ADR Care Homes Limited

St Catherines 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 7, 8 and 11 June 2018 and was unannounced. At the last inspection in January 2016 the service was rated 'Good'. However, at this inspection we found that the provider was not meeting all the regulations that we inspected.

St Catherines 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 Catherines House accommodates 16 people in one adapted building. At the time of this inspection there were 15 people living at the home.

There was a registered manager in post at the time of this inspection. 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 provider and registered manager carried out several audits and checks to monitor the quality of the service. However, we found that these audits failed to identify any of the issues that we identified as part of this inspection. Where issues were found, there was no record or action plan in place stating how the issues were to be addressed or resolved and by when.

Certain aspects of medicines management and administration was not safe. We found numerous omissions in recording, issues with the storage of controlled drugs, lack of 'as and when required' medicine protocols and incomplete paperwork confirming the safe and appropriate administration of covert medicines.

We found issues relating to the health and safety of people in relation to the fabric and condition of the home. Radiator covers were broken and not securely fixed to the wall, wardrobes were not stable and were leaning to one side and not safely secured to the wall. Although the provider addressed these issues during the inspection, the provider's lack of awareness of these issues placed people at risk of harm.

Infection control processes were not in place to prevent cross contamination. Red bags were not available to care staff in order to safely clean soiled clothing and linen.

Staffing levels were not sufficient to safely meet people's needs. Throughout the three days of the inspection we observed numerous times where the main lounge was left unattended. This was because care staff had to either support people who remained in their bedrooms or where other daily tasks such as laundry, cooking or cleaning had to be undertaken.

Care plans did not always contain appropriate documentation confirming people's consent to care. Where people had been assessed as lacking capacity we saw documents confirming they had signed consent to the care and support that they received. Where people had capacity, they had not been asked to consent to

their care.

People ate well. People and relatives confirmed that they and their relative enjoyed the food that was presented to them. However, people were not always offered a choice of meal. Menus were not displayed and alternative meal options were not always available. Drinks were available to people throughout the day, however, we did not always see the availability of snacks including fresh fruit and biscuits for people.

The home monitored every person's food and fluid intake to ensure people were eating and drinking sufficiently. However, the charts were just a formal record of what the person had eaten or drank. Amounts of fluid intake were not recorded and totalled to determine whether a person's fluid intake was sufficient over a 24-hour period.

People's individual needs were not always met by the adaptation, design and decoration of the home. The home had not been decorated and designed in a way which supported people living with dementia.

People and relatives all told us that there was very little provision of activities taking place within the home. Throughout the inspection we observed very little taking place in relation to activities and stimulation.

Results of satisfaction surveys initiated by the provider and completed by people and relatives was not shared with the registered manager and the service. Therefore, the service was unable to learn or implement improvements in response to the contents of the survey.

People and relatives told us that they felt safe living at St Catherines House. Processes and systems in place protected people from the risk of abuse or harm.

Care plans identified risks associated with people's health and social care needs and gave guidance to care staff on how to reduce or mitigate known risk to keep people safe and free from harm.

People were supported to have maximum choice and control in their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Care staff were clearly able to explain their understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and how this impacted on the care and support that they delivered.

Records confirmed and care staff told us that they all received an induction when they began their employment at the service followed by regular training and refresher training. Care staff also confirmed that they were regularly supported through supervision and appraisals.

We observed people had developed positive and caring relationships with the care staff that supported them. People were treated with dignity and respect.

We observed care staff involving people in all day to day decisions and responding to people's individual requests. People and relatives confirmed that they had been involved in the planning of their care.

Care plans were detailed, person centred and listed people's likes, dislikes and their wishes on how they wanted to receive their care and support.

The registered manager confirmed that the service had not received any complaints since the last inspection. The providers complaints policy detailed the steps that should be taken if people, relatives or visitors had any issues or concerns to raise.

People, relatives, care staff and visiting professionals were highly complementary of the registered manager. They found them to be very approachable, hands on and very caring.

At this inspection we found breaches of Regulation 9, 11, 12, 17 and 18 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. Medicines management and administration was not always safe.

Health, safety and infection control concerns in relation to the fabric and condition of the home placed people at the risk of harm.

Staffing levels were not set at sufficient levels to safely meet people's needs. People were left unattended at various times throughout the day.

Care staff knew of safeguarding people from abuse and the actions they would take to report any noted concerns.

People's individual risks related to their health and support needs were assessed appropriately. Information for staff on how to reduce or mitigate those risks was provided to keep people safe and free from harm.

Appropriate recruitment processes were in place that ensured the recruitment of staff assessed as safe to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective. Care staff understood the principles of the Mental Capacity Act 2005 (MCA) and how these were to be put into practice when supporting people. However, care plans did not always confirm that consent to care had been obtained or reviewed with people or where appropriate, with their relatives.

Best interests decisions relating to the covert administration of medicines had not been clearly documented and authorised.

People were supported with their nutrition and hydration needs. However, people were not always given a choice and alternative options of available meals. Food and fluid charts were not effectively completed which monitored people's fluid intake so that action could be taken where low intake had been noted.

People's individual needs were not always met by the adaptation, design and decoration of the home.

Pre-admission assessments and review of care plans had been completed to ensure people's needs and choices were considered and reviewed to ensure the provision of appropriate care and support.

Care staff received regular training and support which included regular supervisions and annual appraisals.

Is the service caring?

Good

The service was caring. We observed care staff supporting people with dignity and respect. Care staff knew people well and demonstrated a good understanding of how people were to be supported.

We observed care staff involving people in day to day decisions about their care and support needs where appropriate.

People and relatives confirmed that care staff were kind and caring and where possible supported them and their relative to maintain their independence as far as practicably possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. People and relatives told us that there very little activity provision. We observed that people lacked stimulation and interaction.

Care plans were detailed, person centred and gave information about people's likes, dislikes and how the wished to be care for. Care plans were reviewed on a regular basis. People and relatives confirmed that they had been involved in the care planning process.

Advance care plans had been completed for people which provided information to the service about people's end of life wishes and preferences.

People and relatives knew who to complain to if they had any concerns or issues to raise.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider and registered manager completed audits and checks to monitor the quality of the service. However, we found that these audits failed to identify

any of the issues that we identified as part of this inspection. Where issues were identified there was no detail available on when and how these issues would be addressed.

Feedback from completed satisfaction surveys was only available to the provider. Outcomes and actions had not been communicated to the registered manager. Therefore, learning or improvements resulting from the survey could not be implemented.

Recent fire safety and food safety inspections had identified issues which needed to be addressed. We found that the provider had not addressed all of the identified issues by the stated deadline but showed us evidence that they were working towards addressing these.

People and relatives were complementary of the registered manager who they found to be approachable and caring.

Care staff told us they felt supported by the registered manager through regular supervisions and staff meetings.

St Catherines 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 7, 8 and 11 June 2018 and was unannounced. The inspection team consisted of one inspector and two experts by experience. One expert by experience visited the home and spoke with people and relatives. The second expert by experience made telephone calls and spoke with relatives of people living at the home. An expert by experience is a person who has personal experience of using or caring for someone who has used or uses this type of care service.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

We also 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.

During the inspection we observed how staff interacted and supported people who used the service. During the visit we spoke with four people using the service, six relatives, the provider and seven staff members which included the registered manager, the team leader, one night shift leader, three care staff and the cook.

We looked at the care records of eight people who used the service and medicines administration record (MAR) charts and medicines supplies for 15 people. We also looked at the recruitment and training files of six care staff. Other documents that we looked at relating to people's care included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that they were happy and felt safe living at St Catherines House. When we asked people if they felt safe with the care staff that supported them, every person we spoke with told us, "Yes." One person commented, "Oh yes I do, they are good carers here." Relatives were asked if the service knew how to care for their relative in a way that kept them safe. Feedback included, "I think they do. She's [relative] very independent, quite feisty in wanting to be independent and I think they are very good at finding that balance" and "Yes, I do. It has been a difficult one for them. She [relative] has never escaped, so obviously they do watch. Doors are always locked at the front." However, despite this positive feedback, there were certain aspects of the service that were not safe.

During this inspection we found that certain aspects of medicines management and administration were not safe. Shift leaders were responsible for administering medicines to people and used Medicine Administration Records (MARs) to record the receipt, administration, refusal and return of all medicines kept within the home.

We found numerous omissions in recording on people's MAR's where we were unable to confirm whether the person had received their medicines as prescribed. We saw approximately 70 omissions in recording for the period between 14 May and 10 June 2018. This was highlighted to the registered manager and team leader who told us that people had received their medicines and that care staff had possibly forgotten to sign to confirm that they had administered the medicine. However, we were unable to confirm whether people had or had not received their medicines as prescribed.

There were no controlled drugs (CDs) in use at the service at the time of the inspection. However, the home did have stocks of CD's which were not in use and had not been returned to the pharmacy. These medicines had not been kept in a CD cupboard but were either kept in a lockable cash box or in the medicines trolley. A CD cabinet was not available. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations.

There were two people receiving their medicines covertly at the time of the inspection. Covert medicine administration is when medicines are hidden in food or drink without the knowledge of the person. The home had not completed the appropriate paperwork which confirmed permissions had been obtained from the GP or the person's relative for this to happen. We did not see records of a best interests decision or advice around the use of covert medicines administration signed and agreed by the GP, home staff, a pharmacist, and the next of kin. This meant that care workers were disguising the medicine in food without obtaining appropriate consent and without having received pharmacy advice on the best way to do this, which was unsafe.

When medicines were prescribed to be given 'only when needed' (PRN), or where they were to be used only under specific circumstances, PRN protocols were not in place. PRN protocols provide guidance to care staff on how and when these medicines are to be administered. Records showed and care staff confirmed that

they had completed medicines management training. However, medicines competency assessments had not been completed for those staff to confirm that their practices when administering medicines were in line with the training that they received. Daily and weekly medicines audits and checks had been completed but these checks had not identified any of the issues that we identified as part of this inspection.

On day one of the inspection we walked around the home and found certain areas of the home in disrepair. We found at least six bedrooms where radiator covers were in place to protect people from burning or scalding themselves. These were either broken or not appropriately fitted to the wall. This placed people at risk of burning or scalding themselves. We found two wardrobes that were not stable and were leaning to one side and not safely secured to the wall. This place people at the risk of the wardrobe falling on top of them and harming them.

In the main lounge and reception areas we found three large loose pump containers of hand sanitiser easily accessible to people. These items were in easy reach to people especially those living with dementia who may not have understood what they were and mistaken them as something to drink or eat.

The home did not have suitable bags available for care staff to use when dealing with contaminated and soiled laundry. Care staff told us that they had to hand wash any soiled clothing before these were put into the laundry. Red bags are designed to prevent the need to personally handle potential soiled and contaminated garments that have come into contact with bodily fluids. Care staff should use these bags to wash such items separately and at high temperatures in order to kill any living bacteria. We looked at the providers infection control policy which did not give guidance to care staff on how to deal with soiled laundry.

All of the above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Rotas confirmed that two care staff were allocated from 8am to 8pm and two waking night staff from 8pm to 8am. A cleaner was available five days a week between the hours of 9am and 1pm and the cook was available six days a week between the hours of 10am and 1pm. Throughout the three days of the inspection we observed numerous times where the main lounge was left unattended where at least eight people spent the majority of their day. This was because care staff had to either support people who remained in their bedrooms or where other daily tasks such as laundry, cooking or cleaning had to be undertaken. We saw times where people, who were unsteady on their feet, would get up to go to their bedroom, go out into the garden or visit the toilet without any support.

We carried out a Short Observation Framework for Inspection (SOFI) to see interactions between people who were unable to communicate or tell us about the care, support and interaction that they received and care staff. We saw that for the duration of the 30 minute observation that the communal lounge area was left unattended intermittently for at least 15 minutes.

Relatives told us that there seemed be less staff available during the weekends. Comments included, "I only tend to go on weekday afternoons and weekends. It doesn't seem to be as many around on a Sunday afternoon. If anything were to happen, would there be enough?" and "I do feel on the weekends it seems very light on staff. I normally come during the week, but I have been there a few Saturdays and Sundays and there doesn't seem to be enough staff."

Care staff also confirmed that there were not enough staff available during the day which meant that people were left unattended so that they could support people who required support from two care staff or where

people chose to be in their bedrooms. Other domestic tasks including laundry, cooking and cleaning at weekends also impacted on their availability in communal areas. Care staff were responsible for preparing the evening meal as the cook only worked from 10am to 1pm. One care staff told us, "There is not enough staff. [Registered manager] has suggested this to the provider. We do not have cleaners at the weekend so the care staff do the cleaning where necessary." Another care staff stated, "We need someone for laundry. If we are caring we don't need to be doing the cooking, cleaning and laundry." A third care staff said, "There is not enough staff. Mornings are very busy. It's a case of saving money."

The registered manager had completed a dependency level assessment to ascertain people's level of needs so that staffing levels could be determined based on people's needs. However, there was no evidence of how the information collated resulted in the determination of appropriate staffing levels.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day one of the inspection, following our feedback, the provider had instructed the handyman to begin addressing some of the issues highlighted above which included the repairing of the broken radiator covers. On day three of the inspection the provider confirmed that red bags had been ordered and delivered for care staff to use. The provider also told us that they were in the process of ordering alcoholic gel dispensers to ensure people were not placed at risk of consuming such liquids kept loosely around the home.

We visited people's bedrooms and found some bedrooms had not be cleaned properly. We saw dirty bathroom cabinets, cobwebs, scuffed and dirty skirting boards. There were broken curtain hooks with some bedrooms having only one single curtain hanging. The decoration of some bedrooms had not been completed where one bedroom had incomplete paint work and a second room with a hole in the ceiling that had not been re-decorated following the work that had been carried out. We highlighted these issues to the registered manager and provider who gave assurances that these issues would be addressed immediately.

The service had processes in place to ensure that only staff assessed as safe to work with vulnerable adults were recruited. Checks included proof of identity, criminal record checks, satisfactory references from previous employment and right to work in the UK. Staff were unable to commence work until these checks had been completed.

Policies and procedures were in place for safeguarding people which gave information about the different types of abuse as well as the procedures that were to be followed if abuse was suspected. The service had not received any safeguarding concerns. However, the registered manager was clear about recording and reporting concerns to ensure that people were protected from abuse.

Care staff demonstrated a good understanding of safeguarding and whistleblowing and were able to describe the actions they would take if abuse was suspected and the professionals they could contact to report their concerns. Comments from staff included, "I would report it!" and "If no one was doing anything about my concerns I would call CQC."

Risks associated with people's health, care and support needs had been identified and assessed. These included moving and handling, falls, skin integrity, nutrition, diabetes and smoking. Older care plan versions that we saw did not always identify and assess people's individual risks associated with health and medical needs. However, the registered manager was in the process of re-writing the care plans onto a new format which were a lot more detailed and comprehensive. We looked at four new version care plans that detailed

the appropriate information and guidance for care staff to appropriately mitigate or reduce the identified risk to keep people safe and free from harm.

The provider recorded all accidents and incidents with details of the person, details of the incident or accident that had taken place, the actions taken and any investigative action taken where required. The manager and care staff confirmed that they would undertake an investigation to ensure that incidents or accidents were prevented and were appropriate lessons were learnt.

Records confirmed that all care staff had received food hygiene training. During the inspection saw that all food preparation and storage areas were generally clean and appropriate food hygiene procedures had been followed. This included cleaning schedules, specific food preparation areas for meat and vegetables, records of cooked food temperatures and food storage temperatures. However, we did note that the one dustbin within the kitchen was broken, did not have a lid to cover it and was not foot operated.

Maintenance records for the home included annual, monthly and weekly fire checks, call bell checks, monthly water temperature checks and equipment checks. These had been completed in a timely manner and no issues had been identified.

Personal Emergency Evacuation Plans (PEEPs) were in place in case of fire. The provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency.

Requires Improvement

Is the service effective?

Our findings

People and relatives both stated that they believed staff were appropriately trained and skilled in carrying out their roles effectively. One person told us, "Oh yes, very good staff here, very helpful." One relative stated, "Yes, as much as I have observed. They are all well aware of her [relatives] needs." However, despite this positive feedback, there were certain aspects of the service that were not effective.

The home monitored every person's food and fluid intake to ensure people were eating and drinking sufficiently. However, the charts were just a formal record of what the person had eaten or drank. Amounts of fluid intake were not recorded and totalled to determine whether a person's fluid intake was sufficient over a 24-hour period. Therefore, the service was unable to ascertain whether a person had drunk enough. Where a person may have drunk very little the service was unable to identify this and take appropriate actions to address this concern. Where a person may have fluid restrictions in place due to specific health conditions this would not have been adequately monitored through the current process.

People and relatives feedback about the meals that they received was overall positive. We observed people to be eating and drinking well and people had access to drinks throughout the day. However, we did note that snacks such as fresh fruit and biscuits were not always readily available for people to access. One person told us, "Very nice, alright, we have a good cook." Another person said, "The cook makes my meal and I enjoy it. I like lots of gravy and have bread with it." Relatives told us, "They most definitely asked her preferences. Mainly vegetarian. They cook especially for her. If she doesn't want something at a particular time, they say she can have it later" and "Yes, she never moans too much about food. Always the meals are very nice when I have gone there."

However, we saw that there were no menus on display which listed the choices of meals on offer. A menu was on display outside the kitchen area but this was not visible to people. On some days there was only one option for the meal. Throughout the inspection we did not see that people were offered a choice of a meal. People were given what had been cooked on the day. One relative stated, "I have never seen or heard of a menu." On the first day of the inspection the menu stated, 'Home made meat pie' for lunch, with no alternative. When we spoke with the cook, this had been changed to roast chicken. There had been no consultation with people that this was an acceptable change. The registered manager and care staff told us that people were always asked what they wanted to eat for the next day and choices were noted but this was not formally recorded.

People's individual needs were not always met by the adaptation, design and decoration of the home. The home had not been decorated and designed in a way which supported people living with dementia. There was no signage or direction available around the home apart from signs that indicated the location of a toilet. There were no orientation aids around the home which enabled people to find their way to their bedrooms or any other area around the home. People's bedroom doors had no signs or names identifying their bedrooms. Some people's rooms had not been decorated in a person-centred way which took into account their identities and personalities. Our observations throughout the inspection was that the home was in need of modernising. Some bedrooms were very basic and in need of attention such as appropriate

bedding and curtains. We told the provider and the manager of our observations who assured us that these issues would be addressed.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care plans evidenced that the service had assessed people's capacity and where people had been assessed as lacking capacity and decisions had been made in their best interests, a multi-disciplinary approach had been taken in order to reach the decision. We saw documentation for decisions that had been made for people such as a 'do not attempt cardiopulmonary resuscitation' (DNACPR) directive, where a person required bed rails or where a person required support with their personal care. However, the service had not given the appropriate consideration for people who were administered their medicines covertly. For two people we did not see records of a best interest decision in relation to the administration of covert medicines. This was brought to the attention of the manager during the inspection.

Care plans did not always evidence that people had consented or where appropriate their relatives had been involved in the planning and delivery of care and support that they received. Where people had been assessed as lacking capacity we saw care plans that had been signed by the person. There was no evidence that where people lacked capacity, their relative or next of kin had been involved in the planning or delivery of care. Where people did have capacity, care plans did not evidence that they had been given the opportunity to sign their care plan.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. During this inspection we found that the service had appropriately submitted authorisation requests for people who lacked capacity and who were possibly being deprived of their liberty. Where authorisations had been granted this had been documented within the care plan including details of any conditions that had been set. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire so that re-authorisation could be requested within a timely manner.

Care staff demonstrated a good understanding of the MCA and DoLS and how they followed the key principles when supporting people with their care and support needs. One care staff explained, "The MCA is about someone's ability to make their own decisions. We definitely give people choices." Another care staff stated, "Each individual has their own mental ability and you treat that person according to their ability. If they lack capacity you need to support them. Show them choice, visual choice and explain what you are doing."

Pre-admission assessments had been completed prior to the person being admitted to home. This ensured

that the service would be able to meet the needs of the person and provide them with the appropriate care and support. The registered manager confirmed that they always completed an assessment of the person's needs prior to agreeing to their placement. The registered manager explained that they had a very good relationship with local placing authorities and felt confident to refuse a placement where based on assessment St Catherines House would not be able to meet their needs. Care plans had been developed to reflect information collated through the pre-admission assessment and included people's choices, wishes and preferences as to how they wished to be supported.

Records confirmed and care staff told us that they all received an induction when they began their employment at the service followed by regular training and refresher training in topics such as moving and handling, medicines administration, safeguarding, dementia, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, we found that the registered manager did not have processes in place to assess care staff competencies following training to ensure care staff were deemed competent in particular areas such as medicines administration. We highlighted this to the registered manager who confirmed that they would ensure competency assessments were completed.

We spoke with care staff about the training that they received and whether sufficient training was provided by the provider to support them in their role. Comments from staff included, "I enjoy doing the training. There is always something to learn", "We receive regular refresher training. We have recently started training on challenging behaviour. We try to better ourselves" and "We get regular refresher training. I do training myself. We could ask for additional training. (Registered manager] is very good like that."

Records confirmed and care staff told us that they received regular supervision and felt appropriately supported through the supervision and appraisal process. Comments from care staff included, "Yes I do feel supported. Anything I need I can ask. [Registered manager] is helping me with my development" and "I get regular supervision. We talk about how is work and how is everything, any ideas of suggestions. [Registered manager] will listen to you."

Where people required professional input in relation to their health and medical records, care staff and the manager were aware of how to access the additional resource where required. People and relatives, told us with confidence, that the home supported them with their healthcare and medical needs appropriately. One person explained their recent experience and said, "I have a pain in my stomach and they give me medication for that, if unwell they come quickly, yes recently after taking medications I had a pain and they got the doctor in." One relative said, "They thought she [person] might have had a stroke some months ago and they responded very quickly. They phoned me immediately to say she was going by ambulance to hospital and kept me informed. They dealt with it extremely quickly."

St Catherines House also worked in partnership with the local Care Home Assessment Team (CHAT), which consisted of nurses, occupational therapists and geriatric consultants, who supported the home with acute illnesses so as to prevent any unnecessary hospital admission. We spoke with the CHAT nurse who told us, "They [care staff] are really responsive to people's medical needs. They really do care about the residents."

Each person's daily diary contained records of all visits and appointments made by a variety of healthcare professionals such as GP's, dentists, chiropodists and district nurses. Details of the visit and any actions to be taken had been recorded as part of the daily diary. However, it was not always clearly visible to note the actions that had been taken without reading through each and every entry. This was highlighted to the registered manager who agreed to separating visiting professional entries for clarity.

Daily handovers between the care staff team took place at the change of each shift so that information

about each person could be communicated to the new team to ensure continuity of care. Information recorded included, medicine checks, GP visits, district nurse visits and any issues with personal care. In addition, where significant changes, observations or incidents had been noted about a specific person this was also passed on so that the appropriate steps or actions could be followed through to ensure that people received the appropriate care and support that they required.

Good

Is the service caring?

Our findings

People and relatives were highly complementary about the caring attitude of the care staff at St Catherine's House. People's comments included, "Yeah very, oh very very, always looking after people, it is a care home", "Oh yes, they have carers in the evening and I get on with them very well" and "They are very nice, [care staff] thinks the world of me and so does [registered manager]." Relatives told us, "Absolutely no concerns over that. The way my relative smiles when they speak to her; I can sit next to relative and she's not speaking to me, but she will open her eyes and give the staff member a big smile", "I think most of them. It's more a look and body language, the tone of their voice" and "By their attitude, by the way they talk to the residents. They will sit by them, chat to them, make sure they're okay."

We saw that people had developed positive and caring relationships with care staff. Care staff knew people really well and were very aware of people's emotions and well being and were able to respond in a kind and caring way when people were seen to be distressed or upset. All of the care staff that we spoke with told of us how they loved working in care and specifically working at St Catherines House. Comments from care staff included, "I love it here. I love the residents" and "People remember the feeling I leave them with."

Care staff were cheerful and were seen to encourage people with daily living and promoting their independence. Care staff were also seen to be observant as people tried to be as independent as possible. During mealtimes we observed care staff to be patient and gentle. Where people were non-verbal we saw care staff read people's non-verbal signals and respond in a way which was reassuring and encouraging through touch and voice.

We observed care staff involving people in all day to day decisions and responding to people's individual requests. People and relatives confirmed that they had been involved in the planning of their care. Care plans detailed people's individual choices and preferences in areas such as when they wished to get up and go to sleep, what they liked to eat, how they wished to be supported with their personal care and their strengths and abilities. One relatives told us, "Yes, completely involved. In the first few months, until she settled in." Another relative explained, "I did quite a lot of research for this home. Visited it with my sister, talked to the manager. I seem to remember they went through her preferences, food. They told us about what activities they offered."

Care staff clearly understood the importance of respecting people's privacy and dignity and gave a variety of examples on how they did this. One care staff said, "I will shut the door when supporting with personal care and cover them up when whilst doing this" and "I will not talk about people in front of others." People and relatives confirmed that they had no concerns with the way in which they or their relative were supported which always respected their privacy and dignity. One relative told us, "Yes. In taking her to the toilet, taking her to her room. Sometimes if she has upset something they will change her blouse. They will let me know if there's anything she needs. Leaving her for privacy when she uses the toilet."

Care staff understood the importance of promoting and maintaining people's independence. Care plans detailed the ways in which promoting people's independence was to be achieved. One care plan stated,

'[Name of person] likes to be as independent as possible and staff will respect this. However, staff will need to be observant and check [person's] skin integrity.' Care staff explained the importance of promoting people's independence and feedback included, "As long as they [people] are not putting themselves at risk let them do what they can" and "Encourage and help them where required."

Care staff demonstrated a good awareness of supporting people from different backgrounds, varying religious and cultural backgrounds and supporting people who may identify as being lesbian, gay, bi-sexual or transgender. Weekly church services were held at the home where a member of the local community church attended to deliver mass for those people who expressed the wish to follow their faith. Care staff told us, "We treat people with respect. We treat everyone the same according to their care plan" and "I fit in with anybody and everybody and work with them."

Requires Improvement

Is the service responsive?

Our findings

We asked people if there were any organised activities taking place at the home. All the people we spoke with stated, "No." Relatives also told us that there was very little provision of activities taking place within the home. One relative said, "One of the concerns is what they do during the day. I have seen some videos of her dancing. There are music sessions. There doesn't seem to a great deal going on. I don't think there's an activities organiser." Another relative stated, "There doesn't seem to be a whole lot of activities to stimulate residents. There's singing from time to time. They don't go outside. I have seen residents out in the garden, but most times it's generally unused. At the other home they had someone to do painting, drawing, singing, there was more involvement with the residents." A third relative said, "I did ask. Two or three years ago there was an activities organiser, but she went. They just sit in the armchairs around. They could do with a bit of music. She has been out in the garden a couple of times."

Throughout the inspection we observed very little taking place in relation to activities and stimulation. People were seen to be sat in the main lounge, doing nothing, with the television playing in the background. People were positioned in such a way that the television was at a side view and not front facing people so no-one was actually watching the television unless they re-positioned themselves to sit sideways. We did not observe anyone being asked what they wanted to watch.

People's care plans occasionally listed some of their social interests which included classical music and art. Where this had been listed we saw for one person that they were supported to listen to classical music on their radio. However, some people's care plans were very generalised and did not specifically list their interests but stated that, '[Person] will fill her time in meaningful activities that she enjoys' or '[Person] will join in if encouraged and gently supported by staff.' Any information about activities and social interests had not been translated into an activity schedule for the individual person.

There was no structured activity timetable available. There was no designated activity co-ordinator within the home. Care staff were responsible for the organising and delivery of activities. Daily activity records had been completed for each person but only listed activities such as singing, dancing, watching television, listening to music, relaxing and dominoes. On occasions these records were not complete and had gaps in recording. Where people remained in their bedrooms, for most of the day, there was very little evidence available that confirmed the person had been engaged in any type of activity or interaction.

We carried out a Short Observation Framework for Inspection (SOFI) and observed six people over a 30-minute timeframe. Throughout the 30-minute time frame care staff only interacted briefly with two out of the six people. The television was left switched on in the background with a radio also playing classical music. There was no other interaction, activity or stimulation that took place during the observation. People were left unattended for short periods of time throughout the observation.

We asked care staff about the lack of activities within the home who agreed that not enough was organised to stimulate and engage people. One care staff told us, "There is a lot more out there in terms of activities. There is so much we can do like outings. People are left unattended when two of us have to support one

person." Another care staff explained, "We need more staff. Mondays are a bit busy. Carers have to assist to cook, laundry. We don't have the amount of time to do activities. A third care staff stated, "Activities! We sing with them and there is the occasional entertainer."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was currently in the process of re-writing people's care plans onto a new format. At the time of the inspection, the registered manager had re-written four care plans. New version care plans were detailed and person centred and listed people's likes, dislikes, choices and preferences. People's life histories had also been recorded which gave care staff information about people so that they were able to engage in meaningful conversations with them. Care plans had been reviewed and relatives confirmed that they had been involved in this process. The registered manager assured us that the remaining care plans would be re-written in the new format over the next month.

Staff understood the term person centred care and were able to explain what this meant for the people that they supported. One care staff told us, "Each person is an individual. They all need different levels of care. We focus on the person." Another care staff explained, "The person is at the centre of their care. What they want, their rights!"

The registered manager confirmed that the service had not received any complaints since the last inspection. The providers complaints policy detailed the steps that should be taken if people, relatives or visitors had any issues or concerns to raise. A comments and suggestions box at the entrance of the home gave people and visitors an opportunity to make any comments or suggestions. People we spoke with felt able to raise any concerns they had and would speak to the care staff or the manager. People felt they would be listened to and that their concerns would be addressed. Comments from people included, "Oh yes I would know", "I am happy with it do not have to bother about that. [Name] the Manager" and "Yes, the manager, [name]."

Relatives told us that they knew who to speak with if they had any complaints or concerns to raise and were confident that they would be addressed immediately. One relative said, "Yes. I would speak to [manager] first off." Another relative stated, "I feel more than confident speak to her [registered manager]. I am confident that my concerns will be dealt with."

People's end of life preferences and wishes had been noted in the advanced care planning section of the care plan. Where people had a 'do not resuscitate' authorisation on file this had been recorded appropriately with their advance care plan. Care plans that we looked had incorporated significant detail about how they wished to be cared for and supported at the end of their life including religious or cultural requirements and details of their proposed funeral arrangements.

Requires Improvement

Is the service well-led?

Our findings

During this inspection we identified significant issues relating to the safe administration and management of medicines, overall maintenance of the home, poor infection control processes, insufficient staffing levels, lack of activities and lack of choice and preference around the provision of meals.

The registered manager and provider completed audits and checks to monitor the quality of the service. These included audits for medicines, care plans, maintenance checks and infection control. Whilst audits for medicines and maintenance had identified some of the issues we found such as a request for the CD cupboard, lack of PRN protocols and issues with the overall condition of the home, there was no details of how and when these issues were to be addressed. Audits identifying some of these issues dated back to January 2018. These issues continued to require action.

Maintenance action plans only detailed completion dates but no further information was available regarding whether certain actions had been completed and by whom. An infection control audit completed in March 2018 identified that the kitchen dustbin needed to be replaced with a foot operated dustbin. We found during this inspection that this issue had not been addressed. Other issues that we identified such as gaps on MARs, poor recording of food and fluids, the non-availability of red bags, poorly maintained radiator covers and lack of activities had not been identified as part of the provider or registered managers internal processes.

On the first day of the inspection the registered manager was not available at the home to support with the inspection process. We were informed that the main office, which held all care plans and relevant documents was closed and only the registered manager had a key to access the office. This meant that in the absence of the registered manager, documents including DNACPR's were not accessible in the event of an emergency. We were informed that daily recording folders did contain copies of the care plan and documents such as DNACPR's but when we look at six people's daily records, we found that none of these folders contained the required documents. We made the registered manager and provider aware of our concerns in relation to this issue and they assured us that access to the office would be made available to care staff especially when the registered manager was not available.

Issues highlighted by the London Fire and Emergency Planning Authority and Food Standards Agency had resulted in enforcement actions to be stipulated which were required to be addressed within specific timeframes. During the inspection we found that not all the issues found had been addressed by the specific deadline and that the provider continued to work towards completing the required work.

During the inspection we asked to look at the results and outcomes of any satisfaction surveys that people and relatives were asked to complete to give their feedback on the quality of service they received. The registered manager told us that this exercise was carried out at provider level and that the results had never been shared with the home. Therefore, the service was unable to learn or implement improvements in response to the contents of the survey.

Most people and relatives that we spoke with had not completed any questionnaires. Only one relative confirmed that, "now and again they want your feedback." This meant that people and relatives were not always engaged and involved in giving feedback about the home and the care and support that they received. The provider acknowledged that results of satisfaction surveys needed to be shared with the home for learning and improvements to take place and assured us that going forward this would happen.

We saw records of minutes for quarterly residents' meetings. The registered manager stated that they encouraged people to participate where possible to give their views on how they wished to receive their care and support. Topics discussed included the Christmas party, activities, health issues, meal choices and cleanliness of bedrooms. However, we did not see any evidence of actions taken or improvements made as a result of people's feedback.

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

We highlighted the issues that we identified to the provider and the registered manager. The provider acknowledged our concerns and told us, "We have looked at our organisation and we know we are lacking." Throughout the inspection we observed the provider and registered manager's dedication, open and transparent attitude and the willingness to the learn and improve.

Relatives confirmed that the home communicated well with them where required and overall there was an open and transparent culture at the service. Relatives told us that the service communicated with them about their relatives especially where incidents or accidents had occurred or where their relative had taken ill. They also found care staff were always approachable and gave them the desired information about their relative.

Despite the issues we identified as above, people, relatives, care staff and visiting professionals were highly complementary of the registered manager. They found them to be very approachable, hands on and very caring. Comments from people included, "Yes, she is alright, she is good", "Very good, very good manager, the best", "She is good, very good, she knows the place well as she used to work here before she became a manager and "She is very lovely, I think the world of her."

Relatives told us, "She's brilliant. What I have been impressed with is she knows all of them very well, gets involved. She doesn't just sit in the office", "I think she is good, seems enthusiastic" and "I have had quite a bit to do with the manager and get on very well with her. She and one of the other carers took my aunt to my husband's funeral."

Care staff stated that they felt well supported by the registered manager who was "approachable" and "hands on." In addition to supervisions and appraisals, quarterly team meetings were held. Agenda items included general information, activities, security and resident's issues. Care staff told us that meetings gave the team an opportunity to learn and share experiences as well as give suggestions and ideas which were listened to.

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals including GP's, speech and language therapists, social workers and the Care Home Assessment Team (CHAT). The CHAT visited people regularly who had complex health needs or who were at risk of deteriorating and also liaised with the wider multidisciplinary team and supported care staff to coordinate care. The registered manager also confirmed that they attended regular provider forums where other providers came together to share practises and

learn.

The home engaged with the local community church and local schools to organise weekly religious services and regular visits from children especially during festivals. People engaged and interacted with children and members of the community through these visits which supported their positive well-being. The registered manager also told us that members of the community church visited the home every two to three weeks as 'buddies' to engage and interact with people living at the home.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's nutrition and hydration needs were not appropriately monitored which gave regard to people's choices, preferences and well-being. The home had not been decorated and designed in a way which supported people living with dementia. The provider did not ensure that appropriate and sufficient activities were organised and provided to people which encouraged stimulation, interaction, independence and involvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of people was not always provided with their consent. Where people lacked capacity the provider did not act in accordance with the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed, administered and stored safely. The provider did not ensure that the health and safety of people was safely managed and

maintained in relation to the fabric and condition of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance audits that were being completed were not effective as they did not highlight concerns and issues around the home that were identified as part of this inspection. Where issues were identified there were no action plans in place on how these issues were to be addressed and resolved. The provider had not mitigated risks highlighted by external safety professionals in order to keep people safe. The provider did not always act on people and relatives feedback for the purposes of learning, continually evaluating and improving the provision of care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not set at sufficient levels to safely meet people's needs. There were insufficient members of staff deployed to appropriately meet people's needs.