V Gulati

Catterall House Residential Care Home

Inspection report

Garstang By-Pass Road
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This comprehensive inspection was unannounced, which meant the provider did not know we were coming. It was conducted on 3 November 2015.

Catterall House is located on the outskirts of Garstang and is within easy reach of the cities of Preston and Lancaster. Accommodation is provided for up to 24 people who need help with personal care. Most bedrooms are of single occupancy. Bathrooms are located throughout the home. A variety of sitting rooms are accessible and a separate dining room is provided. A range of amenities are available within Garstang village centre and public transport links are nearby. There are ample car parking spaces available adjacent to the premises.

Summary of findings

We last inspected this location on 28 May 2014, when we found the home to be compliant with the outcome areas we assessed at that time.

At the time of our arrival to this location the registered manager was not available. However, he attended shortly afterwards. 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 cleanliness of the premises was found to be unsatisfactory. Areas of the environment were found to be dirty and unhygienic. Some areas were also in need of modernising and updating.

Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use. However, during our tour of the home and the external grounds we found that the premises did not meet everyone's needs and there were several areas which were unsafe and therefore this did not protect people from harm.

We looked at medication practices adopted by the home and found failings, which meant that people were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed.

Areas of risk had not been managed appropriately. Therefore, people were not consistently safe. Consent had not always been obtained through best interest decision making processes before care was provided. New staff were appropriately recruited and therefore deemed fit to work with this vulnerable client group.

The three care staff on duty each day were responsible for cleaning and laundry duties, as well as the provision of activities. Meal preparation was also completed by care staff on two days each week, when the cook was off duty. These additional duties for care staff had an impact on the provision of appropriate care being provided for those who resided at Catterall House. Two people expressed their concerns about the staffing levels at the home. We observed one person visibly upset because she had waited a long period of time to be helped to the toilet and another person was transferred by one care worker, when this manoeuvre would have been safer had there been two care workers available to assist the individual.

Records showed that robust assessments of people's needs had not always been conducted and therefore, in one instance this resulted in a person being inappropriately placed and the home failing to meet his needs.

Induction programmes for new employees were formally recorded. Supervision and appraisal meetings for staff were regular and structured. This meant the staff team were supported to gain confidence and the ability to deliver the care people needed. A wide range of training programmes were provided, in line with the nationally recognised care certificate.

Evidence was available to show that surveys and meetings for those who lived at the home were conducted. However, these were not on public display at the time of our inspection. We have made a recommendation about this. There was no information on public display about the use of local advocacy services. We have also made a recommendation about this.

We found that people's privacy and dignity was respected. Guidance from community health care professionals had been consistently followed. The planning of people's care varied. Some records were person centred and well written, providing staff with clear guidance about people's needs and how these were to be best met. However, some had not been updated in line with changes in their needs.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for need for consent, safe care and treatment, staffing, premises and equipment and good governance.

We also found breaches of the Care Quality Commission (Registration) Regulations 2009 in so much as we found that the registered person had not notified the Care Quality Commission of a recent incident, which could have potentially resulted in serious injury or a fatality.

Summary of findings

You can see what action we told the provider to take at the back of the full version of this report. We are taking enforcement action against the service and will report on that when it is complete.

As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures and further enforcement action has been taken. Our guidance states that services rated as inadequate overall will be placed straight into special measures. We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore, we have introduced special measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

•Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration.

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete

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?

Inadequate

This service was not safe.

Some environmental risk assessments had been conducted. However, we observed some areas of risk within the home and in the grounds of Catterall House, which had not all been identified through the home's risk assessment process.

Infection control protocols were not being followed and medicines were not being well managed. Areas of the premises were found to be dirty and unhygienic. Therefore, the prevention of cross infection and contamination had not been promoted.

At the time of this inspection the staffing levels were insufficient for workers to adequately complete the duties expected of them.

Recruitment practices were thorough enough to help ensure only suitable staff were appointed to work with this vulnerable client group.

Is the service effective?

Requires improvement

This service was not always effective.

New employees had completed a formal induction programme when they started to work at the home. There were structured mechanisms in place for staff support, such as formal supervision and appraisal sessions.

Mandatory learning programmes were provided for the staff team and additional modules were available, in relation to the specific needs of those who lived at the home. The training programme provided a wide range of learning modules, which were in line with the nationally recognised care certificate.

Freedom of movement within the home was evident and we did not observe this being restricted. However, we found that the premises did not meet everyone's needs and there were several areas which were unsafe and therefore this did not effectively protect people from harm.

Consent had not always been obtained through best interest decision making processes before care and treatment was provided. No-one was being unlawfully deprived of their liberty.

People's needs were not always being met by the staff team because of poor admission processes.

Is the service caring?

Requires improvement

This service was not always caring.

Summary of findings

People's privacy and dignity was promoted. Staff were seen to engage with people in a kind and caring manner and they were well presented.

However some people told about occasions when staff were not always caring and we observed some interactions which were not positive.

People were supported to access advocacy services, should they wish to do so, or if a relative was not involved and they were unable to make some decisions for themselves. An advocate is an independent person, who will act on behalf of those needing support to make decisions

Is the service responsive?

Requires improvement

This service was not responsive.

An assessment of needs was not always conducted before a placement was arranged, which in one instance resulted in a person's needs not being appropriately met.

Care plans were found to have been completed, but the standard of these varied. Some were well written, person centred documents, but others did not always reflect changes in people's needs. Information about how people wished to be supported and what they liked or disliked was not always recorded.

The provision of activities could have been better. It was evident that the number of staff on duty, were not able to provide a consistent activity programme for those who lived at the home.

Is the service well-led?

Inadequate

This service was not well-led.

Records showed that annual surveys were conducted for those who lived at the home and their relatives. A staff meeting and a resident's meeting had been held. There was clear evidence that the providers husband interfered with the day to day running of the home which had a negative effect on people who lived there.

Systems for assessing, monitoring and mitigating risks were inadequate. The quality of service provided had not been sufficiently established and therefore it was not evident that the home was adequately monitored, so that any improvements could be implemented, in accordance with the results of a robust auditing mechanism.

Evidence was available to demonstrate the home worked in partnership with other relevant personnel, such as medical practitioners and community health professionals.

Catterall House Residential 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 03 November 2015 by two Adult Social Care inspectors from the Care Quality Commission (CQC). The two inspectors were also accompanied by a member of the CQC board of governors.

At the time of our inspection of this location there were 18 people who lived at Catterall House. We were able to speak with six of them and three family members. We also spoke with three staff members and the registered manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the care files of six people who used the service and the personnel records of three staff members. We 'pathway tracked' the care of five people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

We did not request the provider to complete a Provider Information Return (PIR) on this occasion. A PIR 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.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents, injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Catterall House.

Inadequate

Is the service safe?

Our findings

During a tour of the premises we noted a number of hazards, which had not been addressed and as such, created unnecessary risks for those who used the service.

In communal bathrooms we found a range of toiletries, disposable razors and various creams and ointments, including Ibuprofen Gel and Double Base Cream easily accessible by anyone entering these areas of the home. We saw a tub of cream labelled with one person's name, in the bedroom of another resident. This suggested that creams were used as communal applications.

In the smoking room we saw an overflowing ashtray, which caused an additional hazard for people trying to extinguish cigarettes. There were a number of burn marks in the carpet and settee of this room indicating this risk was not being well managed.

We had been informed of a serious incident, which had occurred a week prior to our inspection, in which one person had been able to exit the building during the night, using a first floor fire escape route. This had resulted in the individual requiring hospital treatment following a fall down the external metal fire escape. At the time of our visit to Catterall House we found the fire escape to be in a dangerous condition because it was covered in leaves and moss, which made it slippery. In addition, the fire exit door was not secured correctly and could therefore be easily opened from either side and the lighting on the platform of this fire escape was not working, which meant people would be at further risk if they tried to use it in the dark. We were very concerned to learn that these safety issues had not been addressed, despite the recent serious accident, which could have potentially had fatal consequences. We were extremely concerned about the response of the provider and registered manager to this incident which had occurred one week prior to our inspection. An incident had occurred during which a person has received some minor injuries, but could have been potentially very serious. The registered manager had reviewed the person's care plan as a result and put some extra measures in place to maintain their safety. However they had failed to fully investigate the incident and ensure all possible measures to prevent a recurrence had been taken. This demonstrated that there was a failure to identify risks and learn from adverse incidents.

We requested a visit to the home by a fire officer, who identified areas for improvement and who has confirmed that these have since been addressed satisfactorily.

We saw a number of windows on the upper floor of the home, which opened wide and were not restricted. The patio area in the grounds of the home was uneven creating a falls and trip hazard and the garden area was noted to be overgrown and in need of maintenance. A dual wall light fixture in one bedroom was hanging loose and therefore the wiring was exposed, which created a potential risk for anyone accessing this area of the home.

The temperature of hot water from some of the outlets of wash hand basins, in communal facilities and people's ensuite bathrooms was found to exceed safe limits and presented a scalding risk. The registered manager confirmed there were no systems in place to regularly check water temperatures.

We observed that a soaking wet pillow had been place on a shelf in the sluice room. The water was dripping over electrical sockets, which were in use. This posed a serious risk of electrocution and at minimum damage to the electrical supply which would affect people who lived at Catterall House. The pillow was removed by one of the inspectors.

We established that one person who had been admitted to the home the previous day was unable to use the passenger lift to access the ground floor from his first floor bedroom, because of a long leg Plaster of Paris being in situ. We were told that staff had, 'bounced' him down the stairs in his wheelchair, to enable him access to the lower floor. This created a potentially created a serious risk for this individual.

Some risk assessments had been conducted including a fire risk assessment, dated September 2015, which had been compiled following advice from the fire officer. However, the various safety concerns were highlighted to the registered manager who had not previously identified them. This demonstrated that systems for identifying and responding to risks were not effective.

A maintenance programme had been implemented a few weeks prior to our inspection following an internal environmental audit. This covered each part of the home, showing that areas needed to be painted, decorated or 'brightened up'. Some curtains and carpets needed to be replaced and some extractor fans required repairing.

Inadequate

Is the service safe?

However, it did not include the areas of concern we identified at the time of our inspection, such as fire hazards, window restrictors, cleanliness of the environment, hot water temperatures and the assessment of the smoke room, which just stated, 'curtains need replacing'. There was no reference to the need to replace the carpet and settee in this room because of burn marks. Therefore the environmental risk assessment was not effective and the maintenance programme needed to be reviewed in order to incorporate all areas of risk.

We found the failure to assess the risks to the health and safety of people who use the service and doing all that was reasonable possible to mitigate such risks in particular with respect to the faulty fire escape door and exit route exposed people to risk of significant harm and was a breach of regulation 12 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that the premises were not maintained in a safe and secure way. This was in breach of regulation 15(1)(b)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our arrival to Catterall House there were three staff members on duty. We were told the registered manager was attending a funeral, but would be returning to the home shortly afterwards, which he did. We established that one staff member was going to be carrying out cooking duties on the day of our visit, because the cook was off duty, which meant there would have been only two carers available to provide personal care and support for those who lived at the home. We observed that some people required the support of two care workers to meet their activities of daily living. However, we were also told that care staff were required to undertake all cleaning and laundry duties, as well as provide activities for those who lived at Catterall House.

The cook arrived during the morning to work on his day off. We established that he had been contacted to work because we had arrived to conduct an inspection. However, we were told by staff we spoke with that care workers were regularly expected to cover the cook on his days off each week. We saw an example of one instance where a resident needed the assistance of two staff members to transfer, but only one was available and therefore the manoeuvre was not completely safe.

Two people we spoke with expressed their concerns about staffing levels. They stated that at times they had to wait for assistance, as staff were not able to help them, due to being busy with other people. One person said, "We have to wait an awful long time for help – it's dreadful at night." We later saw this person to be upset because they had to wait for several hours for assistance to go to the toilet.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because there were insufficient numbers of care staff deployed to adequately meet the needs of people, due to them being responsible for all other ancillary duties. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An infection control policy was in place at the home. However, during a tour of the home we saw some examples of extremely poor standards of cleanliness and hygiene. Communal bathrooms and toilets were found to be visibly dirty and had evidently not been cleaned for a considerable amount of time. Several areas of the home were very odorous. This did not provide people with a pleasant and hygienic environment in which to live. A specific infection control audit had not been conducted. Therefore, this did not demonstrate that good monitoring systems of infection control practices had been adopted by the home.

Examples of very poor hygiene were seen in various areas of the home and included some furniture. For example, a fabric chair was found to be heavily stained. Some areas had extensive cobwebs, again demonstrating they had not been cleaned for some time. One toilet we saw was very odorous. The floor was 'sticky', there was a dirty urinal bottle on the floor, the toilet was dirty, there were smears of what resembled faeces on the wall and on the toilet roll dispenser and there was no toilet paper available.

We spoke with one staff member who was dealing with some laundry. This was a care worker who confirmed that there was no staff member dedicated to laundry duties and this was an area expected to be covered by care staff. We asked the staff member about the temperatures soiled items would be washed at. It was evident that they had limited understanding of infection control procedures.

We noted that the Environmental Health Award for the home's food hygiene assessment had been downgraded in May 2015 to that of 'Requires Improvement.' We noted that

Is the service safe?

the chef's allocated hours did not allow for any cleaning time. We asked him about this and he told us he was not aware of any planned changes in his set hours or any plans to arrange for additional staff.

We were advised that a cleaner had not been employed at the home for twelve months. The registered manager advised us that he had not been permitted to appoint any cleaning staff and that the provider had maintained that cleaning duties must be carried out by care staff. The registered manager acknowledged the poor standards of cleanliness. The provider subsequently advised that the registered manager had not been prevented from employing domestic staff, but that recruitment in this area had not been successful. Due to our serious concerns in the area of infection control we requested a visit by the infection control department and the Environmental Health Officer (EHO). These visits were subsequently conducted and the home was notified of the findings and the action needed.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment because infection control practices were poor. This was in breach of regulation 12(1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we assessed the management of medicines. We identified some concerns in this area.

We viewed records relating to medicines and found a number of these to be incomplete. Important information such as people's allergy status and photographs were missing in some examples, which increased the chance of errors.

We found a number of errors on people's Medication Administration Records (MARs). These included incorrect dosage amounts, an incorrect time of administration and names of medicines being incorrectly spelt. Records were generally in a poor condition. Some MARs were ripped and falling out of the medication folder. In some examples, the names of medicines were illegible, because holes had been punched in them (for the purposes of filing).

One person who had been admitted to the service the day before, was not written up for Warfarin on his MAR sheet, despite this medicine being prescribed. On discussion, a senior staff member was not aware of this omission. The registered manager did eventually address this and advised the Warfarin had not been sent from the person's previous care setting. This was later received. This individual was also prescribed inhalers for a chest complaint, but these had not been sent with him on admission and therefore he did not have access to this prescribed treatment should he need it.

Records in relation to 'as required' and variable dose medicines were not always clear. This meant that staff did not have the necessary information to ensure people received their medicines when they needed them.

We found that one ointment which should have been kept in the fridge was being stored in a person's bedroom. This meant the ointment may not have been safe for use, as it had not been stored in accordance with the manufacturer's guidance. Some items with a limited shelf life, such as eye drops had not been dated on opening, which meant staff did not know when they should be disposed of. We also noted that there was no record maintained of temperature checks, so it could not be established if medicines were being maintained at the correct temperatures and therefore if they were suitable for use.

Balances of medicine stock were not recorded and there were no records in place to indicate the quantities of stock that should have been in place. This meant that it was not possible to audit medicines effectively.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were enabled to manage their own medicines within a risk management framework. In viewing the care plan for one person who managed their own medicines we noted that risk assessments had been completed to establish if they required any additional support.

The registered manager was proactive in seeking advice for people in relation to their medicines. He was able to give us a number of examples of contact he had made with prescribing professionals to request medication reviews for people who used the service.

Inadequate

Is the service safe?

During our inspection we looked at the personnel records of three members of staff. We found that these were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place prior to them being offered employment. We also saw good evidence that references had been sought from previous employers. At least two forms of identification, one of which was photographic, had also been retained on people's files. All personnel files contained a copy of a job description and terms and conditions of employment. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring System (DBS). The registered manager told us that he checked prospective employees' DBS documents prior to them starting work at the home and this was supported by records seen.

Records showed that during each new staff member's three month probationary period, reviews were held after each month with the registered manager to discuss work performance and progress. During these meetings objectives were set and personal development plans were introduced, which were reviewed at subsequent sessions. Evidence was available to show that probationary periods were extended, as deemed necessary, should the new care worker require additional support to fulfil their role. This helped the registered manager to be confident that all staff employed were suitable to work with the vulnerable people who lived at Catterall House.

Detailed policies were in place in relation to safeguarding adults and whistle-blowing procedures. Staff spoken with told us that they had received training in this area and were fully aware of action they needed to take, should they be concerned about the safety or welfare of someone who lived at Catterall House. Information about the importance of safeguarding vulnerable people were clearly displayed within the home, so that everyone accessing the service would be able to establish how to make a safeguarding referral, should the need arise.

We saw various risk assessments in people's care plans in areas such as falling, moving and handling or skin integrity. They had been reviewed regularly and reflected the current circumstances of the person. This meant that staff, were provided with up to date guidance about how to support people in a safe manner and protect them from harm.

We observed people were free to move around the home, without any restrictions being imposed. We saw two care workers transferring one person with the use of a hoist. This manoeuvre was performed in a competent and safe manner. The members of staff ensured the service user was comfortable and relaxed throughout the procedure.

Accidents were appropriately recorded and these were kept in line with data protection guidelines. This helped to ensure people's personal details were maintained in a confidential manner.

Certificates were available to demonstrate systems and equipment had been serviced, in accordance with manufacturer's recommendations.

Personal Emergency Evacuation Plans (PEEPs) had been introduced following the fire officer's inspection in May 2015. The purpose of these is to provide guidance for any relevant party, such as the emergency services, about how each person would need to be evacuated from the building in the event of an emergency, should the need arise. For example, in the case of fire or flood.

Requires improvement

Is the service effective?

Our findings

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 make 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 to 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that arrangements to obtain consent form people who lived at the home were inconsistent. The plan of care for one person showed that consent for all aspects of their care had been signed by the registered manager. In discussion we were advised that this was because the person had impaired vision and was unable to sign, which was not acceptable. This person's care included some aspects which could have been restrictive, such as the use of a pressure mat in his bedroom. However, there was no capacity assessment in place and no evidence that best interest decisions had been made through specific meetings and discussions between all those involved in his care.

We viewed the care plan of another person and noted consent for all aspects of their care had been signed by a family member. There was no confirmation as to whether this was legally valid and no capacity assessment was on file for this individual.

We found that the registered person had not ensured people's rights were always protected, because consent had not been obtained through best interest decision making processes prior to the provision of specific areas of care. This was in breach of regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we toured the premises, viewing all communal areas and a randomly selected number of bedrooms. We found areas of the home to be dirty and unhygienic. Some areas were in need of upgrading and modernising, in order to provide a homely environment and pleasant surroundings for the people to live in. This was discussed with the manager at the time of our inspection, who agreed with our findings.

It became clear that the environment was not suitable for everyone who used the service. One person who had been admitted to the home the previous day was unable to access his room on the first floor safely because he could not use the passenger lift, due to a long leg Plaster of Paris being in place.

In some areas, call bells were out of reach. We saw a number of bedrooms where call bells would be out of reach for people when they were in bed and it was confirmed that there were no extension leads provided to rectify this. We spoke with a person who used the service who told us they enjoyed the quiet of the conservatory but worried when they were in there as there were no call bells available to summon staff assistance. This person also commented they were unable to open the doors to the conservatory independently, as they were so heavy.

We found parts of the environment were poorly maintained. We saw in one person's ensuite bathroom that the rear wall was crumbling. This not only looked unpleasant but caused a risk because it could not be cleaned properly.

A number of areas within the home required re-decoration as walls were damaged, wallpaper was peeling off and some carpets were worn in areas. We noted some broken internal doors and a number of doors with broken handles. There was evidence of damp on a wall in one bedroom next to the ensuite bathroom and the underneath of the bed in this room was torn.

We found that the registered person had not ensured the premises were well maintained or suitable to meet everyone's needs. This was in breach of regulation 15(1)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we looked at the personnel files of three members of staff. We found completed induction programmes and a wide range of training certificates were retained on each staff member's file. These included learning in areas, such as medication management, safeguarding vulnerable adults and moving

Requires improvement

Is the service effective?

and handling. It was evident that new staff had been presented with a range of information to help them to do the job expected of them, such as job descriptions specific to their roles, terms and conditions of employment and relevant policies and procedures.

One staff member's record contained very detailed recent observation records of evidence for the care certificate, which is a nationally recognised training programme for care staff. Learning modules were supported by knowledge checks, work books and competence assessments in various areas of care. This helped to demonstrate that staff members had learned from training events. The care certificate training programme covered modules, such as health and safety, core values and principals, mental health, personal development, complaints and care planning. Staff we spoke with told us that they received sufficient training. Records showed that mandatory training was provided, along with modules specific to people's needs.

Records we looked at showed that regular supervision and annual appraisal of staff were conducted. This meant there were structured processes in place to assess the work performance and professional development of the entire work force.

There were no menus on view. However, the cook advised us that he spoke with each resident on a daily basis to establish their choice of meal. He was able to provide evidence of this by way of lists prepared, which demonstrated people had been given a number of choices for their meals on a daily basis. The cook advised us that he was provided with ample resources to stock the kitchen and provide a varied menu.

People we spoke with told us they enjoyed their meals and confirmed that they were offered a variety of choices. One person commented, "The food is always good. It is wholesome and very tasty."

The care files we saw showed the involvement of a wide range of external professionals, such as community nurses, psychiatrists, GPs, dentists, opticians, and psychologists. Hospital appointments were also evident.

Requires improvement

Is the service caring?

Our findings

In discussion with people who used the service we received some positive comments. One person told us, “We are looked after very well. I certainly have no complaints.” Another said, “They [the staff] are always very kind to me, I know I can rely on them.” However, another person told us that although she found the care staff to be kind and helpful, they often appeared to be rushing and rarely had time to just have a chat. This person told us that on the morning of our inspection, they had asked a care worker to help them to move some ornaments in their bedroom. The care worker had responded by saying, “I haven’t got time to mess about with things like that.”

We observed some positive interaction between care staff and people who used the service. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance. However, we did note some occasions when care staff should have taken a little more time to think about their actions. For example, we saw one care worker place a Zimmer frame directly in front of a television that a person who used the service was watching and it was left there, obliterating television viewing.

People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. Plans of care we saw outlined the importance of respecting people’s privacy and dignity and promoting their independence. However, we established that one person had been inappropriately placed and another was visibly upset because she had waited so long to be helped to the toilet. These examples did not promote a caring approach towards those who lived at Catterall House.

A variety of leaflets were available for people to take from the reception area of the home. These included topics, such as Alzheimer’s disease and activities within care homes. However, there was no information readily available in relation to advocacy services, although records showed that people were supported to access advocacy services, should they wish to do so, or if a relative was not involved and they were unable to make some decisions for themselves. An advocate is an independent person who will act on behalf of someone in supporting the decision making process, to ensure that any decisions made are in the individual’s best interests.

We observed staff to be patient and caring towards those who lived at Catterall House. Staff appeared to know people well and what individuals liked and disliked. We saw staff laughing and joking with people in an appropriate manner and chatting with them in a kind and caring way. People were in general well presented. They were clean, with tidy hair styles and men were shaven.

Throughout the day we observed staff members interacting with people in a warm and positive manner. We saw a member of staff reassuring one person who was upset, in a meaningful way, which prompted further conversation and enhanced positive interaction, which was pleasing to see. There was evidence of people being offered choices, in relation to what time they got up in the morning and this was confirmed through our observations.

It is recommended that information about local advocacy services is displayed within the home, so that people have the opportunity to involve an advocate to act on their behalf, should they so wish.

Requires improvement

Is the service responsive?

Our findings

At the beginning of our inspection we spoke with a person who had been admitted to the home the previous day. We also spoke with their relative, who was at Catterall House during our visit. They were both very upset to find on arriving at the home it was completely unsuitable for the person's needs. The layout and design of the home meant that the person was not able to access his room safely.

We viewed the care records of this person and noted that a pre – admission assessment had only been carried out the day before and this had been conducted by telephone. Although a medical history was recorded with a list of prescribed medication, there was no information for the staff team about nutritional needs, personal care preferences or moving and handling techniques, despite a long leg Plaster of Paris being in place. The registered manager had failed to properly identify this person's needs and this had resulted in the person being inappropriately placed.

We observed one staff member assisting the person to mobilise and noted that they did not appear confident. The manoeuvre was carried out with some difficulty and in a manner that did not appear to be safe. We found when viewing the person's care records that a moving and handling risk assessment had not been carried out and that staff had no guidance about how to assist the person with their mobility. The falls risk assessment for this person showed a 'low risk' category, despite them evidently having some difficulty in transferring, due to a long leg Plaster of Paris being in place.

Those who used the service or their representatives had not always been given the opportunity to be involved in the assessment of people's needs or planning of their care, so they were enabled to take part in some decisions about the way in which support was being delivered.

We saw some good examples of person centred care planning where people's preferences were well detailed so that staff could tailor people's care in line with their personal wishes. However, we also saw some examples where people's care plans had not been updated in line with changes in their needs. We saw a note in one person's file, referring to an increase in their confusion but there was no update in their care plan about how this may have impacted on their care needs.

We found that the registered person had not ensured people's needs had been appropriately assessed before a placement at the home was arranged and the plans of care did not always reflect people's current needs. This was in breach of regulation 9(1)(a)(b)(3)(a)(b)(c)(d)(e)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pressure risk assessments had been conducted and pressure relieving equipment had been provided as was deemed necessary. This helped to prevent the development of pressure wounds for those susceptible to skin damage.

A complaints policy was clearly displayed within the home, which incorporated contact details for the relevant authorities. A system was also available for documenting and monitoring complaints received, which included a detailed record of the complaint, set timeframes for responses, the outcome of any investigation, a response to the complainant and any changes made in response to concerns raised. For example, changes were made to the policies in relation to observations to be taken when someone was admitted to the home from hospital, such as a full skin assessment and recording of weights following a complaint investigation.

People we spoke with told us that they would be confident in making a complaint to the registered manager or any of the staff members. We noted that the statement of purpose and the service user's guide contained the complaints procedure, so that people had easy access of information about how to make a complaint, should they wish to do so. Relatives we spoke with told us they would be able to raise concerns with the manager of the home, should the need arise.

Activity records showed that a bonfire tea dance had been arranged and that coffee mornings were held each month, which were open to the public. However, on the day of our visit we saw little activity, in the way of meeting people's leisure interests. It was evident that the staff on duty did not have sufficient time to provide periods of uninterrupted activity for those who lived at the home.

Inadequate

Is the service well-led?

Our findings

Records showed that the registered provider visited the home regularly, following which she produced a monthly report, which outlined discussions held with the registered manager and any areas assessed during her visits. However, these reports were not effective, as concerns we identified at the time of our inspection had not been recognised by the provider or registered manager of the home.

Records showed that a range of audits had been undertaken each month and some quarterly reviews were also conducted. For example, medications, weights, infection control and complaints were audited each month and quarterly reviews were done in relation to admissions, attendance at accident and emergency departments, falls, deaths and respite care. However, many of these systems were ineffective, as failings in the service had not been identified and formally recorded during the auditing and reviewing processes. Therefore, this area was still in need of significant improvement, so that the service could be sufficiently monitored under a continuous assessment process and any improvements needed could be identified and addressed in a timely fashion.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager of the home had been in post for two years. People spoke highly of him and we observed his approach towards those who lived at Catterall House to be kind and caring. He listened to what people had to say and he demonstrated empathy towards them.

We were also informed by the registered manager that the husband of the registered provider was involved in much of the decision making around costs and recruitment processes in the home. We are aware from past records that this interference has led to friction with registered managers which had resulted in many leaving. The current registered manager was due to leave and cited this as a reason. We were also shown written evidence of this interference.

We saw that a regular newsletter was developed and circulated to everyone who lived at the home and their relatives. This helped people to keep up to date with any changes in the home and made them aware of any upcoming events or special celebrations. Questionnaires were also sent out, to allow people to express their views about the service provided. Specific questions had been designed to allow the registered manager to focus on definite areas. For example, one question asked was, 'What does being safe mean to me and how I would raise concerns'? Consultation letters had also been circulated to those who lived at the home. These encouraged people to make suggestions and to be involved in the operation of the home, which was considered to be good practice. One good example we saw was asking those who lived at the home, 'What should we do with the garden at Catterall House and what type of plants should we grow? Everyone responded to this question with their suggestions, which are planned to be taken forward next year.

In addition to the specific questionnaires annual surveys had been conducted, which covered a wide range of areas, such as the environment, food, staff approach and activities. In general, positive comments were received from those who returned the surveys, the results of which were analysed and scored for easy reference. A suggestion box was also available within the reception area of the home, so that people could put forward ideas anonymously, if they so wished.

Minutes of resident and staff meetings were seen. These meetings allowed people to discuss any topics of interest and to talk about any concerns or areas of good practice within an open forum. However, we were told by staff that because the staff team was small, discussions were part of everyday working life. We were told that the manager was very approachable and he was always visible within the home. This we observed during our inspection at Catterall House.

A wide range of written policies and procedures were in place at the home, such as infection control, fire awareness, medication management and health and safety. However, these were not being followed in day to day practice, as we identified significant failings in all these areas.

Inadequate

Is the service well-led?

We noted that the statement of purpose and service user's guide contained some inaccurate information, as they indicated that cleaners and a maintenance person worked five days a week, which was incorrect and misleading for readers.

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We found that the registered person had failed to notify the Care Quality Commission of a safeguarding incident. This was in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found many aspects of the management style to be more reactive than pro-active. This was most likely due to no consistent leadership of the home and a regular change of the management team. It was clear from reading care records and from talking with staff that Catterall House worked in partnership with a wide spectrum of other professional agencies. A district nurse visited the home during our inspection.

It is recommended that the results of surveys and minutes of resident's meetings are displayed within the home, for all interested parties to read.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not assessed risks to health and safety of people and taken appropriate steps to mitigate such risks exposing people to a risk of significant harm. Regulation 12(1)(a)(b)

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.
We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and monitor the quality of service provided or any environmental risks relating to the health, welfare and safety of those who lived at the home. Regulation 17(1)(2)(a)(b)

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.
We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

We found that the registered person had not ensured people's rights were always protected, because consent had not been obtained through best interest decision making processes, prior to the provision of specific areas of care.

Regulation 11(1)(2)(3)

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.
We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed. Regulation 12 (1)(2)(g)

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.
We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of care staff deployed to adequately meet the needs of people, due to them being responsible for all other ancillary duties. Regulation 18(1)

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.

This section is primarily information for the provider

Enforcement actions

We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Areas of the environment were dirty and unhygienic and therefore infection control was not being promoted.** Regulation 12(1)(2)(h)

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.
We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The premises were not suitable for everyone's needs and they were not maintained in a safe and secure way throughout.** Regulation 15(1)(b)(c)(e)

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.
We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **We found that the registered person had not notified the Care Quality Commission of an incident, which could have resulted in serious injury or fatality.**

This section is primarily information for the provider

Enforcement actions

Regulation 18

The enforcement action we took:
As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures.
We have issued the provider with an Urgent Notice of Decision to restrict any new admissions to this home. Where we have identified breaches of regulation during inspection which is are serious, we will make sure further action is taken. We will report on any action when it is complete.