Ms P Goss

St. Catherines Residential Care Home

Inspection report

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17 August 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 18 and 19 July 2017. This was an unannounced inspection. We also returned to the home for a third visit on 17 August 2017 following concerns that we had received; this was an unannounced, early morning visit to check on the practices of night staff.

St Catherine's Residential Care Home provides accommodation and personal care for up to 22 people. At the time of our inspection, there were 19 people living at the home. At the last inspection the service was rated as requires improvement without breaches and sufficient improvements had not been made.

There had not been a registered manager in post since May 2016. The provider had appointed a new manager who had been managing the day to day running of the service since May 2016 but they had failed to successfully complete their registration with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was in breach of the conditions of their registration as they are required to have a registered manager. This is an offence under section 33 of the Health and Social Care Act 2008.

The service was not always safe because the provider had not always ensured that there were sufficient numbers of staff available to meet peoples' needs in a safe and timely way. The environment did not always promote peace, comfort or safety; it was not always clean or free from clutter which put people at risk. The provider's quality monitoring systems and processes had been ineffective in sustaining improvements as well as identifying other shortfalls found during the inspection. Where quality assurance processes had identified areas in need of improvement, the provider had not always responded efficiently to ensure the safety and quality of the service was maintained in a timely manner. Staff did not always feel listened to or supported by the provider. Staff morale was low due to time pressures; staff did not always feel like they had enough time to do everything that was required of them including domestic chores and were unable to support people to engage in activities of interest.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Care was provided to people with consent, where possible. Key processes had been followed to ensure that people were not unlawfully restricted. Staff had the knowledge and skills they required to care for people and to protect people from the risk of abuse and avoidable harm. They also knew what the reporting procedures were and were familiar with the whilst-blowing policy.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary. People's nutritional needs were assessed and monitored to identify any

risks associated with their dietary requirements.

People were supported by staff that were kind, caring and who took the time to get to know them, including their personal histories, likes and dislikes. People were also cared for by staff that protected their privacy and dignity, respected them as individuals and promoted their independence as far as reasonably possible.

People were encouraged to express their views in all aspects of their lives including the care and support that was provided to them and people felt involved in the planning and review of their care. This was because the staff communicated with people in ways they could understand. People were aware of the complaints procedure and were confident that any issues that they had would be dealt with efficiently.

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 has been made within this timeframe and we continue to find 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 of our return visit if they do not improve. After which, this service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will then be conducted within a further six months, and if there is still not enough improvement and an on-going rating of inadequate is awarded for any key question or overall, we will take further 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.

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

The service was not always safe.

People were not always supported by sufficient numbers of staff available to meet their needs and monitor their whereabouts to keep them safe.

People were not always protected from the risks of harm because risks were not always appropriately identified and plans put in place to manage them. Staff practices or the home environment did not always promote people's safety, protect them from cross infections and maintain their peace or comfort.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

People received their prescribed medicines when they required them.

Is the service effective?

Good

The service was effective

People's rights were protected because key processes had been followed to ensure people were not unlawfully restricted.

People received care from staff who had received adequate training and had the knowledge and skills they required to do their job effectively.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People's needs were not always met in a safe or timely manner and the provider had not ensured that people were cared for in a peaceful, comfortable environment.

People were cared for by staff who were kind, caring and helpful and who protected their privacy and dignity.

People received the care they wanted based on their personal preferences and dislikes because staff spent time getting to know people.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to engage in activities that they enjoyed.

People and/or their relatives felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were supported to maintain positive relationships with their friends and relatives.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Inadequate

The provider was not meeting the conditions of their registration because they had not ensured that there was a registered manager in post.

The systems and processes in place to assess and monitor the safety and quality of the service were not always effective. Where shortfalls had been identified, the provider had not always been efficient in addressing these issues in a timely manner.

Staff did not always feel supported or listened to by the provider.

St. Catherines 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 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 unannounced inspection took place on 18 and 19 July 2017. The inspection was conducted by two inspectors and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service who we deploy to assist us on our inspections. We returned to the home for a further unannounced visit on 17 August 2017 following concerns that we had received. On this occasion, one inspector facilitated the unannounced visit.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We used this information to inform our inspection. We also looked at the information that we hold about the service prior to visiting the home. This included statutory notifications from the provider that they are required to send to us by law about events that occur at the home, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection, we spoke with six of the people who lived at the home, five relatives and eight members of staff including the provider, the manager, two senior carers, and four care assistants. Some of the people living at the home had complex care needs, such as dementia for example and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework

for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk with us. We also reviewed the care records of four people, to see how their care was planned and looked at the medicine administration processes within the home. Furthermore, we looked at training records for staff and at three staff files to check the provider's recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Inadequate

Is the service safe?

Our findings

At the last inspection we found that improvements were required to the safety of the service because staff recruitment and medicine management practices did not always promote the safety of people who lived at the home. We found that there were continued shortfalls in several aspects of the service that actually or potentially affected the safety of people receiving a service.

We were told by the manager about a recent serious incident that had occurred at the home whereby a person had not received the care they required when they needed it. Staff had not completed the necessary checks on the person whilst they were in bed and therefore had not identified deterioration in the person's health. This meant there was potentially a delay in calling for the emergency services. We were told by staff that time pressures and inadequate staffing levels were partly to blame for the omission. One member of staff said, "Things like this should never ever happen, but there is just not enough time; when you are rushing and trying to do everything, things get missed; it's not safe". This incident is subject to a criminal investigation and as a result, this inspection did not examine the circumstances of the incident. However the information shared with CQC about the incident indicated potential concerns about the staffing levels and safety within the home. This inspection examined those risks.

We received mixed reviews about the staffing levels within the home from people. Whilst some people told us that staff were usually available when they needed them, other people, relatives and staff we spoke with told us that staffing levels within the home were not always sufficient to ensure that people's needs were met in a safe and/or timely way. One person we spoke with told us, "I think they [provider] could do with more staff. They [staff] are often tearing around trying to fit everything in". A relative we spoke with said, "They [staff] are great; there are just not enough of them". Another relative we spoke with told us, "There are times when they [staff] are really 'stretched'".

Observations we made confirmed this. We saw staff rushing around trying to support people with personal care, attend to people's dietary needs, administer medicines and complete other duties such as record keeping and domestic tasks. We saw one person had to wait over ten minutes to receive support to use the toilet, despite telling staff that they were 'desperate'. When they asked for support to use the toilet again, they said, "Please, someone; this is unbearable, I need the toilet". We also saw other examples where people were at potential risk of harm because staff were not available to promote their safety. For example, on two separate occasions an inspector had to intervene because a person was seen to wander in to the kitchen unsupervised. This person was dependent upon staff to keep them safe through supervision and support and yet staff were not available to promote their safety or had not followed protocol. We also saw that people spent lots of time sitting in the lounge area without any meaningful stimulation, because staff had not got the time to engage with people in activities of interest.

Staff we spoke with told us that they had been raising their concerns about the staffing levels and time restraints with the manager for at least the last two to three weeks. One member of staff we spoke with said, "We are really struggling; staffing levels are just ridiculous. We can't do everything and be everywhere at the same time. We have brought it up time and time again; I know [manager's name] has told [provider] again

more recently but nothing has changed". Another member of staff told us, "It is particularly difficult of a morning because we only have three members of staff; one is a senior so they have to do medicines from 8am, and the other two [staff] are left to assist people to get up, washed and dressed. Some people require two to one support and we also have to answer any buzzers that go off too; it's just too much". Staff told us that up to seven people required assistance from two members of staff with their personal care, either because of their mobility or complex care needs, meaning that at times, one member of staff would not be able to support them independently. A third member of staff said, "I enjoy my job but there is just not enough time to do everything; we [staff] don't have time to spend with people, we don't get our breaks; we have raised it with the manager and provider". Records we looked at showed that time pressures and staffing levels had been reported by staff and were discussed at a team meeting back in April 2017. However, the provider felt that this was due to ineffective time management on the staffs behalf. Other records we looked at confirmed that the manager had passed this information on to the provider more recently. The manager told us, "You can see from my weekly manager's report that I had shared it with [provider's name] and staff were told that it was under review". The provider has since informed us that they had used two different staffing levels dependency tools which are designed to support providers to assess the staffing levels required to meet the varying needs of people living at the home. They felt that there was adequate staff to meet the needs of people living at the home. We were also told that a new protocol had been introduced within the home which meant that daily duties were shared amongst staff; this meant that staff were allocated 'floors' to work on and also included laundry duties. The provider told us that this had been working and that 'organisation was the key'. However, they had found that the efficiency of shifts were dependent upon the staff on duty. Despite these measures, we found that people remained at risk.

Following our inspection we were told that the provider intended to deploy a 'floating' member of staff from 8am to 12 noon to support care staff with personal care and then from 2pm to 4pm to support with additional duties, such as activities and laundry. However, when we returned to the home on 17 August 2017, we found that this had yet to be implemented. We also found that one person who was supposed to be in receipt of one to one care, had not received this level of support due to staff shortages and had experienced a fall. We saw the ambulance service were present and that this was for the second time that night. Staff we spoke with told us, "It's been crazy". The manager explained to us that one member of staff had called in sick and that a second member of agency staff had not arrived. We did not see any evidence that the provider had a contingency plan to ensure that people were kept safe and their needs were met in these circumstances. The manager also told us that following a staff meeting, it had been decided that the extra 'floating' member of staff would not be deployed until 28 August 2017.

As part of the recruitment process the provider carried out Disclosure and Barring Service checks to ensure that only appropriate people were employed. We saw that although DBS checks were carried out the information received was not used effectively to ensure people's safety by assessing the level of the risks and putting plans in place to monitor and manage the risks. We saw one example of where the absence of a risk assessment and management plan had failed to recognise a potential link between a staffs history and poor professional conduct.

At the last inspection we found that improvements were required to the home environment and although some improvements had been made some risks to people remained. For example, we found that some of the stairways remained a risk to people as these did not have any protective barriers, despite people living in the home who were independently mobile and who potentially lacked the capacity to be able to foresee or protect themselves from such risks. Instead, the provider told us that 'child safety gates' had been used on the doors of people's bedrooms of whom were considered to be at risk; however we saw that these measures were ineffective at promoting peoples safety. For example, on 17 August 2017, we saw that one person was attempting to climb over the gate to get out of their room. Staff told us that they had been doing

this through the night. Records we looked at showed that this person had, on at least one occasion, managed to climb over the gate and had attempted to walk down the steep stairway with their walking aid. Staff had documented that this person had 'almost fell'. We did not see any evidence to demonstrate that this had been risk assessed.

We saw rooms including the medicines room, shower room and corridors were cluttered that posed a potential falls risk to people. We saw that the medicines room door was propped open to ensure that the temperature that medicines were stored in was maintained appropriately however, this left a potential risk that people could enter the medicines room unseen by staff and access medicines that they did not require and that could be harmful to them. We also found that whilst most medicines were stored safely in a locked medicine cabinet, we saw that some medicines, such as those that were due to be returned to the pharmacy were kept in either unlocked storage boxes or in bottles on a shelf in the medicine room and accessible to people using or visiting the service.

People and staff could be at risk of cross infections because used incontinence pads and protective clothing such as gloves were disposed of in general bedroom bins rather than in a bag and then in a clinical waste bin. Despite raising this as a concern on our first day of inspection, we continued to find the same practice when we returned on 17 August 2017. We saw dried faeces was smeared on the corner of a mirror in one of the corridors, a soiled duvet had been left uncleaned in an unoccupied bedroom and green mildew had developed around the toilet rim of one persons' en-suite facilities which was easily removed when the inspector tried to clean it with a toilet brush. We also saw one persons' bedroom and the downstairs bathroom had damp to the walls, another persons' bedroom had threadbare carpet placing them at risk of trips and falls.

This shows that the registered provider was in breach of regulation 12 because care and treatment was not being provided in a safe way for service users and was failing to take all that was reasonably practical to mitigate risks to people's health and safety.

We saw that since our last inspection some improvements had been made to the recruitment procedures so that all the required recruitment checks had been carried out. Some improvements had also been made to the environment including redecoration of some of the communal areas of the home and bedrooms and the replacement of some carpets.

Everyone we spoke with told us they received their medicines when they needed them. One relative we spoke with said, "They are good [with medication]; there were some issues when [person] first arrived because [person] wouldn't take it [medicine] for staff so they were calling us, but once they knew how to encourage [person] to take it, we have not had any other problems at all". Another relative we spoke with told us, "They are absolutely brilliant, even to the point of making sure they had all of the necessary [end of life] medicines ready to ensure [person] was kept comfortable and had what he needed when he needed it". We saw that medicines were administered to people safely and where possible, people were given choices about whether or not they wished to take medicines that were prescribed on an as required basis, for example, for pain relief. However, we found that protocols were not always in place for medicines that were prescribed in this way. Nevertheless, staff we spoke with did know how and when to administer these medicines and people we spoke with told us that they received their medicines when they required them.

People and relatives we spoke with told us that they felt people were safe living at the home, some were also aware of having risk assessments associated with the care they received. One relative we spoke with said, "My brother is very much safe". Another relative we spoke with told us, "Mum is very well looked after and safe; when she first arrived and ever since they have kept her care plans and risk assessments under review

to ensure she is kept safe". Records we looked at showed that people had risk assessments and care plans in their care files which were specific to their individual care needs and associated risks. For example, we saw that people had risk assessments and detailed management plans for symptoms related to their mobility, skin integrity and behaviours associated with dementia. Staff we spoke with were knowledgeable on people's individual risks and knew what support they required to keep them safe. One member of staff told us, "Our priority is the resident, so as long as they are safe, we know we have done our job; we know people really well and if anyone is knew, we talk with them, their families and read their care plans to make sure we care for them properly".

Staff we spoke with told us how they kept people safe in an emergency situation such as a fire. One member of staff said, "We have fire training. If there was a fire, the fire doors will shut automatically to prevent it spreading and protect against smoke, we call the fire service and where possible evacuate to the nearest exit. We have just had a new 'Evac chair' but we are waiting for training on how to use it". Records we looked at showed that the provider had a fire risk assessment and protocol, we also saw that people had individual personal emergency evacuation plans (often referred to as PEEPs) which was an improvement since our last inspection.

All of the staff we spoke with knew what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "We have really good [safeguarding] training; there are lots of things we look out for such as a change in their persona, physical signs like bruising, financial concerns; it is my responsibility to keep people safe from harm and to make sure they are not mistreated or exploited in anyway so I would definitely take it further and report it. I would speak with [manager's name] and document it". Records showed that staff had received safeguarding training and they were knowledgeable in recognising signs of potential abuse. Staff knew how to escalate concerns about people's safety to the provider and other external agencies. The manager was also aware of their roles and responsibilities in raising and reporting any safeguarding concerns. Information we hold about the provider showed us that any safeguarding concerns that had been raised since the last inspection had been reported to the relevant agencies and had been investigated thoroughly with appropriate action taken. The new manager told us, "We all have a duty of care to the people we are looking after and we have to do the right thing to make sure it is all investigated properly".

Good

Is the service effective?

Our findings

People we spoke with, observations we made and records we looked at showed that staff had the knowledge and skills they required to do their job. One person told us, "The carers are all good at their jobs". A relative we spoke with told us, "The [staff] are excellent! They are definitely well trained; I'd say they have more knowledge than some of the nurses at the hospitals". Other relatives we spoke with told us they were confident that staff had adequate training and were skilled to care for people safely and effectively. Staff we spoke with confirmed this. One member of staff we spoke with said, "The training is really good; it's interesting and enjoyable! We always come out feeling really motivated".

We were told and records showed us that the manager offered support to staff through regular team meetings and supervision to staff. One member of staff told us, "[manager's name] is good; we have team meetings, supervision and she will often send out memos and updates; she is here to speak to anytime". Another member of staff said, "We do have team meetings and I feel confident to raise anything just so I know it has been recorded; we don't always feel listened to or see changes, but [manager] tries her best". The manager told us that they spoke with the staff regularly, made themselves available and often 'worked on the floor' to help out and to ensure staff felt supported. They said, "We are a team here and I am a part of that team, I try to make the staff feel as though they can come to me with anything both in and out of supervision; if I have any concerns I will call a supervision or team meeting so staff are clear on what the expectations are but also so they feel supported; I will do anything I can to help them". They went on to tell us about how they had promoted the care certificate to ensure that all staff were trained to the same level and any additional training needs were identified through spot checks, observations and supervision.

It was evident when speaking to the manager and the staff that they had an understanding of the Mental Capacity Act 2005 (MCA). 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that staff were able to tell us about people's capacity to consent to the care that they were receiving and that people were cared for in the least restrictive ways possible. For example, one member of staff said, "Sometimes we have to act in people's best interests; if someone refuses personal care, we offer gentle reassurance and encouragement but sometimes that don't work and we have to just leave them be and go back a little while later, other people for some reason will let one staff member [support them] but not another, usually depending upon how they feel on the day, so we will handover to each other as the shift progresses so that everyone tries and eventually we will be able to assist them, it just takes time and patience". A relative we spoke with told us, "It must be so difficult for them [staff] when they are trying to help people but they [people] are refusing, but they [staff] are so good. Day in and day out they remain

caring and patient; they [staff] try to explain and reassure; it's just marvellous". Records we looked at showed that capacity assessments had been facilitated and best interests decision processes had been followed which included people, relatives, staff and other healthcare professionals where required. People had care plans about how they would have preferred to receive care with guidance to staff on how to act within the person's best interests. Where people were deemed to lack the mental capacity to consent, applications to deprive the person of their liberty within their best interests had been sent and the provider was either awaiting assessment and/or authorisation from the local authority. The manager had a folder dedicated to 'DoLS' which enabled them to monitor and update the progress of the applications with ease. They also told us that they would use this folder to keep any additional information such as conditions and expiry dates in order to keep the authorisations under review and easily accessible.

People we spoke with were complimentary about the food at St Catherine's Residential Home. One person said, "It's [food] very good. There's a menu and there's plenty to eat". Another person told us, "Pretty good for most part; I enjoy breakfast most of all. There is a choice on the menu and if I want snacks I usually just ask the staff and they are happy to deal with it". We saw that there was a menu available in the dining room and people had a choice of two meals and everyone we spoke with assured us that if people did not want what was on the menu, they were always offered an alternative. For example, we saw that one person chose to have sandwiches instead of a hot meal. As part of our inspection, we joined in with a meal time at the home and saw that the food looked and smelt appealing and people appeared to enjoy the food. People were offered seconds and gladly obliged. We found that the meal time was a social event and people appeared relaxed and received the support they required from both the care staff and catering staff. We also saw that drinks and snacks were available to people throughout the day including hot and cold drinks, fruit and biscuits.

We saw that nutritional assessments and care plans were in place for people who were at high risk associated with their diet or fluids and they were referred to the appropriate medical professionals as required. Staff we spoke with were aware of people who required a specialist diet and people's cultural needs and preferences were catered for. One member of staff said, "We have people who are diabetic, people who require fortified (high calorie) diets and people who have special requests like halal meat or prefer to eat curries". We saw evidence of this in people's care plans and people's weights were monitored to ensure that any significant changes were identified and medical assistance/advice was sought. However, we found that where action was required in relation to weight management, this had not always been reviewed or recorded as such and therefore greater attention was required in this area.

We found that people living at the home had access to doctors and other health and social care professionals. People and relatives we spoke with told us they saw the GP, Chiropodist, Optician, Dentist, District Nurses and the hair dresser. One person said, "I can see the doctor if I need to". A relative told us, "They ensure the doctor visits regularly". On the day of our inspection we saw GP's, District Nurses and Community Mental Health nurses visiting the home. Records we looked at confirmed that people were supported to maintain good health and to attend any medical appointments they were sent.

Requires Improvement

Is the service caring?

Our findings

Whilst individual staff members were reported and observed to be caring, we found that some aspects of the care being provided to people were not always caring. For example, people, relatives and staff we spoke with and observations we made, showed that people were not always assisted in a timely way and the provider had not always ensured enough members of staff were available to keep people safe. The environmental issues that were identified throughout the inspection also showed that consideration had not always been given to the safety and experience of people living at the home, including their quality of life. One relative we spoke with said, "The environment isn't the best is it? It's not how I would choose to live, but I suppose you get used to it". A staff member we spoke with said, "The clutter and the noise isn't good; it drives us mad so god knows what it does to them [people]. We have very limited storage space and little time to keep on top of things [like tidying up]; our priority has to be caring for people". We saw that people were prevented from utilising rooms such as a bright, spacious, accessible shower room because they were being used as a storage rooms as well as a staff room that was also storing old furniture. We heard closures on fire doors beeping continuously which were potentially disruptive to people's sleep and peace and quiet in bedrooms and communal areas. Staff we spoke with told us that this happens frequently and means that either the fire doors need re-setting or the batteries needed changing. We were told that on this occasion, the doors had been sounding for over a week. Staff we spoke with told us that the alarms were 'very annoying' but both staff and the manager told us that no-one had complained, despite the noise sounding continuously even through the night when people were sleeping. Staff believed that because some people were hard of hearing or deaf, that these alarms had not caused them any disturbance.

Nevertheless, everyone we spoke with praised the caring approach of staff and told us consistently that staff were kind, caring, friendly and helpful. One person we spoke with told us, "I think they are kind and caring". Another person said, "Oh yes, the staff are all lovely". A relative we spoke with said, "It's absolutely amazing here; the staff just can't do enough to help, they are always so kind and caring; not only to the residents but to us too; I think the staff definitely go above and beyond in order to provide the best care they can for people". They went on to tell us about how staff spoke 'calmly' and 'nicely' to people in order to offer reassurance and encouragement despite sometimes having to manage 'difficult' and 'challenging' situations. They said, "It must be so difficult but they [staff] remain patient and kind". They also told us, "They [staff] make every interaction count; everything is made to feel nice, even tea and biscuits are made to feel like a nice event because it is always served with a smile". Another relative we spoke with separately confirmed this and told us, "Mum is very well cared for, the staff are friendly and helpful". They said, "Everywhere else we have been, mum has always complained about the staff; but that hasn't happened here, so that is credit to the staff; they must be doing something right! We didn't think anywhere would be able to care for her as good as us but we are happy now she is here".

During our inspection we observed staff interacting with people with warmth and compassion. We saw that staff adapted their communication and interaction skills in accordance to the needs of individual people. For example, one person required regular and consistent reassurance which all staff offered reliably. Staff communicated with people in ways they could understand in order to promote choice, consent and autonomy. For example, we saw a member of staff showed a person a cup and a mug to enable them to

distinguish between the two and make a choice in accordance with their preference. We also found that people were encouraged to be as independent as possible. One person told us, "I like to do what I can [for myself] and that's okay here". They told us that staff encouraged them to dress and change their clothes themselves and offered assistance where required. We saw people walking around the home freely, helping themselves to drinks that had been pre-prepared, using the toilet independently and coming and going as they please. A relative we spoke with said, "They [staff] are very good; [person] likes to go out and about but the staff keep an eye on him and make sure they know where he is going and when he comes back to make sure he is safe". We saw that the manager had provided the person with a safe and well card which had their name, address and telephone number in case of an emergency when they were out on their own. The manager said, "We like people to remain as independent as possible and if they can, to come and go as they please like they would if they were still at home, but we do as much as we can to make sure they are safe".

Staff we spoke with had a good understanding of people's needs and we found that people received personalised care and support from staff that took the time to get to know and understand their history, likes, preferences and needs. Records we looked at showed that people had care plans in place that were person-centred and detailed; they included information about people's preferences, hobbies and interests. This information reflected what staff had told us about people during the day and what we saw throughout the inspection. For example, we were told by staff that one person enjoyed a can of bitter with their meal. This was confirmed by the persons' relatives and had been included in their care plan. At lunch time, we saw that this person was given a can of bitter with their meal. The relative said, "See? We told you he liked Bitter and that he has it with his meal!" The person indicated that they were enjoying this beverage.

People we spoke with told us and we saw that staff treated people with dignity and respect and privacy was maintained. One member of staff said, "We respect people as individuals and know that people like things done in a certain way; some people don't mind receiving help, whilst others can get a bit embarrassed, so we do as much as we can to make it as dignified and as private as possible". They gave us examples of closing doors and curtains and speaking to people throughout personal care in order to offer some distraction. However, some relatives we spoke with and records we looked at showed that people had consistently raised concerns about clothes going missing, which showed a lack of respect for peoples' belongings. Staff we spoke with told us that the laundry was an issue mainly because of time pressures and that more time, care and attention needed to be given in order for this to be done properly. One persons' room did not have any curtains hung. Records we looked at showed that staff had raised their concerns on 7 July 2017 stating they were reluctant to assist a person to bed without curtains but continued to do so because they were 'following instructions'.

Relatives we spoke with expressed their sincere gratitude and praise for the staffing team, including the manager, in relation to the care that was given to people at the end of their life. We heard about how the manager went 'above and beyond' and had worked as an ambassador for the family in order to ensure people's final wishes were met. One relative said, "We can't thank them [staff] enough and [manager] was just brilliant; sometimes you just need someone on your side who can express what you want to say when you don't feel strong enough to fight and that's what she did". They went on to tell us that their loved ones final weeks were 'so much better' because staff made sure that they got to spend time with others and were kept comfortable. For example, we were told that one person had spent such a long time in bed in hospital, but as soon as he returned to the home, despite the challenges, staff supported him to spend time in communal rooms with the company of others which he really enjoyed. They said, "His quality of life at the end was so much better for being here [at the home], staff really cared for him with 'TLC', made sure he was comfortable. They got everything in place in such a short space of time to make it happen, like a new air matrass, oxygen machines, medicines were ready, district nurses were involved, just everything; it was truly outstanding care that we all received, not just [person] they looked after us too". We fed this feedback to the

manager at the time of our inspection and it was evident that caring for people at the end of life was something that the service was proud to provide. They said, "It is a privilege to help people and to get people's final wishes met; we could not receive better feedback".

Requires Improvement

Is the service responsive?

Our findings

People, relatives and staff we spoke with told us that the provider arranged for some structured activity and entertainment to take place within the home, such as singers, exercise classes and the 'animal man'. However, outside of this time, we found that staff were responsible for facilitating activities with people and that this was not always possible due to time pressures. One member of staff said, "We just don't have time to do things with people anymore". The hairdresser was visiting the home on the day of our inspection and we saw that some people appeared to enjoy having their hair done. However, apart from this, we saw that most people spent much of their time sat in the conservatory area without any structured, meaningful or purposeful activity, unless they were able to occupy themselves. For example, we saw that one person was able to self-engage in a word puzzle and another gentleman spent time reading the newspaper; apart from this we saw that people were unoccupied, sat in a large open space that was busy with the comings and goings of visitors and staff who were tending to care tasks. This made hearing and watching the television that was on, very difficult. We fed this back to the manager and the provider at the time of our inspection who told us the activity provision within the home was under review.

People, relatives and staff we spoke with as well as some of the records we looked at showed us that where possible, people and/or their relatives, had been involved in the planning and review of their care. A relative told us, "I was involved in the care planning and we have had reviews; they keep us well informed and get us involved". Another relative told us, "We have meetings with the manager every so often; she [manager] keeps me informed and highlights any issues or concerns that I may not be aware of and we work through them together". Records we looked at showed that the manager had introduced a new care review record which provided a quick reference guide to any updates or changes. However, it was not always clear who had been involved in the review meetings and any updates or changes had not always been recorded, in order to ensure staff were provided with the most up to date and relevant information. We fed this back to the manager and the provider at the time of our inspection and they agreed that the completion of these new records needed to be improved and monitored.

As part of the care planning and review, we saw that people were encouraged to share their preferences on how and who they wanted to provide their care, such as gender specific care requests. We saw that care plans clearly stated whether the person preferred male or female care staff. We heard about how staff respected and supported people to express themselves as individuals which was also evident in care planning. For example, one member of staff told us about how one person was very particular about their appearance, so staff always ensured their clothes were matching and that their hair, make-up, and jewellery were all co-ordinated. We saw that rooms were personalised and people were encouraged to bring in their own furniture, ornaments and pictures as this promoted familiarity and comfort. Staff we spoke with were unaware of anyone living at the home who had openly identified themselves as being gay, lesbian, bisexual or transgender; they said, "I am not aware of anyone, but I don't think we explore it really with people; if they were open about it, then that's different but I think it can be quite a sensitive issue so I personally wouldn't ask someone directly". We found that people were supported to maintain romantic relationships within the home, for example we saw a man and a wife living together at the home and staff we spoke with told us that there was a culture of acceptance within the home and people from all backgrounds would be welcomed.

People we spoke with also told us that their friends and relatives were always welcome to visit them at St Catherine's Residential Home and they often went out to spend time with people that were important to them. A relative we spoke with told us, "There are no restrictions, I am welcome any time and can come and go as I please". Another relative said, "We visit whenever we want; we just pop in". Another family told us that the home was very flexible and that the staff even supported them when they stayed overnight to be with their loved one. They said, "[relative] wanted to stay the one night because [person] was very poorly; staff made her feel welcome, looked after her, made sure she was comfortable and offered drinks; just like home from home".

People and relatives we spoke with gave mixed reviews about whether or not they were asked for feedback on the care and service being provided. Records we looked at showed that the provider had sought and received feedback from people which was mostly positive. Everyone we spoke with told us that they felt confident and comfortable sharing their views with staff or the manager and they were confident that things would be addressed. We saw that the provider had a policy and procedure for complaints and everyone we spoke knew how to complain. One person told us, "I've never complained because I have never felt the need to". A relative we spoke with said, "Anything that we have had to speak with them about has been dealt with straight away but they have only been minor things, like the toilet seat was broken and this was replaced really quickly".

Inadequate

Is the service well-led?

Our findings

At the time of our last inspection, we found that improvements were required to the management and monitoring of the service. At this inspection, we found that some improvements had been made, but these were not always sustained. We also found that further improvements were required. This meant that the provider has a history of requiring improvement in these areas and have demonstrated that they cannot always make or sustain the required improvements.

The provider is required to employ a registered manager as part of the conditions of their registration. There was not a registered manager in post at the time of our visit because the person who was registered to manage the home had left in May 2016. The provider had appointed a new manager who had been managing the day to day running of the service since May 2016 but they had failed to successfully complete their registration with us. Information we hold showed that two attempts had been made by the manager to initiate their registration process, but on each attempt, they had not progressed past the first stage. We were told that this was because they did not fully understand the application process. We did not see any effort on the manager or the provider's part to follow up their registration application with us in a timely way or to seek advice or support as necessary, despite prompting from the inspector. This is an offence under section 33 of the Health and Social Care Act 2008 for failing to comply with the conditions of registration. Since the inspection, we have been told that a further application process has been initiated by the manager.

It is a legal requirement for providers to display their rating, to show whether a service was rated as outstanding, good, requires improvement or inadequate following an inspection. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of the care provided. The provider has a regulatory duty to ensure that ratings are displayed legibly and conspicuously at both the home and on their website within 21 calendar days of the date at which the inspection report was published. At the time of our last inspection we found that the provider had not displayed their rating on their website. On that occasion, we contacted the provider who told us that they were unaware that they had a website. We provided advice, guidance and support to the provider to enable them to become compliant with the requirements of the Health and Social Care Act 2008. However, when we were planning for this inspection, we checked the provider's website again. We found that the website had since been updated and the rating was no longer displayed. This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The rating was displayed on the premises at the time of our inspection and since the inspection, has now been added to the website with an interactive link to the report.

We found that the provider had some systems in place to monitor the quality and safety of the service and that some of these had been used effectively to identify areas for improvement. For example, we saw that the provider had deployed a consultancy agent to support them in making the improvements required since our last inspection. We found that some improvements had been made to the care records, medicine management processes and some parts of the environment. The provider had also installed CCTV cameras into the communal areas of the home to enable them to monitor the safety and security of the home. We saw that this had been used to look at how accidents or incidents had occurred and to take the necessary

actions to minimise future risks to people, as an example. However, we found that some of the quality monitoring systems had not always been used effectively to implement or sustain improvements made, and where shortfalls had been identified, the provider had not always responded to these in a timely manner. This was evident for some of the shortfalls we found during our inspection. We found that the provider had allocated additional hours to improve the medicine management processes including the medicine auditing systems, however results from these audits showed that the improvements made were changeable and compliance was fragile, with fluctuations identified in the provider's own ratings between red (non-compliant), amber (improvements required) and green (complaint) compliance ratings. The provider also told us that some of the issues we had identified within the environment had already been noted but they had not yet gotten around to addressing them; these included the continuously sounding fire door systems, damp in the bathroom, the lack of curtains in one persons' bedroom and threadbare carpets in another as well as the cluttered and disorganised communal areas. The provider told us that they had increased the number of domestic staff, but we continued to find concerns with the cleanliness of the home. We also found that safety issues that we identified at the time of our last inspection, including the open steep stairways and issues with the recruitment practices had not been fully addressed in a way that promoted peoples safety. We saw that following our feedback on the first day of inspection, the provider had responded by attending to many of these shortfalls. However, we explained that this was a reactive rather than proactive response and improvements needed to be made to the monitoring and timeliness of the quality assurances processes.

Collectively, this demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because the provider had failed to effectively implement or respond to findings of the quality monitoring systems and processes in place to ensure they were compliant with the requirements of their registration and that the safety and quality of the service being provided to people was maintained.

Staff we spoke with were mostly positive about the manager of the service .One member of staff said, "[manager] is supportive and is around to help; she tries her best and will put things to [provider] but I guess sometimes her hands are tied". Another member of staff told us that the manager was approachable and they felt confident in seeking help, advice or offering suggestions. However, staff we spoke with were concerned that they did not always feel listened to by the provider. We were told that when issues around staffing levels had been raised, they had continuously been told that this was under review but nothing more had been done about it. One member of staff said, "I don't think there is always an understanding about just how difficult it can be and we are told that some people who need two staff only need one, but this is not always the case and that not all aspects of care requires two staff, but this can be disruptive if we have to keep stopping and starting".

People and relatives we spoke with were positive about the management of the home. One person said, "I see the manager most days; she is pretty approachable. The staff are happy on the most part, but I have heard them having discussions about the work load and the amount of things they have to do". Another person told us, "I would say it [service] was well-led. The manager is always around and very approachable and the staff seem happy enough". A relative told us, "I get on very well with the manager. Both her and [senior carer] are very good at their jobs, as are the other girls [staff]; but there are times when they seem to struggle with staff cover".

Records we looked at showed that the manager had offered time and support to staff and had encouraged them to come to her with any concerns or suggestions that they may have. The manager told us, "I am always here for them, all of them, I do my very best to support them in any way that I can. I understand that life can be hard and the work here isn't always easy and I will do everything I can to help out; they know that".

Information we held about the service showed us that the provider had ensured that information that they were legally obliged to tell us, and other external organisations, such as the local authority, was passed on. The provider was working collaboratively with other external agencies such as the local safeguarding authority, Social Services and community mental health teams to ensure people's needs were met.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and that they were actively encouraged to raise any concerns. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved. Staff we spoke with told us that they felt comfortable raising concerns with their new manager and would contact external agencies if they needed to. Information we hold about the service showed that a whistle-blower concern had been raised with us and the issues concerned had been followed up as part of the inspection process.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always ensured that peoples needs were met in a timely manner and risks to peoples safety and comfort had not always been identified and/or addressed.

The enforcement action we took:

We imposed a condition on the provider's registration telling them what action they needed to take in order to promote the safety and comfort of people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes had not always identified the shortfalls found within the inspection. Where shortfalls had been identified by these quality monitoring systems, the provider had failed to respond to these in a timely manner in order to promote the safety and comfort of the people living at the home.

The enforcement action we took:

We imposed positive conditions on the Provider's registration for this location. These conditions required the provider to undertake monthly quality assurance activities and to provide us with an analysis of these on a monthly basis to demonstrate how they are working towards making the required improvements and sustaining the improvements made.