The Cote Charity

Katherine House Rest Home

Inspection report

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Date of inspection visit:
14 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 14 November 2016 and was unannounced. The care home was last inspected on 8 July 2014 and met the legal requirements at that time. Katherine House is registered to provide personal care for up to 41 people. There were 39 people living in the home on the day of our visit.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
People and their relatives all spoke positively about the care and support provided by the care home team. They told us that staff were, "Very kind and helpful" and that, "They [the staff team] look after you very well." People told us that staff were respectful and thoughtful.

People's needs were assessed by the management team before people moved into the home. Care plans were devised with input from people and their relatives. Risks to people were assessed, and actions were taken to reduce the risks and keep people safe.
Staff understood how to safeguard people, and knew the actions to take if they suspected abuse. People who were supported by the service told us they felt safe.

People received personalised care that was responsive to their needs. Care plans reflected that people's individual needs, preferences and choices had been considered and acted upon. Staff were knowledgeable about people's individual needs.
People were supported to have their nutritional needs met. Where people required special or modified diets, external specialist support was obtained, and their advice, guidance and instructions were followed.

The home was well-managed. The registered manager monitored the quality of the service and sought and acted on people's feedback. Quality assurance systems were in place to monitor and mitigate the risks relating to the health, safety and welfare of people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people were identified and actions agreed with people were recorded in risk management plans. These were reviewed on a regular basis.

Plans were in place to provide support to people in the event of an emergency.

People received their medicines safely and in accordance with their individual prescription.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Accidents and falls were recorded. Appropriate actions were taken in response and recorded.

Staffing levels were sufficient for the needs of the people living in the home.

Is the service effective?

Good

The service was effective.

People's health care needs were effectively managed. People were supported to have regular health checks. Advice, guidance and support provided from external health professionals was acted upon.

The rights of people were upheld because staff acted in accordance with the Mental Capacity Act 2005.

Staff had the skills to provide the care and support people needed.

People were offered a choice of food and supported to keep as healthy as possible.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected and maintained. Staff reassured people when they needed it.

People felt comfortable and confident they could make decisions about their day to day activities.

People and their relatives were actively consulted and involved before and after they moved into the care home.

Is the service responsive?

Good

The service was responsive.

People were involved and received care in the way they preferred. Their needs, wishes and preferences were taken into account.

The care records reflected people's choices and were written in a person centred way.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Good

The service was well-led.

Quality assurance and monitoring systems were in place.

People who used the service and their relatives were given the opportunity to share their views and provide feedback at meetings and in surveys. Actions were taken in response to issues identified.

Staff felt well supported by the registered manager and the senior staff. Staff were motivated and committed to providing a personalised service for people.

Katherine House Rest 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 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 14 November 2016 and was unannounced. This meant the provider and the staff did not know we would be visiting. The inspection was carried out by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information we held about the service. We read previous inspection reports and we looked at notifications we had received for this service. Notifications are information about specific events the service is required to send us by law.

On the day of the inspection, we spoke with nine people who lived at the home, two relatives and a visiting health professional. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people. We spoke with the registered manager, the deputy manager and seven staff that included housekeeping, laundry, catering, activity and care staff. We observed medicines being given to people. We observed how equipment, such as pressure relieving mattresses and hoists, were being used in the home.

We read four people's care records. We looked at medicine records, staff recruitment files, quality assurance audits, feedback from surveys, staff and resident meeting notes, complaints records, staff training records and other records relating to the monitoring and management of the home.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. Their comments included, "I feel pretty safe," "It's perfectly safe" and, "There's always a carer around if I need one."

People were protected from the risk of abuse and staff understood their responsibilities with regard to keeping people safe, and for reporting concerns. Staff had received training and were able to describe actions they would take if they suspected abuse. Staff knew they could contact the local authority safeguarding team to report concerns. Staff were confident they could whistle blow to the management team or to the Commission if they had concerns about other staff care practices.

Risks to people were assessed. These included key risks specific to the person, such as eating and drinking, falls, moving and handling and pressure ulcers. Risk management plans were in place and these were reviewed on a regular basis. This meant risks were identified and minimised to keep people safe.

Accidents and incidents were recorded by staff onto an electronic reporting system. All reports were reviewed and a management report was completed. A checklist provided prompts to make sure all appropriate actions had been considered and taken after an accident or incident. The records confirmed the actions taken. The registered manager completed monthly reviews to look for emerging trends or patterns. This led to further actions being taken where needed. For example, one person had fallen on more than one occasion. They were referred to the GP, blood tests were completed and they were referred to the falls clinic. This meant people could be confident that accidents and incidents were investigated and actions taken to eliminate or reduce the risk of recurrence.

People had access to call bells in their bedroom. People told us their calls for help were promptly responded to most of the time. Comments from people included, "Sometimes you have to wait if they [the staff] are busy," "I give a shout or ring a bell, they [the staff] come very quickly" and "Staff may be quite busy but they always come when I need them."

The staff we spoke with told us there were sufficient numbers of staff to meet people's needs. The registered manager told us they used a dependency tool to determine the staffing levels needed throughout each area of the home. Staffing levels were increased if people's care needs changed, for example, when people became unwell and needed additional care.

Medicines were managed safely. Policies and procedures were in place. These were provided to support staff and to ensure medicines were managed in accordance with current regulation and best practice guidelines. Staff received training and their competency was assessed before they were allowed to administer medicines unsupervised. Regular refresher training was provided for staff that administered medicines.

Medicines received into the home were checked by senior staff and the amounts recorded on people's individual Medicine Administration Records sheets (MARs). Most medicines were received in a monitored

dosage system. Medicines left over from previous months were recorded. Medicines no longer required were recorded in a disposal book and collected by the pharmacy.

Medicines were stored securely in lockable cabinets in people's bedrooms or in an air conditioned room in locked cabinets and trollies. Arrangements were in place for medicines that required cool storage and for medicines that required additional security. We saw that people were encouraged and supported to self-administer their medicines if they were able to do so safely. The GP completed a self-administration assessment and this was reviewed on a regular basis.

We saw people being supported to take their medicines by staff. Where people were prescribed medicines to be taken when required, such as pain relieving medicines, staff checked if these were needed. Staff were able to tell us the reasons for people needing painkillers and the types of pain people experienced. Medicine reviews were completed on a regular basis and actions were taken when needed. For example, one person wanted the administration time of their evening medicine to be changed. It was noted the person wanted to receive their medicines earlier when they were not so tired. The records confirmed this was discussed with the person's GP. The administration time was changed so the person received their medicine earlier, as they had requested.

Staff were safely recruited. Staff completed application forms prior to employment and provided details about their employment history. Previous employment or character references had been obtained. Disclosure and Barring Service (DBS) checks were completed. The DBS check ensures that people barred from working with certain groups, such as vulnerable adults are identified.

Plans were in place to support people if they needed to be moved from the home in the event of an emergency. People had personal emergency evacuation plans (PEEPs). These were records that confirm the help and support people required if they needed to be moved in an emergency situation.

We found the home was clean and housekeeping staff were employed to maintain standards of cleanliness. Personal protective equipment was readily available and we saw gloves and aprons being used appropriately. Health and safety checks on the premises were completed. This included checks on portable equipment such as hoists, and checks on mains equipment such electrical and gas safety.

Good

Is the service effective?

Our findings

People were supported by staff who had received training to help them carry out their roles effectively. Staff were positive about the induction, training and supervision they received. One member of staff who had recently started in post told us they had, "A really good induction and a lot of support."

The provider's induction process encompassed the Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The Care Certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support.

On-going and refresher training was provided. These records confirmed the refresher training, such as first aid, infection control, fire safety and moving and handling had been completed by staff in the required timescales. Staff told us about other illness specific training they had received, such as understanding diabetes and stroke awareness. One member of staff told us, "They [the management] are very hot on training."

The registered manager had a system to support staff through regular performance supervision and annual appraisals. Supervision meetings were held every six months. Staff told us the supervision meetings gave them the opportunity to discuss their progress and agree areas where they may need further support and direction.

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.

Staff received training about the MCA as part of their induction. They told us they understood they needed to obtain consent from people before they provided care and support. We heard staff checking with people and asking before they provided care or treatment. The care records stated that consent was to be obtained from people on a continual basis.

Where people needed support to make decisions, this was clearly documented. For example, one person's care records stated, "Can be forgetful…Always involved in deciding day to day care." The records showed the person communicated their decisions with staff. The records showed when advocates and relatives had been involved in making best interest decisions for people.

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 applications procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection there were no people living at the home who had a DoLS authorisation in place.

People told us they liked the food. One person said, "The food is very nice" and another person commented, "It's [food] fine." People told us if they didn't like the food on the menu they could ask for something else. Mealtimes were relaxed and enjoyable for people. Where people chose to eat in the dining room, this was a sociable occasion, and people chatted to others at their table.

People were supported to eat and drink and encouraged to maintain a balanced diet based on their needs and preferences. Where people had swallowing difficulties, and were at risk of choking, appropriate professional support was provided. Assessments were completed by a Speech and Language Therapist (SALT) and recommendations made about the texture of diet the person needed. We saw that one person occasionally made a decision not to eat the textured diet that was recommended for them. They had the capacity to make this decision. The person's GP was consulted, and staff documented the choices the person made.

We spoke with the chef who was aware of people's dietary needs, likes, dislikes and preferences. They told us communication in the home was good and they were kept up to date with changes in people's needs and requirements. The chef told us how they adapted people's diets. They gave an example of how they fortified food with cheeses and cream to add more calories for a person with a marked weight loss.

We spoke with a person who had a particular health condition that meant their eating and drinking needed to be monitored. They told us, "They [the staff] watch very carefully what I eat." Where people had their food and fluid intake monitored, this was recorded. Most of the recording charts we looked at were fully completed. We did note for one person, the records stated they sometimes declined their meals and this should be recorded. There were occasional gaps where there was no recording to confirm the person had either been offered or if they had declined their meal.

People received the healthcare support they needed. There were records of the visits made by various health and social care professionals involved in people's care. These included GPs, dieticians, district nurses, social workers and dentists. A visiting health professional commented, "This home is proactive. They call us when needed and our instructions are followed." A relative commented that staff, "Understand their tasks" and were, "Aware of their responsibilities."

Good

Is the service caring?

Our findings

Everyone we spoke with was positive about the caring attitudes of the staff team at the home. Comments from people included, "It's a lovely place" "They look after you very well" and from a relative, "She [person receiving care] adores staff" and "Their [the staff team] attitude is brilliant."

One person told us how they had been supported that morning. They told us a member of staff had helped them to get washed and dressed. They commented, "Staff are very kind, they've done just what I need this morning. Some are better than others, but none here that worry me at all."

We heard kind and respectful interactions between staff and the people they were providing care for. For example, one person was unsure about the time of day when a member of staff approached their room. We heard the member of staff reassure the person that it was still quite early in the morning, They told the person, "There's absolutely no rush, it's quarter past eight, just checking if you're ready for your tablets." There was evident warmth and closeness between the member of staff and the person they supported.

All the staff we spoke with told us how they provided a caring service for people. All staff commented that they enjoyed their job. A staff member from the housekeeping team told us, "This is a good place to work" and, "The carers are really good." Throughout the day, staff demonstrated how they showed respect for people. For example, they knocked on peoples' doors before entering. Staff were mindful of the need to ensure people's privacy was maintained when they were being supported with personal care.

Staff popped into people's rooms regularly to check people were comfortable, and to ask if they needed anything. For example, we heard people who needed support with their mobility, being asked if and when they would like to go to the dining room for lunch. We watched as one person thanked a member of staff for providing support to them. The member of staff responded, "You are so very welcome."

Staff knew the people they cared for well. They knew people's likes, dislikes, preferences and their preferred form of address. The care records provided details about people's hobbies, careers, interests, people who were important to them and important events. Relatives and friends were invited to provide additional information in documents called, 'This is my relative/friend'. A relative told us they could visit the home whenever they wanted. People told us their visitors were always made to feel welcome.

The provider encouraged people or their relatives to use a national website to give feedback on the service. The website had three reviews from relatives, all posted since June 2016. They were all positive and described all areas of the service as excellent or good. Comments from the three reviews included, 'All staff showed genuine kindness and care, to the extent that several felt like friends' 'My mother is so happy and content at Katherine House. The staff look after her really well- chatting to her and cheering her up' and, 'The staff are marvellous and treat my Mum as if she was their own mother. For a residential home, they go beyond the care you would expect.'

There were no people receiving end of life care when we visited the home. Where people had agreed, their

end of life wishes had been recorded. For example, for one person their records stated the familiar things the person wanted to have around them. The records also confirmed the type of music the person would like and that it should be playing in background. This meant information was available to inform staff so the person's wishes could be met.

Good

Is the service responsive?

Our findings

The registered manager or the deputy manager completed initial assessments with people and their relatives, before people moved into the home. This was so they were aware of people's individual needs, preferences and choices. Further assessments were completed when people moved into the home. Care plans were developed, and these provided detail about how people's identified care and support needs would be met.

People told us they were able to follow their own preferred routines by getting up at the time they wanted and being supported to go to bed at a time of their choosing. The care records provided details of the person's preferences. For example, for one person, their care plan stated, 'Likes to go to bed 9-10pm. Likes two pillows. Likes to wear socks.' This reflected that people's individual choices and preferences were respected.

Monthly reviews of risk assessments and care plans were completed with the person's allocated key worker. Annual review meetings were undertaken and there was evidence that people and their relatives, where appropriate, had been involved.

Staff provided the care and support people needed. They encouraged people to do what they were able for themselves, and helped with what they were not able to do independently. Staff completed timed entries in the electronic daily notes records during the day and night. These records confirmed the support people had received. For example, one person's daily record confirmed, 'assistance given to wash and dress… [Name of person] saw to their own oral hygiene and shaving needs.'

People told us they had enough to do during the day and had regular opportunities to follow their interests and take part in social or physical activities. An activities programme was available and copies were displayed in communal areas and on notice boards. The programme included musical afternoons, visiting entertainers, exercise sessions, coffee mornings with people involved with the provider's charity, visits into the community and visiting 'speakers.' During the week of our inspection, the weekly programme included a talk from a person who had worked in the Magistrates Court.

We saw the afternoon musical session on the day of our inspection was well attended. The activity coordinator told us that most afternoon entertainment sessions were attended by over 20 people. Staff had encouraged people to attend. We also saw that staff were respectful of people's decisions if they declined the invitation to attend. For people who were unable, or chose not to attend group activities, the activity coordinator or activities assistant spent time with people in their rooms.

The care records provided detail about the activities people had participated in and the one to one sessions with people in their rooms. For example, one person's records stated, 'I sat with [name of person] and showed her a book that her granddaughter made and went through the pictures which she enjoyed.'

The provider had a complaints procedure available for people and their relatives. People told us they would

feel able to raise concerns or make a complaint if they needed to. We reviewed the complaints files and saw that very few complaints had been received. There was one recorded complaint within the last 12 months. The registered manager told us how they responded to this complaint and this was in accordance with the details recorded in the provider's complaints policy.

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the management of the home. They all told us the home was well-led and well-managed. Relatives told us they were always made welcome and kept informed and up to date with changes and developments. Everyone spoke positively about the staff employed in the home. One person commented, "I have always found Katherine House staff to be kind and helpful."

Staff were positive about the support and direction they received. One member of staff told us, "Little things get noticed and picked up on [by the registered manager and deputy manager], such as breakfast trays being left in resident's rooms." Another member of staff commented, "This is a really good place to work. We get good support." Staff told us they were given opportunities to provide feedback, either at staff meetings, supervisions or informal meetings with the registered manager or deputy manager.

Staff spoke positively about the values of the organisation. We were told by staff the provider wanted to provide a 'home from home' for people. The registered manager told us how they wanted to make sure they continuously improved the quality of the service they provided for people. They told us they had been exploring ways to further develop a 'whole home approach' to the provision of activity and engagement for people. They were introducing a training programme to help raise staff awareness of their individual roles in providing people with meaningful activities and engagement.

Quality assurance systems were in place to monitor the health, safety and welfare of people living in the home. Audits were completed, for example, for accidents and falls, medicine management, health and safety practices and care records. We saw that actions had been taken in response to issues identified. For example, a recent medicines audit had identified staff had not always fully completed the MARs when they applied people's prescribed topical creams. This importance of completing the recording on the MARs was discussed. A recent care plan audit had identified an incorrect risk rating had been calculated for a person's risk of malnutrition. It was noted the shortfall had been discussed with the member of staff and actions taken to correct the risk rating. These examples meant people benefitted from living in a care home that could demonstrate its commitment to continuous learning and improvement.

The registered manager told us how they kept up to date with current and best practice. They had recently updated their health and safety skills and completed a recognised health and safety training course. This had been recommended by the provider following the completion of a health and safety audit of the home. The registered manager and deputy manager had completed a dementia practice training module that was university accredited. The registered manager told us they also obtained guidance and support about best practice from visiting health professionals such as the district nursing teams.

The registered manger said they felt well supported and able to contact the representative of the provider at any time for advice, guidance or support. The representative of the provider visited the home and completed an audit each month. The most recent audit was completed on 2 November 2016. It was noted that staff and residents were generally happy and content and there were no areas of concern. The representative of the provider and the registered manager discussed and agreed improvements that could

be made and agreed actions were recorded. These included the implementation of a different approach to staff refresher and update training and the completion of a food survey within three months from the date of the meeting.

Resident meetings were held and actions were taken in response to the feedback people gave. For example, at the most recent meeting, one person had commented about the clock showing the wrong time in the dining room. Another person raised an issue about their bedroom door being left open. Actions were taken to resolve their concerns. People's feedback was also obtained in surveys. We read the feedback from the last survey which was all positive. One comment read, 'I am very happy here. I like my room very much.'

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.