Community Integrated Care

St Catherines Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 2 and 6 November 2017.

St Catherine's Care Home is a nursing home based in Nantwich and is registered to provide accommodation with nursing and personal care for up to 40 people. There are currently 39 bedrooms, one of which is for double occupancy. There are two units within the home which are all based on one floor. On the day of our inspection there were 31 people living in the home.

The home does not have a registered manager. The manager in post who assisted with this inspection was applying to be registered but has now resigned from the service. 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 last inspection took place on 23 January 2017. At that inspection we identified four breaches of the relevant regulations in respect of the safe management of medicines and people's risk assessments not being followed, people being restrained without best interest decisions being recorded, people's privacy not being respected and actions had not been acted upon when improvements to the service were needed and identified by the provider's audits. At this inspection, we found that there were improvements in some areas; however the provider was in breach of four regulations.

We are taking further action against the provider for repeated and serious failures to meet the regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Risks to people were not managed safely and there was no clear guidance for staff on how to reduce the risks identified. There was no oversight or learning from incidents and accidents that happened in the home.

Staff had completed safeguarding training and we saw instances where incidents had been recorded, however the provider's systems for reporting to the local authority were not robust. We found some safeguarding incidents had not been appropriately referred to the local safeguarding team. There was no managerial oversight of these incidents so there was no learning on how things may be improved or prevented in the future.

We found that there had been some improvements in the management of medication such as medication was being stored and administered safely, but further improvement was required. Topical creams were not dated when opened and charts indicating where topical creams needed to be applied were not always completed. This meant we could not be confident that people's skin care needs were not always met.

The provider was not acting in accordance with the Mental Capacity Act 2005 to ensure that people were receiving the right level of support with their decision making. We found that capacity assessments and best interest decisions were not clearly recorded. There was a tracker in place to alert the manager when DoLS applications expired, however this was not effective as we found a number of applications for DoLS which had not been updated when they had expired.

We received a complaint and information about some people not being able to have baths or showers and only having access to bed baths. The manager acknowledged that equipment had been ordered and bathrooms were being refurbished in order that everyone would have this choice.

We found that care records were confusing, disorganised and often contained conflicting information. It was not clear that these were being reviewed on a regular basis. We found that advice given by other professionals was not always reflected in care plans and was not always being followed. Where risk assessments had been completed, care plans did not address how those risks to people would be reduced or managed.

People's preferences were not always respected in relation to their care and their care was not always given as described in their care plan.

We found that the provider had no effective systems to monitor and improve the standard of care provided

in the home. The manager did not have oversight of the risks to people within the home and subsequently actions had not been taken to address these risks.

The registered provider did not have an effective quality assurance system in place. Where audits had been completed, actions were not followed up. Little progress had been made since the inspection earlier in the year and the provider remained in breach of a number of the same regulations.

We asked the people living at St Catherine's and their relatives about the home and the staff members working there. Relatives gave high praise to the permanent staff working at St Catherine's and we observed positive relationships between staff and people living in the home.

There were sufficient staff to meet the needs of the people living in the home. We did receive negative comments from relatives about the levels of agency staff working within the home as this impacted on the quality of the care given as they were not familiar with their family members. At times agency staff did not attend for their shifts. The provider was actively recruiting for more staff and had addressed the issues with the agency around staff not attending. Recruitment of staff within the home was safe.

We asked staff members about training and supervision. They all confirmed that they received regular training and supervision throughout the year. We saw that further improvements were needed as regular supervision with staff was not consistently carried out. The provider had identified additional core training that staff needed to attend and plans were in place for this.

We saw regular checks on the property were undertaken and the premises were safe without restricting people's ability to move about freely.

People had access to various activities within the home and were observed to enjoy these on both days of our inspection.

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.

Risks to people were not managed safely and there was no clear guidance for staff on how to reduce the risks identified. There was no managerial oversight or learning from incidents that happened in the home.

We found some safeguarding incidents had not been appropriately referred to the local safeguarding team. There was no oversight of these incidents so there was no learning on how things may be improved in the future.

There were sufficient staff to meet the needs of the people living in the home; however the provider was using agency staff in order to cover staff vacancies. Relatives told us this caused confusion for their family members who were living with dementia and the agency staff did not know their family member well. The provider was actively recruiting more staff.

We found that medications were administered and stored safely, however there was room for further improvement with topical creams. Cream were not dated when opened and charts indicating where topical creams needed to be applied were not always completed.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not acting in accordance with the Mental Capacity Act 2005 to ensure that people were receiving the right level of support with their decision making. We found that capacity assessments and best interest decisions were not clearly recorded and applications for DoLS were not updated where these had expired.

We saw staff received regular training and the provider had identified further core training for all staff to attend. Supervisions had taken place recently, but we saw that these were still not occurring regularly. The manager had plans in place to improve

this.

We received mixed feedback about the food provided at the home. We saw the service was consulting people about food to try to make improvements.

Is the service caring?

Requires Improvement

The service was not always caring.

We received a complaint and information about some people not being able to have baths and showers, only bed baths. The manager told us that equipment had now been ordered and so everyone in the home would have this choice.

We asked the people living at St Catherine's and their relatives about the home and the staff members working there and people we spoke with were positive about the permanent staff that worked in the home.

Is the service responsive?

Inadequate

The service was not responsive.

We found that care records were confusing, disorganised and often contained conflicting information. It was not clear that these were being reviewed on a regular basis.

We could not always be confident that care was given as described in people's care plan and we saw that risks to people were not always clearly recorded in care plans. Where risks had been identified, they were not robust care plans in place to reduce these risks. People's preferences were not always recorded in their care plans as we found some that had empty sections.

The provider had a complaints policy and processes in place to record any complaints received and we saw concerns raised were addressed within the timescales given in the policy.

Is the service well-led?

Inadequate

The service was not well led.

We found that the provider had no effective systems to monitor and improve the standard of care provided in the home. The manager did not have oversight of risks to people within the home and subsequently actions had not been taken to address these risks.

The registered provider did not have an effective quality assurance system in place. Where audits had been completed, actions were not followed up. Little progress had been made since the inspection earlier in the year and the provider remained in breach of a number of the same regulations.

We saw that staff and relatives meetings were being held regularly within the home.

St Catherines Care 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 2 and 6 November 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day of inspection and one adult social care inspector on the second day of inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked information that we held about the service and the service provider. We looked at any notifications received and reviewed any other information held about the service prior to our visit. We invited the local authority to provide us with any information they had about St Catherine's Care Home. We were aware that the service was working to an action plan with the local authority.

During the inspection, we used a number of different methods to help us understand the experiences of people living in the home.

We spoke with seven people who lived at the home, 19 relatives and 11 members of staff including the registered manager, the clinical lead, the activities co-ordinator, two members of domestic staff, two nurses, three members of care staff as well as the regional manager and director of adult social care for the provider. We spoke to a visiting GP and two visiting health professionals as well as two visiting ministers to the home.

Throughout the inspection, we observed how staff supported people with their care during the day.

We used the Short Observational Framework for Inspection (SOFI) and undertook a SOFI during the course

of the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked around the service as well as checking records. We looked at five care plans. We looked at other documents including policies and procedures; staffing rotas; risk assessments; complaints; staff files covering recruitment and training; maintenance records; health and safety checks; minutes of meetings and medication records.

Requires Improvement

Our findings

We asked the people living in the home whether they felt safe. People we spoke with told us they felt they were safe. One person told us, "There are enough staff, I am well-treated and staff come when I call with my bell". Relatives visiting the home gave us mixed feedback on how safe they felt their family member was. Many commented on the use of agency staff and that they were happier when permanent staff were in the home. Comments included, "Sundays are terrible, there is always a shortage of staff and no co-ordination", "There are lots of lovely staff, but at times I don't want to go home as I'm worried about his safety". In contrast, other relatives told us, "When we went on our holidays, we felt really secure that she'd be well looked after whilst we were away. I think it's wonderful", "I am confident and trust them [the staff] with my wife's health" and "They always come quickly when he presses the bell".

At our last inspection in January 2017, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that medicines were managed safely and where risks to people's health and well-being had been identified, these had not been appropriately managed to reduce the risks to people. At this inspection, the provider continued to be in breach of this regulation.

We looked at risk assessments and could see that where people had been identified at high risk for instance from malnutrition and dehydration, the care plans did not always contain sufficient information of what action was being taken to reduce this risk. We looked at one person's care file and could see that they had lost significant amounts of weight. They had been reviewed by the GP, but their care plan did not reflect what action staff should be taking to ensure this person received sufficient food and fluids. We checked their daily charts and could see that on some days, they had eaten and drunk very little and there was no evidence to suggest that they had been offered snacks or alternative meals to encourage them to eat. In another person's care plan, we saw that they had been seen by the dietician and the Speech and Language Team in relation to their eating. They had recommended that the person needed one to one support when eating for encouragement and prompting, again to try to reduce their weight loss. We looked in the care plan and could see that this had not been updated to reflect this advice. Furthermore, we saw that this person was left alone at breakfast on the first day of our inspection and was not receiving support. We spoke to one staff member in relation to this advice and they had not been made aware of this.

We looked at the accident and incident records in the home. We could see that staff completed an incident form when anything happened in the home. We saw that one person had three falls in July 2017, two falls in August 2017 and three further falls in October 2017. We checked this person's care plan and we found that

the section on mobility was empty and we could not locate a care plan in relation to falls. This meant the provider was not taking all reasonable steps to minimise risks to this person in relation to falls. We asked the manager whether there was any analysis of the accidents and incidents that may identify any trends and patterns in how and when people fell so that preventative action may be taken. We were informed that there was no analysis of these accidents and incidents.

We looked at medication and how this was managed. We could see there had been some improvements since our last inspection, however there was scope for further improvement. We saw both the medicines trolley and the treatment rooms were securely locked and daily temperature checks were made. We observed medicines being dispensed and saw that practices for administering medicines were safe. We checked medicine administration records, which showed people were getting their medicines when they needed them and at the times they were prescribed. The morning medication rounds were completed before lunch. We saw records were kept of all medicines received into the home and if necessary their disposal. Controlled drugs were stored securely and in the records that we looked at, these were being administered and accounted for correctly. However we found that ointments and creams were not dated when opened and the records for the application of these creams were not consistently completed. Topical creams that have been opened for too long may lose their effectiveness. On some of the records that we looked at, there were no body maps, therefore staff may be unsure where these creams were to be applied. We saw that the clinical lead undertook medication audits, however we could not see that where issues had been identified that these were followed up in a timely manner.

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

We saw that the provider had a safeguarding policy in place. This was designed to ensure that any safeguarding concerns that arose were dealt with openly and people were protected from possible harm. The manager told us that they were aware of the relevant process to follow and the requirement to report any concerns to the local authority and to the Care Quality Commission (CQC).

Staff members confirmed that they had received training in protecting vulnerable adults and when we checked the records we could see that this had been completed recently. The staff members we spoke with told us that they understood the process to follow if a safeguarding incident occurred and they were aware of their responsibilities for caring for vulnerable adults. Staff were aware of the need to report safeguarding incidents both within and outside of their organisation. We saw that the provider had a whistleblowing policy in place. Staff were familiar with the term whistleblowing and each said they would report any concerns regarding poor practice they had to senior staff.

However, we found a number of safeguarding concerns that had not been reported to the local authority or CQC. We saw that staff raised any safeguarding incidents via an incident form to the manager. These were triaged and the manager made the necessary safeguarding referrals to the local safeguarding authority. We saw two incident forms which had been completed by staff in August and September 2017 and reported via this system, however these had not been referred sent to the local safeguarding authority. Furthermore, we saw reference in someone's daily notes to unexplained bruising in September 2017, which staff recorded as being reported to the management and this again had not been reported to the local authority or CQC. We spoke to the clinical lead about these incidents and they could not account for why these had not been reported. The manager told us that they had raised with the provider that where incidents were classified as low level within this system, they were not escalated to another manager when he was not present in work. This meant that incidents had not always been appropriately referred or investigated.

We asked the manager whether the provider had a tracker of safeguarding incidents in order that they had an overview of the outcomes of any investigations and what lessons could be learnt. The manager told us that each incident was recorded but there was no tracker or analysis of these incidents.

We saw that two people were receiving their medication covertly. We checked the records to see whether the appropriate authorisations had been submitted in relation to Deprivation of Liberty Safeguards. We found that the authorisations for these people had expired, which meant that they were being unlawfully deprived of their liberty.

These issues constitute a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to people living in the home and their relatives about staffing in the home. Most relatives commented on the use of agency staff and that now there were more permanent staff, it was becoming more stable, but this remained an issue. Comments included, "There are too many agency staff who do not know the procedures and this can cause an issue as regular staff have to 'train' agency staff", "Irregular arrival of agency staff [is an issue], the core staff are brilliant" and "There are lots of agency staff and there are not always enough staff".

We spoke with staff and they told us that in general there were enough staff, but felt things were easier when the permanent staff were on shift. We spoke to the manager about staffing and recruitment and we checked the rotas. We were told that there had been a large turnover of staff since our last inspection, which meant that they were using agency staff, particularly agency nurses. The manager was aware that there were occasions when agency staff did not attend for their shift. The provider was in communication with the agency in relation to this and often other staff would work later in order to cover the shifts. The provider had developed a nursing strategy to look at how to improve recruitment to the vacant nursing posts and they were actively recruiting. The manager completed a dependency tool to look at the changing needs of the people living in the home and this was currently being reviewed as some people's needs had changed within the home.

As part of our inspection we used the call bells in people's rooms on a number of occasions and each time these were answered promptly. At the time of our inspection there were 31 people living in the home. During the two days of our visit there were two nurses on duty between the hours of 8am and 8.30pm and eight carers. At night there were two nurses and four care assistants between the hours of 8.30pm and 8am. The manager was in addition to these numbers as well as the clinical lead. We looked at the rota and could see that this was the consistent pattern across the week and we saw that the manager was drawing together all the occasions where agency staff had not attended in the last month for this to be addressed with the agency.

In addition to the above there were also separate ancillary staff including one administrator, two catering co-ordinators, one activity co-ordinator, a housekeeper and three domestic assistants. There was also a maintenance person who visited the home each week.

We looked at the files for three members of staff to check that effective recruitment procedures had been completed. We found that appropriate checks had been made to ensure that they were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each file held suitable proof of identity, the application form with full employment history, a medical check and references.

Staff members were kept up to date with any changes in people's care during the handovers that took place at every staff change. However, we did note that not all staff were aware of the changes in relation to the person who needed one to one support with eating. In addition to this, there was a diary that noted any appointments, referrals that needed completing as well as any visits into the home each day.

We checked some of the equipment and safety records for bath hoists, bed rails and other safety equipment and saw that they had been subject to recent safety checks. We conducted a tour of the home and our observations were of a clean, fresh smelling environment which was safe without restricting people's ability to move around freely.

We could see that a number of maintenance checks being carried out weekly and monthly. These included the fire alarm system, emergency lighting and water temperatures. We saw appropriate safety certificates were in place for gas, electrical installation and legionella prevention.

The home conducted regular fire drills and staff had regular training on fire safety. We found that the people living in the home had an individual Personal Emergency Evacuation Plan (PEEPS) in place. PEEPS are good practice and would be used to assist emergency personnel evacuate people from the home in the event of an emergency such as a fire.

Requires Improvement

Our findings

All the people and their relatives we spoke with felt that their needs were met. They said staff were caring and knew what they were doing. Comments included, "I trust the staff because they care", "I cannot praise the core staff enough. [name] in particular is a godsend – she's very committed and puts people first" and "Staff seem to know him well. Everyone is so kind. What's lovely here is that there is no smell – it's so pleasant".

At our last inspection in January 2017, we found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always recorded best interest decisions and we saw someone being restrained against their will in order to give them personal care. At this inspection, whilst we did not see any unauthorised restraint and we saw some paperwork had been completed, however there were many instances where paperwork and the correct procedures had not been followed, therefore the provider remained in breach of this regulation.

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).

We saw that four people in the home were given their medication covertly. This meant their medication may be hidden in food or crushed. We could see that some paperwork had been completed in relation to this and the GP had been consulted, however we could not see clearly in each case that mental capacity assessments had been completed or best interests decisions recorded to look at whether this was the most appropriate and least restrictive option in which to administer the person's medication. We also saw for two people who were given their medication covertly that their DoLS authorisations had expired which meant that some people were being unlawfully deprived of their liberty.

We saw that a tracker had been introduced to keep abreast of any DoLS authorisation and when they needed to be renewed. We found that this was ineffective as two DoLS authorisations had expired and new applications had not been submitted despite the tracker being in place. We also found that the tracker was not up to date as it contained the names of people who no longer lived in the home. The tracker identified

that a number of people may not be able to consent to their care and needed their capacity to consent to care and treatment to be assessed. Despite this, we could not see any evidence that these assessments had been carried out.

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

We saw that new staff were enrolled and completed the Care Certificate when starting in post. This is a nationally recognised and accredited system for inducting new staff. Staff told us that they also completed shadowing of existing staff prior to working unsupervised.

We asked staff members about training and they all confirmed that they had received regular training throughout the year. We subsequently checked the staff training records and saw that staff had undertaken a range of training relevant to their role including emergency first aid, safeguarding and mental capacity training. Where people's training was out of date, there were plans for people to undertake this training. We did note that some areas of training were not part of the provider's core training, for instance infection control and food safety and it was only provided to specific roles. We spoke with the regional manager and director of adult social care, who advised that the provider had recognised this gap and this training was now booked to be completed by all staff.

Staff we spoke with advised that they received regular support and supervision. We checked records which confirmed that supervision sessions for each member of staff had been held. We spoke with the manager regarding supervision and he acknowledged that this had not been happening regularly and still needed some improvement. This was due in part to not having a stable staff team in which to cascade supervision. This was an area that they were continuing to work on.

During our visit we saw that staff took time to ensure that they were fully engaged with each person. Staff explained what they needed or intended to do and asked if that was acceptable rather than assuming consent.

We saw that people were weighed regularly and if someone had gained or lost significant amounts of weight, appropriate advice was sought. However as outlined in the safe domain, we found that care plans were not always clear with regard to what action staff should take to support people's dietary intake. Visits and advice from other health professionals were recorded on the care files, but people's files were disorganised and people sometimes had more than one care plan, so it was not always clear to see this advice. This is discussed further in the responsive domain.

From our observations and discussions we found that permanent staff knew the people they were supporting well. They were able to tell us about their likes and dislikes as well as some of their history.

The provider employed catering co-ordinators who prepared food from a catering company who delivered meals on a monthly basis. There was a four week menu that was nutritionally balanced and specialist diets such as gluten free were catered for. Staff members we spoke with confirmed that people could request an alternative option if they did not like the meal of the day and we saw on the first day of our inspection that someone had been given an alternative meal. There was a four weekly menu, with two options at lunchtime, various choices for breakfast and soup and sandwiches in the evening. Special diets such as soft diets were provided. We received mixed feedback from people living in the home about the food. Four people we spoke with confirmed that they had choice of where to have their meals and what they could have. However other comments included, "The food is fine, but not enough salt so I have my own to add", "The food is horrible, I

only eat sandwiches and the soup. I like the soup" and "All the food is fine, could be hotter, and I don't like the soup". We spoke to the housekeeper about the food and they advised that they had been working with people and their families and had recently completed taste tests of different meals. They continued to monitor the meals and where they received negative feedback, they did not order this option again.

We observed lunch being served and noted that very few people ate in the dining rooms, preferring to eat in their own room or the living room or other seating areas. We saw wherever people were seated they had been provided with a lap table with appropriate cutlery and napkins. We saw that when people needed support, they were assisted by staff members in a patient and unhurried manner. However we did see one instance where someone's care plan stated they needed prompting and support to eat their meal and on the day of our inspection, we observed that this support was not provided.

We asked relatives if they felt involved in their relative's care. Most relatives felt that they were involved in their family members care and kept up to date. Two relatives felt that they were not consulted or involved in their family member's care. Comments included, "Staff keep me informed if there are any incidents or falls calling me at home or when I arrive", "They let us know if there are any problems and communicate this" and "Any changes are not discussed and we are not involved in the care plan".

Visits from other health care professionals such as GPs, chiropodists and dieticians were recorded but as people's files were disorganised it was not always easy for staff to see when the visits had taken place and why. We spoke to a GP and two other health care professionals during the course of our inspection. They commented that things had settled down since there were more permanent staff in post and they felt that there had been some improvement in the home. Comments included, "It seems more settled than earlier in the year, sometimes care plans are not up to date" and "We have a good working relationship. The staff are incredibly caring and know the residents really well. They are doing remarkably well under difficult circumstances as there has been lots of instability with staff changes. There have been lots of changes of paperwork and no-one knows where anything is, but people receive a very good standard of care".

A tour of the premises was undertaken. This included all communal areas including the lounges and dining room and with people's consent a number of bedrooms as well. We saw that there were pictures and people's names outside their room to help them navigate around the home. Bathrooms were clearly sign posted and in different colours to help distinguish them from people's rooms. There were a number of different seating areas on each unit which enabled people to move about the unit freely and seek quiet time if activities were being conducted.

The laundry within the service was well equipped. It was clean and well organised. One relative commented that the person in the laundry was 'brilliant'.

Requires Improvement

Our findings

We asked people who lived in the home and their visitors about the home and the staff who worked there. Everyone we spoke with was very positive about the permanent staff who worked in the home. People told us, "I'm well treated". Visiting relatives told us, "The staff are wonderful", "She could not be in a better place" and "The staff are lovely and treat people with care. They are kind".

At our last inspection, we found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's privacy and dignity were not respected. We found that some people were entering other's bedrooms uninvited and this was causing anxiety to some of the people living in the home. At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

We saw that motion sensors had been introduced in people's rooms in order that staff were alerted to people going in and out of certain rooms. This meant people's privacy was respected. We saw that staff knocked on people's doors before entering and one person who wanted privacy had a door bell system installed with signage on the door to advise people to ring the door bell and wait for the door to be answered.

Prior to our inspection we received a complaint and safeguarding information from the local authority that some people were only receiving bed baths and did not have the option to have baths or showers. We spoke to relatives and people during our inspection and received mixed feedback with some people advising that they had access to baths and showers whilst some relatives told us that their family member had never had a bath and they had been informed that the equipment was 'not up to scratch'. We spoke to the manager in relation to this. They acknowledged that after this had been brought to their attention by the local authority and the complainant that they found that they did not have sufficient equipment to enable some people to access baths or showers and that this equipment had now been ordered. The manager also advised us that communal bathrooms were being refurbished in order to make them more inviting.

It was evident that family members were encouraged to visit the home when they wished. People told us, "I always feel welcome and they always ask if I would like a drink. It's very relaxed" and "We can come in whenever we want and are always made to feel welcome". One person did share with us that they did not always feel welcome. We were aware that they had recently had a meeting with the manager and their concerns were ongoing.

We viewed cards and compliments that had been sent into the service. One person's relative wrote, "We are very appreciative of the professional care given to Dad during his stay at St Catherine's. We particularly enjoyed the fun and laughter you all shared. This is a happy home". Another relative write, "I would like to take this opportunity to thank you and the rest of the staff at St Catherine's for making the last year of Mum's life the best it could be."

The staff members we spoke with caring and demonstrated that they knew the people they were caring for well. Many of the staff had worked in the home over a long period. They told us that they enjoyed working at St Catherine's and had very positive relationships with the people living there. One person told us, "The girls give 110% to the residents all the time" and "I love the people I look after, I do love it".

We undertook a SOFI in both units over lunch on the first day of our inspection. We saw that staff members were speaking to people with respect and were patient and not rushing whilst they were supporting people.

We saw on both days of our inspection that the people living in the home looked clean and well cared for. Those people being nursed in bed also looked clean and comfortable. Relatives commented that the home was clean and fresh smelling. We did receive one concern that a family member did not always look clean when relatives visited and this was being looked at by the manager. Other relatives commented that their family member always looked clean and their hair was always done.

People's personal information was kept securely in the nurses' office on each unit. We did see on occasion that the doors to the filing cabinets on one of the units were not closed.

Inadequate

Our findings

We asked people who lived at the home whether they had choices with regard to daily living activities and whether they could choose what to do, where to spend their time and who with. People who were able to speak to us confirmed that their choices were respected. One person told us, "I get to play dominos and have a bottle of spitfire beer after dinner". Another person showed us the knitting that they were enjoying and someone else spoke to us about a book they were reading.

We looked at the care plans and found that they were disorganised and not always completed. It was not easy to find information and in some cases where risks had been identified, there was no care plan in place to inform staff how to keep the person safe. For instance, we saw in one care plan that the person was assessed as being at high risk of pressure sores as well as malnutrition and dehydration, but there were no support plans in place to advise staff how to mitigate this risk. We saw another person had two care plans in place and when we spoke to the agency nurse, she was not clear which one was being used. Subsequently we found that advice from professionals was being recorded in one version and had not been transferred to the updated plan. We found it very difficult to find the correct information about people's needs and preferences and it was not clear to see whether care plans had been updated. We also found that other paperwork was poorly completed, for example topical cream charts. We saw that these were not being completed on a consistent basis. We found three different types of paperwork in operation in relation to covert medication. We spoke to staff who told us that there had been a number of different versions of paperwork and they acknowledged that it was hard to find information. Permanent staff knew people well and were able to speak knowledgeably about the people living in the home and their needs. However there was a number of agency staff working in the home and care plans were not written in a way that was easy to see people's needs and preferences.

We saw that people were offered drinks throughout the day, however when we looked at the fluid charts, on some days we saw large gaps on a number of charts so we could not be confident that everyone had access to drinks.

We spoke to the manager and regional manager in relation to care plans. They told us that they had been reviewing care plans and were transferring everyone over to a new format. We highlighted some shortfalls in the new paperwork. The regional manager stated that they would look again at the paperwork and focus on ensuring that the care plans were up to date prior to transferring them to the new format.

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

2014. The provider was not keeping an accurate, complete and contemporaneous record in respect of each service user.

We saw that risks to people were not clearly recorded in people's care plans. Even where risks were identified, care plans did not contain sufficient detail as to how staff may reduce the risks to people. We saw records that people had lost significant amounts of weight, however the care plans did not reflect what support staff should be offering to people in order to minimise further weight loss. Where additional monitoring of people's food and fluid intake was in place, it was not clear in the care plans what staff should be doing where fluid and dietary intake was low and the charts were not always completed correctly as there were gaps and the charts were not totalled at the end of every day.

We saw a letter in one person's care plan that they had been seen by the Speech and Language Team and they assessed that the person needed support with eating. This advice was not reflected in the care plan as the care plan stated that they could eat independently. Furthermore, we saw during our inspection that this person was not receiving this support at every meal time as we observed them left alone with food.

This is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a full time activities co-ordinator. On both days of our inspection, we observed that there were activities in the home for people to join in should they wish, but also that the activities co-ordinator provided quieter one to one time for people chatting or playing games and reading the paper for people who did not wish to take part in the group activities. We asked to see a schedule of activities, but they advised that they spoke to people each week and were flexible in what was offered. External activities were arranged in advance. We saw that there was an animal therapy session and communion on the first day of our inspection. These were taking place at the same time. These activities were not advertised anywhere in the home. The activities co-ordinator kept a log of activities undertaken, who had taken part and their participation in the activities. They told us that the activities programme was constantly adjusted as a result of observations of what people had enjoyed. We spoke with the activities co-ordinator about advertising the activities so everyone in the home and their relatives were aware of what was taking place.

We found that appropriate 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were in place on some of the care files that we reviewed. We saw that the person, their relative or health professional had been involved in the decision making. Records were dated and signed by a GP and were reviewed appropriately. A DNACPR form is used if cardiac or respiratory arrest is an expected part of the dying process and where CPR would not be successful. Making and recording an advance decision not to attempt CPR will help to ensure that the person's advance decisions about their end of life care are respected.

The service had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. We looked at the concerns that had been raised in 2017 and could see that these had been dealt with appropriately. People living in the home and their relatives told us that they were able to raise any concerns and were confident that these would be dealt with. Comments included, "We did make a complaint and this was dealt with satisfactorily". One relative told us that they did not feel that their concerns were being dealt with and we could see that this complaint was still being dealt with.

Inadequate

Our findings

There was no registered manager in place at the time of our inspection. The current manager had been in post since April 2017 and was in the process of registering with CQC, but had resigned from post at the time of our inspection and was working out their notice period. They were supported by a clinical lead, a regional manager and clinical governance manager and quality assurance team. Since our inspection we have been informed that there is a new manager in post.

We spoke to people about how the home was run. People we spoke with were positive about the permanent staff in the home; however people were not always positive about the management in the home. Comments included, "The staff are absolutely brilliant, but are not getting the full support of the manager" and "Nothing has changed since the last inspection. It's all talk and no action". Staff morale was low and they told us that they had experienced an unsettled period with a number of staff and management changes.

At our last inspection in January 2017, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had ineffective systems and processes in place to ensure compliance with the regulations. At this inspection, we found that there had been no improvement in the systems and processes in place to monitor and improve the service and the provider remained in breach of this regulation.

There were no systems in place to monitor and analyse safeguarding incidents or other incidents and accidents. We saw evidence that one person had repeatedly fallen and no analysis was carried out to look at whether preventative action could be taken. No audits were being completed on care plans and the plans that we looked at were completed to a poor standard and did not provide sufficient information on what people's needs and preferences. Neither did they provide sufficient information on how risks to people safety could be reduced. We identified these issues at our last inspection yet no appropriate action had been taken.

The clinical lead had produced a clinical governance report in August 2017 which identified people who were at risk for instance of malnutrition. We saw two people who had experienced significant weight loss were not included in this report. The report was submitted to the registered provider but there was no evidence that the registered provider had reviewed the report and organised that appropriate action was taken to address people's nutritional risks.

We saw that medication audits had been completed by the clinical lead, but we found that where issues had

been identified, these had not been followed up.

We saw that advice from the provider's quality assurance team in relation to one care plan had not been implemented. Other action plans from the regional manager and the local authority designed to improve the service had not been properly compiled with. This meant the provider was not taking appropriate action to improve the quality and safety of the service.

A complaint and safeguarding information from the local authority about some people not having access to baths or showers had not been picked up as part of the providers quality assurance or feedback systems. The manager told us that plans were now in place to address this.

We requested a number of documents from the manager who struggled to produce these during the inspection. We have subsequently gained further information from the regional manager.

There was little or no progress on many of the areas that we identified at our last inspection in January 2017 and we found additional breaches as part of this inspection.

The above issues constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to notify CQC of events or changes that affect a service or the people using it, for instance serious injuries or where the provider has made an application to deprive someone of their liberty. We found instances where the provider had not notified CQC of incidents within the home. We have written to the provider separately about this matter.

We saw that a number of relative's meetings had taken place since the last inspection and we were able to view the minutes from the last meeting. We saw that items discussed included food, staffing and activities.

We saw that staff meetings had been held and issues such as care plan reviews, issues from the relatives' meeting, confidentiality, equipment and staffing had been discussed.