Wellburn Care Homes Limited

St Catherine's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Catherine's Care Home was providing personal and nursing care to 37 people, some of who were living with dementia. The service can support up to 55 people.

People's experience of using this service and what we found
People had received or were at risk of receiving poor quality and unsafe care. Their health and wellbeing were not always monitored to ensure action was taken if they required additional support, for example; where they had not received enough to drink. Staff did not always follow the systems the provider had in place to protect people from avoidable harm. For example, the medicines management system.

Staff had not been trained in specialist areas to help them support people living with dementia who may become distressed. Staff intervened the majority of the time with kindness and compassion. However, due to lack of knowledge and confidence they may at times of high anxiety be at risk of treating people in an unprofessional or ineffective way.

The amount of staff on duty provided people with safety, but they did not receive care and support in a timely way. People felt rushed at times and also had to wait for support. Immediate action was taken to increase staff in the evenings. The provider completed a full review and following recruitment of new staff an increase in staff will occur.

Where incidents had occurred, people in distress or errors with medicines, there were no reviews to understand if any lessons could be learnt to prevent a reoccurrence.

The provider had a system to check the quality and safety of the service which had not effectively highlighted all of the areas for improvement.

The provider and registered manager displayed a commitment to improving the experience of people who used the service. They had an action plan to develop the staff through training and support, introduce better systems to ensure safety and quality and also develop a positive culture and morale of the team.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 23 February 2018).

Why we inspected
We received concerns in relation to the management of people's nutrition and hydration, safe moving and handling, staffing levels and support to people who exhibit distressed behaviour. As a result, we undertook a focused inspection to review the Key Questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The provider responded positively to our feedback and has already started to make improvements to the service.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Catherine's Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the safe care and treatment and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

St Catherine's Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors carried out this inspection. On day one of the inspection two local authority workers supported the inspection by observing the care people received and talking to people about their experiences. They also looked at people's care records. The evidence they gathered has been used to make our judgements at this inspection.

Service and service type
St Catherine's Care Home 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Day one of the inspection was unannounced. We told the provider we would be visiting on day two.

What we did before the inspection
We reviewed all the information we had received from the provider and local authority since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with 11 members of staff including the registered manager, deputy manager, nurses, care co-ordinator, care workers and agency care workers. We spoke with the nominated individual and area manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and multiple medication and care monitoring records. We looked at four staff files in relation to recruitment, induction and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider around the evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• People's health and wellbeing were not monitored effectively, and they could become unwell because of this. For example; not all people at risk of dehydration had monitoring in place. Where people did have monitoring in place the records were not reviewed to understand if people had received sufficient amounts of drinks. Staff handover records did not contain a full status of people's health and wellbeing to enable the next shift to monitor people effectively.
• Where people were at risk of falling, care plans did not contain details of how to support them safely from the floor if they had fallen. We saw one member of staff lift a person inappropriately as they started to fall, which could have caused harm to them.
• People were at risk of receiving inappropriate care from staff when they were distressed. The provider did not provide robust training to staff to help them understand and support people who may become distressed. At times staff needed to hold people to enable them to care for their needs. Care plans did not contain details of how to intervene physically or with medicines in a professional way.
• Staff had not all taken part in simulated fire evacuations to ensure they knew what to do in an emergency.
• Not all incidents of challenging behaviour and medicines errors were recorded and reviewed to ensure lessons could be learnt to prevent a reoccurrence.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• We were unable to determine the reasons why people were or had not been administered 'as and when required' medicines. People took such medicines to prevent constipation, to relieve anxiety or pain. Staff did not always have robust protocols to help them know when to administer such medicines. When medicines had been given it was sometimes unclear as to why.
• People living with dementia may have their medicines hidden in food or drinks at times because refusal to take them could be life threatening. The provider had failed to ensure this was approved by the GP and pharmacist to ensure it was in the person's best interests.
• We were unable to determine if people had received their medicines as prescribed on some occasions because the amount of medicine believed to be in stock was not the amount we counted. Staff had not always signed the medication administration record to say they had supported people to take their medicines. The errors we found had not been highlighted through the provider audit system. They had also

not been reported as errors, so the registered manager could investigate them properly.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People did not always receive care in a timely way. People told us they had to wait for support and at times this was rushed. Staff felt that more staff were required so they did not have to rush to provide support for people. A relative had raised concerns about staffing via the provider's complaints process to say they observed staff were not able to cope with people's needs.
• The provider used a tool to understand people's needs and the number of staff that were required to meet them. This showed staffing levels were safe. However, the tool did not take into consideration people's nursing needs or those related to people living with dementia.
• The provider listened to our feedback and instigated a full review of staffing at the service. This has involved talking to staff about their daily workload. An immediate change was made to ensure people were supported to bed in a timely way. Further changes will be implemented following recruitment of new staff.
• The provider had a safe recruitment process, but this was not always properly followed. For example; references were not always sought from staff's previous employer and gaps in staff work history had not always been explored and recorded. The registered manager understood the policy and agreed to improve records around staff recruitment.
• The provider was using agency staff to cover staff absence and vacancies. Agency profiles did not contain all the information required to ensure the agency had recruited them safely or that workers had the right skills and training.

Systems and processes to safeguard people from the risk of abuse
• People were at times not safeguarded from harm or abuse. The provider had not ensured all staff had up to date training around safeguarding people from abuse or how to deal with people's distress. Staff historically had not always recognised or reported incidents in the service to managers.
• The provider and registered manager had reflected on the situation and had an action plan to improve training and awareness of how to raise concerns to them or other agencies such as the CQC. They had also arranged sessions where staff could come and talk with the registered manager or provider to discuss any concerns they had.
• People and their relatives supported at the time of the inspection felt the service was safe. One person told us, "I am happy with the care I receive 100%." Another person said, "I feel safe and happy here, staff can't do enough to help me."

Preventing and controlling infection
• Staff understood their responsibilities to prevent and control infection. They had access to supplies of personal protective equipment.
• The service was clean and free from unpleasant odours.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager and provider had completed checks of the service to assess safety and quality. Some of things we have highlighted had been noted such as medicine errors and poor training compliance. However, no robust action plan was developed and followed to ensure improvements were made and monitored.
- The provider had not always picked up on concerns we found because their audits did not include checks on certain areas; for example, staffing levels and authorisation for medicines people have hidden in their food or drink.
- The provider had received feedback about staffing levels from complaints, via staff meetings and from the registered manager but had failed to act on this to improve the service.
- The provider had not established systems and processes to effectively deliver a nurse led service. Nurses had no clinical supervision or clinical procedures to follow and ensure professional practice. They were also not supported with a clinical training programme.
- At our last inspection we highlighted the systems around monitoring people's hydration, 'as and when required medicines' and clinical care plans, were not robust. People remained at risk because of the same issues at this inspection.

Systems were either not in place or robust enough to demonstrate safety and quality was effectively managed. This placed people at risk of harm and at risk of receiving a poor-quality service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager and provider displayed a genuine motivation to improve people's experience of using the service. They responded quickly to feedback and implemented immediate change to drive improvement.
- The registered manager and staff showed genuine concern for people's welfare and understood people's preferences. Lots of positive work was being carried out to improve people's lives in a person-centred way.

• The registered manager was very open during inspection and understood their legal responsibilities. The provider has worked alongside the registered manager to embed their values, develop a positive culture and to improve morale. People, relatives and staff felt they were able to see improvements since the registered manager had started. One person we spoke with said, "I think the service is run well and the staff are polite."

Working in partnership with others
• The registered manager had started to develop links with other agencies to support improvements at the service. The provider and registered manager were keen to work with other agencies. Better working relationships with the GP had already been reported.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: People's needs were not fully assessed and all that was reasonably practicable had not been done to keep people safe and prevent them from harm. This included specialist training for staff on management of behaviours which may challenge and medicines. Regulation 12 (2) (a) (b) (c) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The providers governance systems did not effectively assess safety and quality in the service. Feedback received was not used to continuously improve the service. Contemporaneous records were not always kept in respect of the care people received. Regulation 17 (1) (2) (a) (b) (c) (e) (f)