the support of the manager from another home, senior staff were being supported to understand the importance of clear leadership. One senior member of staff told us, "We've had some good guidance. We're now going to have an allocation sheet each morning".

People and relatives knew the home manager and felt improvements were being made and that they were listened to. For example, one person told us that concerns had been raised in relation to lack of access to call bells when people were outside or in communal areas with no staff present. The home manager had purchased mobile alarm buttons which enabled people to call for assistance when needed.

There were regular meetings for people and their relatives which were well attended. People were aware of the meetings and attended if that was their choice. One person told us, "I know too there is a residents' meeting this evening and my children go to it and make their own notes". Records of meetings showed people and relatives were involved in decisions about the home and were listened to. For example, a suggestion had been made to have pictorial menus available. We saw these were now available in dining

areas.

Staff were positive about the home manager. Staff comments included: "Manager is available and very supportive. She has an open door policy"; "I have a lot of support. I can go to manager and discuss any issues"; "We've got a very open relationship. They're very accommodating" and "Manager is a strong person and a very good leader".

Staff felt valued and listened to. One member of staff told us, "They [provider] listened when we asked for wages to be reviewed". Another member of staff said, "We have staff meetings and I can always speak out". Records of staff meetings showed that staff were involved in the development of the service. For example, staff were involved in discussions about the changes to the rota system.

The provider had a clear vision and strategy which was recognised and valued by staff working in the service. One member of staff told us, "This is an open and honest organisation. We can voice our concerns".

The service worked closely with other agencies. This included the Care Home Support Service, the Commissioners of the service and local GP's to support care provision.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user. Care records were not always up to date and did not always reflect changes in people's condition.