Care Quality Commission

Grovewell Estates Limited

St Catherines Nursing Home

Inspection report

Spring Road
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Hertfordshire
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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 21 October 2014 and was unannounced. We last inspected St Catherines Nursing Home in December 2013. At that inspection we found the service met the essential standards assessed.

The service is registered to provide nursing and personal care for up to 39 older people, some of whom live with dementia and physical disabilities. At the time of our inspection 32 people lived at the home and a registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People told us they felt safe at the home. We found that staff were knowledgeable about the risks of abuse and reporting procedures. Although we received mixed views about staffing levels, we found there were sufficient staff available to meet people's needs and that safe and effective recruitment practices were followed.

Summary of findings

There were suitable arrangements for the safe storage and disposal of people's medicines. However, prescribed creams and 'as needed' (PRN) medicines, such as pain relief tablets, were not managed as effectively as they could have been.

The CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection no applications had been made to the local authority in relation to people who lived at St Catherines Nursing Home. However, we found that in some cases where people lacked capacity to make their own decisions, consent for their care had not always been properly obtained in line with the MCA 2005.

People had access to healthcare professionals such as GP's, dentists and chiropodists. However, some people's health needs had not always been met effectively. We found that people were provided appropriate levels of support to help them eat and drink where necessary. They were looked after by staff who were trained and had the skills necessary to provide safe care.

Most people were happy at the home and we saw that staff treated them with kindness, dignity and respect. Relatives were positive about the care and support provided. We saw that staff helped and supported people in a kind, patient and caring way. They knew and used people's preferred names and worked at a pace that best suited people's individual needs. However, there were not enough group or individual activities provided at the home and most people were not provided with adequate support to help them pursue their social interests or access the local community.

People who lived at the home, relatives and staff were positive about the registered manager and felt that most aspects of the home had improved since they took up the post in September 2014. However, we found that action plans drawn up and used by the manager to tackle concerns highlighted in feedback and other quality assurance measures had not always proved effective.

We recommend that the provider reviews security arrangements for the storage of people's care records, confidential information and medical histories. We found that cupboards used to store them were not always locked or secured in a way that adequately preserved confidentiality.

At this inspection we found the service in breach of Regulations 9, 10 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches correspond with Regulations 9, 17 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 01 April 2015.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe at the home and we found that staff were knowledgeable about the risks of abuse and how to report concerns.

There were sufficient staff available to meet people's needs and effective recruitment practices were followed.

There were suitable arrangements for the safe storage and disposal of people's medicines. People were supported to take their medicines by trained staff.

Good

Is the service effective?
The service was not always effective.

People's consent to care and treatment had not always been obtained in line with the MCA 2005.

People's health and nutritional needs were not always met effectively.

People were looked after by staff who had the knowledge and skills necessary to provide safe care, treatment and support.

Requires Improvement

Is the service caring?
The service was caring.

People and their relatives were positive about the way in which care and support was provided.

Staff were knowledgeable about people's needs, preferences and personal circumstances.

People told us they were happy at the home and that staff treated them with kindness, dignity and respect.

Good

Is the service responsive?
The service was not always responsive.

Activities had not always been planned and delivered in a way that met people's needs.

People were able to raise complaints or issues of concern and provide feedback about their experiences.

Requires Improvement

Is the service well-led?
The service was not always well led.

Some aspects of the quality assurance and risk management systems used at the home were not effective.

Requires Improvement

Summary of findings

The service promoted a positive and inclusive culture. People, their relatives and staff were encouraged to share their views to help develop the service.

The registered manager has demonstrated visible leadership and put systems in place to drive improvement.

St Catherines Nursing Home

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 met 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 21 October 2014 and was unannounced. The service was found to be meeting the required standards in the areas we looked at at their last inspection on 18 December 2013.

The inspection team included two inspectors, an expert by experience and a specialist professional advisor who is a registered nurse. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before our inspection we reviewed information held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with nine people who used the service, three relatives, the registered manager, two nurses and six care staff members. We received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

We reviewed care records relating to 10 people who lived at the home and three staff files that contained information about recruitment, induction, training, supervisions and appraisals. We also carried out observations in communal lounges and dining rooms.

Good

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "I haven't seen staff treat anyone badly, I would shout out if they did." Another told us, "I am not frightened of anything here, the staff treat me alright." A relative commented, "We are happy they [family member] are safe here, no concerns on that score."

We found there were suitable arrangements to safeguard people against the risk of abuse, including reporting procedures and a 'whistleblowing' process. We saw that advice about how to report concerns was displayed and included contact details for the relevant local authority. The registered manager documented and investigated safeguarding incidents appropriately and had reported them to the local authority and the CQC where necessary.

Staff were knowledgeable about the risks of abuse and reporting procedures. One member of staff told us, "I have no concerns about safeguarding here. We have all been trained and the seniors and nurses constantly remind us about the importance of challenging and reporting inappropriate behaviour. I would not hesitate to report any concerns."

People expressed mixed views about staffing levels. One person told us, "They [staff] are always very busy, particularly in the mornings, but I find they are generally quick to respond when you need them." Another person said, "There are always quite a few staff about to call on." A relative commented, "[The] only problem is that staff are very busy in the morning, meal times and in the evening. Staff are too busy and sometimes [relative] has to wait a long time [for staff] to answer call bells."

However, during our inspection we found that there were sufficient staff available to meet people's needs and keep them safe, including during busy periods such as first thing in the morning and at mealtimes. The manager kept staffing levels under review, managed absence effectively and used suitable agency and bank staff where necessary and appropriate. For example, vouchers were made available to help them meet the cost of flu vaccines and remain fit for work. People's dependency levels were closely monitored and used by the manager to make decisions about staffing in a way that reflected their changing needs and the demands placed upon staff at busy periods.

For example, an additional member of staff was rostered to start at 7:00am each day in light of people's increased dependency needs first thing in the morning. We spoke with staff who told us that although busy in the mornings, the extra staff meant they were able to meet people's needs more effectively. The manager provided clear guidance to senior carers and nursing staff about the importance of getting the right blend in terms of staffing numbers, skills and experience. We saw that throughout our inspection, including in the morning, staff answered call bells promptly. We also saw that where people required help and support it was provided to them in a patient way at a pace that best suited their individual needs.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs. New staff did not start work until satisfactory employment checks were completed. Some people who lived at the home told us that they took part in interviews and that their views were valued as part of the selection process.

People were cared for by staff trained to administer medicines safely and were supported to take their medicines when they needed them. One person said, "I am given my tablets and they [staff] tell me what they are as I always forget." Another person told us, "They [staff] don't get tablets mixed up, they have a list and wear a coloured vest [red tabard] when they do it."

There were suitable arrangements for the safe storage and disposal of people's medicines. We spoke with a pharmacist who regularly reviewed medicines and training at the home. They had no concerns and found that staff responded positively to suggestions for improvement. A nurse said, "We take medicines seriously here. Training is good and we are re-assessed on the floor regularly. There are checks and procedures to reduce the chance of errors occurring."

However, systems used at the home to manage 'as needed' medicines (PRN) and prescribed creams were not as effective as they could have been. We checked a stock of PRN medicines but were unable to reconcile them correctly because some pain relief tablets could not be accounted for. We also found that staff had not always made a note of when people had been supported to use creams which meant that it was not clear if prescription guidance had been followed in all cases. However, people told us they had been helped with their creams and were provided with

Good

Is the service safe?

pain relief tablets when they needed them. The registered manager told us that immediate steps would be taken to make sure that systems used accurately reflected that people had been supported to take their medicines safely.

Requires Improvement

Is the service effective?

Our findings

People told us that staff asked for their consent before care was provided. One person said, "Staff always ask me what I want to do, I have a voice. They mostly get my consent before doing anything." We saw that staff explained what was happening and gave people the opportunity to make decisions and provide their consent about the support and personal care they required.

The registered manager demonstrated a good understanding of MCA 2005 requirements about Deprivation of Liberty Safeguards (DoLS). These apply when people who lack capacity have their freedom restricted, usually when it is in their best interests to keep them safe. The registered manager told us that nobody who lived at the home was subject to a DoLS authorisation. However, although most staff had received MCA 2005 and DoLS training, few were able to explain how the requirements worked in practice. One staff member told us, "I have been trained but I don't really get the DoLS bit. I think it just means that we value their choices and do what's best for them."

We found that people's capacity to consent had not always been properly assessed or reviewed where appropriate. This meant that the requirements of the MCA 2005 had not been followed in all cases and that some decisions may not have been in their best interest. For example, we found that relatives of one person, who had capacity to make their own decisions, had provided consent regarding their medicines, care and treatment.

Three people were routinely given prescribed medicines covertly in food or drink (without their consent or prior knowledge) because they refused to take them. However, capacity assessments had not been carried out to establish if they could make their own decisions about medicines and were entitled to refuse. This meant that, although the medicines had been given safely, the MCA 2005 had not been followed and the decisions taken may not have been in people's 'best interests.' The registered manager mistakenly believed that the local authority had carried out capacity assessments.

We also found that 'do not attempt resuscitation' (DNAR) decisions had been taken in relation to four people without their proper involvement or consent. Capacity assessments had not been carried out in accordance with the MCA 2005 to establish if people could make their own decisions. In some cases relatives had given consent despite the fact that it was not clear whether or not they were legally entitled.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's health needs may not have been met in all cases because identified risks were not managed effectively. For example, one person was assessed as living with dementia and being at risk of depression and urinary tract infections (UTI's). However, staff had not been provided with adequate information or guidance to meet those needs or reduce the potential risks.

The same person was also identified as being at risk of pressure ulcers and malnutrition. Plans and guidance were in place to help staff reduce the risks but these had not been reviewed or updated to reflect the person's changing needs.

Another person had been provided with a pressure relieving mattress to reduce the risk of pressure ulcers. However, the wrong size and type of bed sheets had been used which may have significantly reduced effectiveness and increased the risks of skin breakdown. We saw that a person at risk of malnutrition was closely monitored and that staff noted steady and consistent weight loss over a long period of time. Another person was found to have experienced adverse weight gain. We spoke with a nurse and the registered manager who did not know what steps had been taken to address the risks or whether the advice and guidance of specialist healthcare professionals had been sought. This meant that some people had not always been supported effectively to help them maintain good health.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were provided with appropriate levels of support to help them eat and drink at mealtimes where

Requires Improvement

Is the service effective?

necessary. Menu choices and alternatives were offered and people had access to fresh fruit, snacks and sufficient quantities of both hot and cold drinks. One person said, "I like the food here, I have a cooked breakfast which I enjoy."

People were looked after by staff who had been trained and supported to provide safe and effective care. One person said, "Staff know what they are doing; some have been here a long time." A relative commented, "The staff all seem very experienced and certainly seem to know what they are doing."

New staff were required to complete an induction programme and not allowed to work alone until assessed as competent in practice. Staff had been supported in their personal and professional development during appraisals and regular 'one to one' sessions [supervisions] with senior staff. One member of staff told us, "I have worked here a long time, I know what I am doing and the training is good. I can always ask for help if I need it." This meant that people received care from staff who had the skills necessary to carry out their roles and responsibilities.

Good

Is the service caring?

Our findings

People told us they were happy at the home and that staff were patient and treated them with kindness. They were very positive about the staff and described the home as being friendly and a nice place to live. One person said, "It's a home from home, they really care. I never feel sad here." Somebody else commented, "I have been here a while, I like it. It's very friendly here."

Relatives were also positive about the way in which care and support was provided. One relative told us, "Staff are wonderful, really kind and caring." Another commented, "The staff are all very respectful and courteous. They treat [relative] in a lovely way. [They] are a very private person and staff respect that."

We observed staff interaction with people in communal lounges and dining areas on both the ground and first floors of the home. We saw that all staff members helped and supported people in a kind and caring way. They knew and used people's preferred names and worked at a pace that best suited people's individual care and support needs.

All of the staff we observed, including agency workers, demonstrated a genuine and positive interest in people they looked after and responded quickly to their needs and requests for assistance. A relative commented, "The staff are wonderful, really kind and caring. [My relative] is well looked after here without a doubt." Staff were compassionate and people clearly benefited from the caring relationships that had been developed.

Care and support was delivered in a way that protected people's privacy, promoted their dignity and respected their wishes. People told us that staff always knocked before entering their bedrooms and made sure that doors and curtains were closed during personal care. One person said, "I am too embarrassed to have a male nurse, they [staff] respect my wishes." Another person told us, "I can do what I want but I stay in my room as I like to have privacy."

Staff were knowledgeable about people's needs, preferences and personal circumstances. We saw that most people had been involved in discussions about their care and that relatives had been invited to reviews where appropriate. One person commented, "They [staff] know what I need and we just get on with day to day things. I generally stay in my room but staff pop in a lot." A staff member told us, "We have a handover [briefing] in the morning so we are clear on what's been happening." Another said, "It doesn't feel like work here, I love it. I really enjoy it. [We are] a good team and we treat people like individuals, it's their home."

People told us that friends and relatives were able to visit at any time without restrictions and were involved in discussions about the care and support provided. One person told us, "My son pops in all the time, they [staff] address him by name and chat." A member of staff commented, "I like to spend time with the residents who never get visitors."

We saw that information about advocacy services had been displayed and was included in a guide book given to each person at the home. This meant that people had been supported to access independent advice and guidance about their care needs.

Requires Improvement

Is the service responsive?

Our findings

People told us there were not enough meaningful group or individual activities provided and that they were not supported to go access the local community or pursue social interests. They were positive about the activity coordinators but told us wanted to go out and do more. One person said, "I have been on one trip. We need more as we don't go out much. We do some chair exercises and a bit of singing, I wish there was more."

Activity schedules were displayed but few people we spoke with had seen them or knew what had been arranged. One person said, "I have no idea what's planned for us, not much other than TV or sleeping." A relative told us, "[In my experience] staff don't do any 'one to one' work. People are just sitting around all day sleeping in chairs or looking bored. There is not enough for them to do, they never get out and weekends are worse." We saw that two activity coordinators worked at the home Monday to Friday but not on weekends. This meant that people may not have had adequate support to pursue their interests at all times.

On the day of our visit we did not see any meaningful group or individual activities provided. Most people stayed in their rooms or watched television in communal areas. One person commented, "Not really my choice [of TV programme] but it's OK. I can't change it [channel] as I don't have the controls…. I'm bored, there's nothing to do." This showed that activities had not been planned and delivered in a way that met people's individual welfare needs.

This is a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were personalised and contained some information about people's life histories, social interests and preferences. We saw that staff used this information to good effect when providing care and support, for example when helping people decide what they wanted to eat. However, it had not been used to develop activities that linked in with and met people's individual needs and social interests. We saw that information about religious services, library and hairdressing services were displayed and that people could choose to have newspapers delivered.

A range of risk assessments and personalised plans had been developed to help and support people maintain good health. These included information and guidance in areas such as moving and handling, nutrition, medicines and pressure care. People also had access to healthcare professionals such as GP's, dentists and chiropodists. One person commented, "I had to have the doctor [who] was called and came quickly. I went to hospital in a taxi with a carer to have an x-ray."

People and their relatives were able to raise complaints or issues of concern and provide feedback about their experiences. Information about a complaints procedure was made available, regular meetings for residents and their relatives were held and survey questionnaires used to obtain feedback. One person said, "I have a voice and I see the registered manager regularly." Another person commented, "I would complain to [the registered manager], they sort things out and are competent." Complaints were recorded, investigated and resolved effectively. We saw that action plans with areas for improvement and learning outcomes were circulated and discussed at staff and resident meetings where appropriate.

Requires Improvement

Is the service well-led?

Our findings

We found that, although a range of audits had been carried out on a regular basis, some had proved ineffective in providing adequate protection against the risks of inappropriate or unsafe care and treatment. For example, audits had not properly assessed the circumstances of medicines given covertly and failed in some cases to identify gaps and inconsistencies with systems used to manage the administration of PRN medicines and prescribed creams.

Audits carried out to monitor, review and manage identified risks in areas such as nutrition and pressure care had also proved ineffective in some cases. For example, we found that inconsistencies around the management of risks concerning a person who had suffered adverse weight loss had not been identified. Auditing processes used at the service had not identified that people's consent to DNAR's had not always been obtained in line with the MCA 2005.

In some cases it was unclear as to whether important referrals to healthcare professionals had been made and in others plans and assessments to address identified needs, such as depression, dementia and UTI's, had not been drawn up and put in place. This meant that some aspects of the quality assurance and governance systems used had not effectively managed risks or driven the improvements required to deliver high quality care and keep people safe.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about our concerns and they were committed to making the improvements required at the home. It was clear they demonstrated visible leadership and had made significant progress in a relatively short space of time. People told us that things had improved and staff felt better supported in terms of training, supervision and staffing levels.

The registered manager was fully aware of the challenges that remained and has been supported by the provider to implement changes required to drive the improvements required. For example, they have linked in with a reputable professional care provider's association to obtain additional support and guidance. However, some of the governance and quality assurance systems put in place, such as auditing processes and action planning, will need to be improved so that effective change can be achieved and sustained.

People who lived at the home, relatives and staff were positive about the registered manager and told us that most aspects of the home had improved since they took up the post in September 2014. One person said, "I can see [the registered manager] if I need to, they sometimes pop into my room. If I had a problem I would speak to them." Another person told us, "[The registered manager] is regularly around. I talk to them a lot [and] they listen." A relative commented. "They [the registered manager] is always around the home talking with residents and staff. Things have really improved since they started." A member of staff said, "We are of course very busy at certain times, like any care home, but the registered manager is very flexible and makes sure there are enough of us at the right times. They are really good like that." People were kept involved in developments through regular meetings, feedback surveys, a newsletter and by taking part in recruitment interviews.

The registered manager was already at the home when we began our inspection at 8:00 am. They told us they had arrived early to liaise with night staff and observe the handover briefing with the early shift. Staff told us the registered manager was often on duty outside normal business hours and regularly worked with them on the floor. One member of staff said, "[The registered manager] is approachable, I would never be worried about speaking up." Another commented, "We have regular staff meetings and [the registered manager] reinforces the need to attend. I feel valued and that I have a voice here, they are very approachable. They put on extra care staff in response to our suggestions about the need for more people in the mornings which really helps." Staff told us that training, supervisions and support was more effective under the new registered manager and new staff had been recruited to help improve the levels of care provided.

Staff innovation and commitment to high quality care was recognised by the 'staff member of the month scheme.' The award, which includes gift vouchers, is given to the member of staff who attracted the most votes from colleagues and people who lived at the home. One member of staff said, "I won it [the award] once and it was

Requires Improvement

Is the service well-led?

great, it made me feel proud and valued." Staff had also been supported and trained to become 'champions' of excellence in areas such as dementia, nutrition, diversity and dignity.

A new staff handbook had been introduced that included guidance about roles, responsibilities and the minimum standards expected. The book also includes the provider's vision and values. One member of staff commented, "The manager is really good, everything is for the residents. We have seen a real improvement in how the place is run since they took over. There is a big emphasis on choice, nutrition, preferences, dignity and independence." The service is supported by a professional care provider's association in terms of shared learning, training and best practice and has participated in a pilot scheme to improve infection control standards.

Action plans were used to monitor the progress of work carried out to address concerns and issues raised in survey feedback, meetings and audits. For example, we saw that activity coordinators had been recruited as a result of concerns raised by people who lived at the home and sluice facilities improved following issues identified by staff. However, people told us, and our observations confirmed, that insufficient group and individual activities were provided. This meant that the steps taken may not have been as effective as they could have been.

We recommend that the provider reviews the security arrangements for people's care records which contain confidential information and medical histories. We found the cupboards used to store them were not always locked or secured in a way that adequately preserved confidentiality. This meant that the records and data management systems used were not as effective as they could have been.

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 did not take formal enforcement action at this stage. 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving treatment of care and support that is inappropriate or unsafe. Regulation 9 (1) (b) (i) (ii) (iii). **This corresponds with Regulations 9 (3) (b) to (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users, or others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to; identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. Regulation 10 (1) (b) **This corresponds with Regulations 17 (1) & (2) (a), (b) & (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in

This section is primarily information for the provider

Action we have told the provider to take

accordance with, the consent of service users or another person able lawfully to consent on their behalf. They did not establish or act in the best interests of service users in line with the MCA 2005.

Regulation 18 (1) (a) and (b) and (2)

This corresponds with Regulations 11 (1) to (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.