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Catherine House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Catherine House is a small home for five adults with a learning disability. The home is situated near a main road close to Taunton town centre. At the time of the inspection there were three people living there on a permanent basis and one person receiving a regular respite service.

The provider is also the registered manager of the service. There was a manager who had the responsibility of the day to day running of the service, and who was available on the day of the inspection. The registered manager joined the inspection at a later stage in the day.

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.

At the last inspection in November 2014, the service was rated Good. At this inspection people and relatives told us they felt safe however we found areas that required improvement. For example, although medicines were safely administered and stored by staff who had received specific training and supervision to carry out the tasks, we found when medication errors occurred the outcomes of investigations had not always been recorded. The registered manager reviewed their policy following the inspection.

Care plans contained risk assessments. However some risk assessments did not identify ways of supporting people to remain as independent as possible within the home and their local community.

People who lived at the home were able to make decisions about what care or treatment they received. However we found they had not been fully consulted about restrictions relating to access to areas of their home, staff were able to demonstrate knowledge and understanding about their responsibilities to follow the principles of the Mental Capacity Act (MCA) when making decisions for people in their best interests.

We recommend the least restrictive option is reviewed and discussions held with individual people regarding the management of the risks in regards the least restrictive practice.

People were supported by sufficient numbers of staff who had a clear knowledge and understanding of their personal needs, likes and dislikes. Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their needs and individual wishes. People living at Catherine House told us they were happy with the care and support provided.

People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. In addition to completing induction training new staff had opportunities to shadow more experienced staff. This enabled them to get to know people and how they liked to be cared for. People told us they felt safe at the home and with the staff who supported them.

People accessed various activities in the local community. People were supported to maintain contact with the important people in their lives. A relative told us, "The staff all seem nice and have a chat when we visit". People confirmed they received visits from family and friends.

The service had a complaints policy and procedure which was available for people and visitors to view. People said they were aware of the procedure and knew who they could talk with. People and staff said they felt confident they could raise concerns with the registered manager and they would be dealt with appropriately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who received appropriate checks to ensure they were suitable to work with vulnerable people.

There were adequate numbers of staff to make sure people received care at a time which met their needs and wishes.

People received their medicines when they needed them from staff who were competent to administer them.

Is the service effective?

Requires Improvement

The service was not consistently effective

People received care from staff who did not always fully understand or demonstrate practices required to support people to remain as independent as possible.

People received a diet in line with their needs and wishes.

People had access to appropriate healthcare professionals to make sure they received the care and treatment they required in a timely way.

Is the service caring?

Good

The service was caring.

People were cared for by kind and caring staff who helped to promote their well-being.

People were treated with respect and dignity.

People, had information in a way they understood.

Is the service responsive?

Good

The service was responsive.

People's care and support was responsive to their needs and

personalised to their likes and dislikes.

People were supported to attend meaningful activities which enabled people to maintain links with the local community.

People knew how to make a complaint and said they would be comfortable to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's quality assurance system had not operated effectively in identifying and making changes to address areas for improvement.

There were systems in place to monitor the quality of the service and seek people's views

People and staff were supported by a registered manager who was approachable.

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 checked 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 31 March 2017and was unannounced. It was carried out by an adult social care inspector.

The provider completed a Provider Information Return (PIR) which asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service.

During the inspection we met with the registered manager and manager. We also spoke with three people, who lived at the home and four members of staff. Following the inspection we spoke with one health professional, four relatives, and one further member of staff.

In addition to speaking with people, we looked at documentation relating to four people who used the service, four staff recruitment and training records and records relating to the management of the service.

Good

Is the service safe?

Our findings

The service continues to provide safe care. People told us they felt safe at the home and with the staff who supported them. One person said "Yes" when asked if they were safe, another person told us, "They [staff] make sure I stay safe when I am out and about". Relatives we spoke with all felt their family members were safely supported at Catherine House.

Although medicines were safely administered by staff who had received specific training and supervision to carry out the tasks, we found when medication errors occurred the outcomes of investigations had not always been recorded. For example following a tablet being 'lost' there were no records of the investigation undertaken by the registered manager. When we discussed our concerns with the manager, they informed us although they had held an internal investigation they had not made any formal record of the investigation with staff. This meant we were unable to check any action taken to prevent further incidents. Following the inspection the registered manager amended their process and informed us all staff would receive refresher training on medicines, and action to be taken in regards medication errors.

There were suitable storage facilities for medicines. Medication administration records (MAR sheets) were accurate. The MAR sheets were legible, a photograph of the person was on the front sheet to aid identification, and allergies were clearly recorded. Up to date staff signatures and initials were attached to the MAR. Clear records showed when medicines had been administered or refused. People confirmed they were happy with the support they received, and that they received their medicines when they were supposed to.

People's care plans included detailed risk assessments relating to specific aspects of their care for example risk of falls, medicines and health conditions. These documents were individualised and provided staff with a clear description of identified risk and specific guidance on how people should be supported in relation to the identified risk. However, staff felt some risks were not being addressed by managers. For example, whilst people were being supported in the community staff felt people were at risk due to there not being additional staff available to support chosen activities. One staff member told us, "We used to support some people on a one to one to the [chosen activity], now we are one staff to two. I worry about the risk. I'm not sure this is manageable".

We discussed the issue of the risk with the manager who told us "The people involved know they need to stay together with the staff member at all times". This meant risk management processes were not being safely used to maximise people's independence at all times. The manager told us following our discussions with staff they would readdress the issues regarding risk that staff had discussed. They told us they were aware of the concerns and were monitoring the situation whilst safeguarding investigations took place.

There were sufficient numbers of staff to keep people safe and make sure their needs were met. Throughout the inspection we saw staff met people's individual needs. One person told us, "I always get help when I want it". Staff told us they felt there were enough staff within the home. Rota identified which staff member was supporting people to their daily activities. We looked at rota over a four week period and found them to

be consistent with identified support for people. Sleeping in cover was arranged on the rota and people told us they knew staff were available at night.

Risks of abuse to people were minimised because there were effective recruitment processes for all new staff. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Staff had been trained how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected. Relatives confirmed they felt their family members were safe living at Catherine House.

Where accidents or incidents had occurred these had been appropriately documented and investigated. Risks to people, visitors and staff were reduced because there were regular maintenance checks on equipment used in the home. There was an emergency plan in place to appropriately support people if the home needed to be evacuated. Personal emergency evacuation plans (PEEP's) had been prepared, and were held in people's care plans. This meant in the event of an incident the emergency service would be able to support people safely.

Requires Improvement

Is the service effective?

Our findings

At the last inspection this key question was rated good. However, at this inspection we found. Improvements were needed. Although people continued to receive effective care and support from staff who had the skills and knowledge to meet their needs. Some practices in the home needed to be reviewed in line with current good practice in regards consent and control.

Although people were able to move freely around most of the home, there were areas where people movements were restricted by a key pad system. For example, all people living at the home were unable to access the kitchen without the presence of staff support. We also found people were unable to leave the home without the assistance of staff to open the front door by way of a key fob. We asked one person how they felt about not being able to independently access the kitchen, they told us, "Staff let me in when I want to go in". One member of staff told us the kitchen door was locked, "As some people may hurt themselves with the kettle or knives". There were no risks assessments in place to demonstrate these specific risks, or evidence of previous incidents relating to these risks. Some relatives were unsure why their family member would not be able to access the kitchen area freely. One relative told us, "Yes [person's name] used to be able to make a cup of tea and a snack, I am not sure if they would still be able to do this". Most people had previously lived in homes where they had access to kitchens. Another relative told us, "[person's name] has always been able to access a kitchen, I don't understand why the door is locked they have never come to any harm in the past". There was no evidence that people had agreed to the doors being locked and the reasons for this. This meant people did not have choice and control in all aspects of their day to day living, and had the potential to lose independent living skills.

We addressed our concerns with the registered manager and the manager who also felt some people would be at risk of harm if the kitchen door was left open, they told us. "The door is locked when staff are busy to ensure people remain safe. Staff are normally in the vicinity of the kitchen so the door is usually unlocked." They told us the front door was locked, to keep people safe due a "Busy road" outside the home. There were no agreements about restrictions in people's care records. We observed access to the kitchen was restricted throughout the day of the inspection including when staff and people were using the kitchen.

We recommend the least restrictive option is reviewed and discussions held with individual people regarding the management of the risks in regards the least restrictive practice.

People were able to make their own decisions as long as they were given the right information, in the right way and time to decide. Staff sought people's consent before they assisted them. Staff had received training about the Mental Capacity Act 2005 (MCA). 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 received care from staff who had the skills, knowledge and understanding needed to carry out their

roles. New staff completed an induction programme which gave them the skills to care for people safely. The induction required new care workers to be supervised by more experienced members of staff to ensure they were safe and competent to carry out their roles before working alone. The manager told us, "All new staff have a training schedule which I sign off, they are not allowed to lone work or give out medication until I have deemed them competent."

Staff received on going training and had opportunities to complete nationally recognised qualifications in care and on going training in specific topics relevant to the people who used the service. One member of staff told us, "Training is good and makes us aware of good practice". They gave an example of knowing how to support someone with a particular health condition. Staff files showed staff had completed training in health and safety issues such as manual handling and safeguarding vulnerable adults and Mental Capacity Act, (MCA) and also in subjects relevant to the people they were supporting.

Staff understood their roles and responsibilities and had regular supervision (one to one meetings with line managers). The manager told us that appraisals were now due and plans in place to complete. Staff told us the registered manager and manager were approachable and there was good communication within the home.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. People were complimentary about the food served in the home and said there was always a choice of meals. Although people were able to discuss their likes and dislikes around menu planning, a member of staff told us the shopping was done by another member of staff with out the involvement of people who lived at the home. People were able to help prepare their meals with the support of staff. One person told us, "I like to make cakes." People told us if they wanted anything to eat they "Just asked the staff" who helped them to make it.

People could see health care professionals when they needed to. Records demonstrated people attended appointments such as doctors, dentists and other health professionals. Staff said they knew who to call if they need to speak with other professionals involved in people's support. Records demonstrated where people's needs had changed the appropriate referrals to health professionals had been made. For example a referral had been recently made to health services following a change in a person's mobility.

Good

Is the service caring?

Our findings

The home continues to provide a caring service to people. Staff interactions were warm, and respectful, and laughter and playful dialogue was witnessed throughout the day. The atmosphere in the home was calm, unhurried and caring. One person told us, "The staff are kind in here". One relative told us, "The staff all seem nice and have a chat when we visit". One professional told us, "Lovely staff very caring".

Each person was allocated a keyworker. The keyworkers held the responsibility of ensuring the person had opportunities to discuss their needs and wishes. Care plans included reviews were people had been involved in discussing their care needs. Staff told us sometimes it is difficult to get people to go out one member of staff said, "We do try to get people out as much as we can, we look at area that interest people such as bowling, or going to the theatre. Of course if we had more staff we could do so much more".

Staff respected people's privacy. All rooms at the home were for single occupancy. People could spend time in the privacy of their own room if they wanted to. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people feel at home. Some people had key pads on their doors, but were seen to be able to access the rooms independently. One person told us when we asked about the lock, "That is so only I can go in my room, I don't like people going into the room if it is in a mess". Staff knocked on doors and waited for a response before entering.

People were treated with dignity and respect. We observed staff spoke to people in a polite and caring manner. 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. People told us they liked their home and were proud to show us around. One relative told us, "We are happy with the support [person's name] receives".

Where needed, people had access to walking frames and wheelchairs. One person told us they needed the support of a mobility aid they said, "The staff know I don't like it [mobility aid] but always remind me to take it." Additional aids were seen around the home to support people independence, for example grab rails on the stairs. The home was light and there were different areas people could choose to spend time, either alone or with their visitors. People were given information and explanations in a format that best suited their needs. For example information in the kitchen area had picture prompts in regards some instructions or guidance. One relative told us, " I know [relative's name] is happy, the staff make sure information is shared in a way [relative] understands". Another relative told us, "We can call anytime". This meant people were able to have visitors when they wished.

The home was well maintained light and airy. People were seen relaxing in lounge areas, one person told us, "I like sitting here, I have a big television and can watch what I like". They told us they liked to watch their football and supported the same team as members of staff, they said "We watch the match together, I like that". Another person told us they liked their home and the people they lived with they said, "I like living with [person's name] sometimes we go to the disco together".

Good

Is the service responsive?

Our findings

The service continues to be responsive. People received care and support which was responsive to their needs and respected their individuality. The registered manager told us each person had their needs assessed before they moved to the home and from these assessments they created person centred care plans.

Care records were up to date and accurate. There were detailed larger care plans, with small care plans where daily records were written. Each care plan had quick reference guides providing an overview of each person's care needs and preferences likes and dislikes. Records were comprehensive and had been reviewed on a regular basis. Separate daily records of the care and support, weight monitoring records were also being kept up to date. Communication books were used to keep staff up to date of any changes within the home or with people using the service.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis. Some people said they had seen their care plan whilst others indicated they knew they had one but had not seen it. One person said, "Yes I talk about what I like and don't like." Each person was allocated a keyworker. The keyworkers held the responsibility of ensuring the person had opportunities to discuss their needs and wishes. Care plans included records of reviews where people had been involved in discussing their care needs.

People had a variety of interest and day activities. Rotas showed which staff member would be supporting which individual to their chosen activities. On the day of the inspection people were reminded to be ready in time to be escorted to their daily activity. People told us they also enjoyed going out in the evening to social clubs. Transport was available to support people to their daily activities.

People told us they could see their relatives when they wanted. Relatives confirmed they were able to visit when they wished. People and their relatives were aware of how to make a complaint or who to complain to if they were unhappy. The manager told us, "My door is always open, we have an open door policy." One relative told us, "I can talk with the manager anytime, they are around often when we visit".

Each person received a copy of the complaints policy when they moved into the home. Although people didn't have any complaints about the quality of care they received, they were aware of how to make complaints. People told us they would raise any issues or complaints with staff. Relatives were aware of the complaints process. One relative told us, "I have never had to complain but I would if I needed to. I am sure the manager would respond". Records showed where a complaint had been raised with the manager this had been acknowledged and responded to within the time scale of the complaints policy. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The provider sought people's feedback and took action to address issues raised. Any issues raised from the feedback questionnaires were dealt with and people and relatives informed of the issue raised and action

taken. Relatives told us they received annual feedback surveys. One relative told us, "I know I get them, but to be honest I am not always good at returning them". People living at the home had an opportunity to discuss any issues or choices at their residents meeting. The manager told us minutes of meetings were available for all to see. Staff confirmed they had regular staff meetings and were able to contribute to the agenda.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection this key question was rated good. However, at this inspection we found. Improvements were needed. The provider had a quality assurance system but this had not operated effectively in identifying and making appropriate changes to address the areas that required improvement we found during our inspection.

Although the registered manager and manager were in regular contact, systems and processes were not in place which showed how their audit and governance systems remained effective. For example, although people were able to consent to restrictions on their movements, restrictive practices were not being reviewed to ensure they were the least restrictive for each individual. This meant risk assessments were not being effectively used to maximise people's independence in line with individual risks.

Some improvements were also needed to make sure the manager was fully supported in their role. Most staff received regular supervision with a more senior member of staff. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. However there was no formal supervision for the manager or another member of staff, and therefore no way for them to have their concerns or training needs recorded and acted upon. The manager told us they were unsure who held the responsibility of managing the other member of staff. We discussed this with the registered manager who said that although they met regularly with the manager these meetings were not recorded. The registered manager told us they would address these issues.

There was a divided culture within the staff team. Some members of staff felt they "Worked well as a team", others felt they "Did not promote people's independence as they should". One staff member told us, "We generally like each other as a team, but we are very poor on supporting people to be as independent as possible". Another staff member told us, "We speak with the management about risks and updating the risks." A third member of staff told us, "The manager and [staff member's name] are a good source of support, always at the end of the phone if we need them". The manager told us, "We are a small home and small team; we have good links with other professionals in the area". The registered manager told us they were regularly in the home, although the manager oversaw the day to day management of the home. We spoke with relatives who seemed unsure of the roles of the management team and who held the lead responsibility. We advised the registered manager to clarify staff roles to ensure people were aware of the management structure.

Staff we spoke with told us they felt supported in their role, and that they felt confident to raise issues with a member of the registered manager and manager. A daily communication book was used by staff to record any information the next member of staff on duty needed to be aware of.

Staff we spoke with knew about the whistleblowing policy, and were confident to raise concerns. Whistleblowing is the process for raising concerns about poor practice. Staff told us, "I would always report any concerns I had to the manager". Staff meetings showed a wide range of topics had been covered in the

meetings including training needs, staff protocols and practice.

The registered manager told us their statement of purpose "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". Staff were aware of the aims of the service but were divided in how they thought the aims were being met. For example some staff felt people could be supported to be more independent.

All accidents and incidents which occurred in the home had been recorded. There had been no major accidents or incidents, since the last inspection. The records of each incident had been clearly recorded, and showed that each incident had been taken seriously, investigated, and actions taken to prevent recurrence, even where these were minor in nature.

The registered manager knew and understood the requirements for notifying us of all incidents of concern and safeguarding alerts as is required within the law and we saw that these had been reported appropriately.