ADR Care Homes Limited

St Catherines House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: St Catherine's House is a residential care home that was providing personal and nursing care to 13 people aged 65 and over at the time of the inspection.

People's experience of using this service: The provider and registered manager had failed to make any improvements to the identified issues found as part of the last inspection in June 2018.

Furthermore, we identified additional issues around the safety, fabric and condition of the home as well as poor recruitment practices. The quality of care had deteriorated since the last inspection. People were not experiencing a good standard of care.

Management oversight processes in place were ineffective and did not identify any of the issues we found as part of this inspection.

Medicines management and administration was unsafe. People did not always receive their medicines on time and as prescribed.

Risks associated with people's individual health and care needs were not always assessed and guidance was not available to staff on how to minimise known risks to keep people safe.

Recruitment checks were not fully completed to ensure that only those staff assessed as safe to work with vulnerable adults were recruited.

The safety and condition of the building and the equipment used was not always safe. Significant issues found with cleanliness, infection control and the environment meant that people could be placed at risk of harm.

People did not receive appropriate person-centred care that promoted their dignity.

Staff did not receive appropriate training and support to safely and effectively carry out their role.

People were not stimulated or involved in activities that promoted their well-being.

The registered manager could not locate records relating to accidents and incidents that had occurred within the home. Therefore, we were unable to assess whether the service analysed accidents and incidents to enable them to learn and improve to prevent future re-occurrences.

Poor staff deployment and availability meant that people's needs were not always safely met.

The service did not always work within the principles of the Mental Capacity Act 2005. Care plans did not

evidence consent to care had been obtained. Capacity assessments had not been completed where required and where decisions had been made in people's best interests these had not been documented.

People's individual needs were not always met by the adaptation, design and decoration of the home. The home had not been decorated and designed in a way which supported people living with dementia.

People and their relatives told us that they and their relative felt safe living at St Catherine's House. Overall, feedback about the service and the care people received was positive. However, our findings did not support this positive feedback.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. 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 take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

We have also informed the local authority of our concerns who are currently in the process of reviewing each person's placement at the home.

Rating at last inspection: At the last inspection the service was rated Requires Improvement. (Report was published on 6 November 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: We are taking enforcement action and will report on this when it is completed. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor the service closed and discuss ongoing concerns with the local authority.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

St Catherines House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection team consisted of two adult social care inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
St Catherine's House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. St Catherine's House can accommodate up to 16 people in one adapted building.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:
Prior to the inspection, we reviewed the information that we held about the service and the provider including notifications affecting the safety and well-being of people who used the service. We had also received monitoring information from one local authority. We looked at the action plan that the provider had submitted following the last inspection in June 2018 which listed the improvements they planned to make. We had not received a Provider Information Return (PIR) from the provider. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the

improvements they plan to make.

During the inspection we spoke with five people using the service and eight relatives of people using the service to obtain their feedback on the care and support that they and their relative received. We also observed interactions between people and care staff.

We spoke with the nominated individual (the responsible person on behalf of the company running the home), the registered manager, four care staff, the chef and a volunteer.

We looked at the care records of four people who used the service and medicines administration records (MARs) and medicines supplies for seven people. We also looked at the personnel and training files of five staff. Other documents that we looked at relating to people's care included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely
• At the last inspection in June 2018 we found that people were not receiving their medicines safely. Poor systems and processes meant that people did not always receive their medicines as prescribed. During this inspection we found that the service had not addressed or made any improvements to the issues we had identified.
• There was one person receiving their medicines covertly. Covert medicine administration is when medicines are hidden in food or drink without the knowledge of the person. Authorisation had been given by the GP for the service to follow this practice. However, the service had not followed the required procedure.
• We did not see records of a best interests decision or advice around the use of covert medicines administration signed and agreed by the GP, home staff, a pharmacist, and the next of kin. This meant that care workers continued to disguise medicines without obtaining appropriate consent and without having received pharmacy advice on the best way to do this.
• One person had been prescribed eye drops to be administered twice a day. Two bottles of the prescribed eye drop were in stock. We found that both bottles were almost full and had not been used which meant that the person had not been receiving the eye drops as prescribed. The eye drops bottle had no recorded opening date so we were unable to evidence when the medicine had been opened for administration.
• People who had been prescribed medicines to be administered on an 'as and when' (PRN) basis, such as painkillers, still did not have protocols in place so that staff could identify when they were in pain and when to give the appropriate treatment.
• We asked to check the stock levels of medicines that were provided in their original packaging to see if they had been given as prescribed. However, the service did not keep a record of stock or stock levels. This meant that the service could not be sure that people were receiving their medicines as prescribed. This included medicines to protect the stomach, prevent seizures and for agitation which could be essential for people to have.
• Care staff had not received any recent medicine administration training and had not had their competencies assessed, since the last inspection, to refresh their knowledge and competency in this area.
• Daily, weekly and monthly medicines audits were ineffective. Checks had been completed but these checks had not identified any of the issues that we identified as part of this inspection. Audits completed stated that there were no issues or concerns noted with the administration and management of medicines.
• Following our findings the nominated individual arranged for an immediate audit of medicines management and administration to take place to ensure people were receiving their medicines safely.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection
• At the last inspection in June 2018, we found that older versions of people's care plans did not always assess and address people's individualised risks associated with their health, care and support needs. At

that time the registered manager showed us new care plans that were due to be implemented which appropriately assessed people's risks. However, at this inspection we found that those stated improvements had not been made. We found that people's individual risks such as those related to behaviours that challenged or specific health conditions had not been assessed. Sufficient guidance had not been provided to staff on how to minimise those identified risks to keep people safe.
• Risk assessments that had been completed for people included those at risk of falls, malnutrition and skin breakdown. However, these were not always fully completed and where people were noted to be at high risk no further information or guidance was available on what that meant for the person and how the service was supporting the person with their identified risk.
• At the last inspection, we found that the service did not appropriately monitor people's fluid intake and were unable to identify when a person's fluid intake was low so that appropriate steps could be taken to address this.
• At this inspection we found that although the service had made changes to the way fluid intake was monitored and recorded, fluid intake was still not adequately monitored. There were gaps in recording and fluid intake was not always totalled at the end of the day to ensure that people's fluid intake was sufficient. This left people at risk of dehydration.
• The service was unable to locate any records of accidents and incidents that had occurred at the service since the last inspection. Therefore, we were unable to assess how many accidents there had been or whether the service implemented improvements and learnt lessons to ensure steps could be taken to prevent further re-occurrences.

Unsafe medicine administration and management, the lack of individualised risk assessments, poor monitoring of assessed risks and the poor recording and monitoring of accidents and incidents meant that the service was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At the last inspection we found that home was in disrepair and issues that had been identified may have placed people at the risk of harm. During this inspection we found that most of the issues we had found remained and had not been addressed.
• The main kitchen in the service was dirty and in disrepair. We found the floor, work and storage surfaces to be covered with dirt and food and sticky to touch. Tiles around the main cooking area had not been cleaned. The extractor fan above the cooker did not work and was dirty.
• The service had been visited by the environmental health department as part of a food hygiene inspection in December 2018 and had been given a one-star rating. Significant issues had been identified as part of the inspection. The notice for this inspection was not on display. We noted that the service had still not addressed the issues that had been found.
• Rat traps were visible in the kitchen and around the home. The registered manager confirmed that there was a rat infestation. The local authority were aware of this.
• We found people's bedrooms in disrepair. Wardrobes had not been securely fixed to the wall, bedroom window frames were found to be rotting, curtain rails and hooks were broken and curtains were left hanging off the broken rails and a water leak which had left a damp patch in one person's bedroom ceiling had still not been addressed.
• Carpet and flooring in certain areas of the home had lifted and had been secured using tape instead of being replaced or secured safely, however, this remained a trip hazard for people living at the home.
• We found some people's lap tables, which were used for people to have their meals and keep their drinks upon, were badly chipped at the edges. This was an infection risk as well as a hazard as a person could easily scratch or cut themselves on the rough edges.
• The provider had not taken any steps to address the issues and concerns that had been identified which meant that the premises and equipment was not safe and suitable for the purpose for which they were

being used.

The poor condition of the home and the equipment being used means that the service was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• At the last inspection in June 2018 we found that there were not always sufficient numbers of staff available to support people safely. At this inspection, we found that this had not been addressed and insufficient numbers of staff and poor staff deployment meant that people were left unattended and placed at risk of harm.
• On the first day of the inspection, when we arrived at the home at 07:30am, we found that there was only one member of night staff on duty when there should have been two. We were told that the second member of staff had to leave due to unforeseen circumstances. The staff member on duty could not tell us what time the staff member had left. Therefore, we were unsure of how long the home had been left with only one staff member in attendance. The nominated individual and registered manager assured us that this would be addressed and would not happen again.
• Furthermore, other staff members that we spoke with confirmed that this particular staff member regularly finished their night shift earlier than scheduled which meant that the home was left with only one night staff member on duty until the morning staff arrived at 08:00am. This placed people at risk of harm especially in the event of an emergency.
• Throughout the inspection we observed numerous occasions where the communal lounge was left unattended where at least 10 people spent the majority of their day. This was because care staff had to either support people who remained in their bedrooms or where other daily tasks such as cooking and laundry had to be undertaken. We saw times where people, who were unsteady on their feet, would get up to go to their bedroom, go out into the garden or visit the toilet without any support. This left them at risk of falling.

The lack of availability of staff and their poor deployment means that the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Recruitment processes in place to ensure only those staff assessed as safe to work with vulnerable adults were not always appropriately followed.
• Appropriate recruitment checks had not been carried out on a volunteer who was working with people living at the home. Although a criminal record check by the Disclosure and Barring Service (DBS) had been applied for, the outcome had not been received and so the service had not obtained the appropriate assurances that the volunteer was safe to work with vulnerable adults.
• Past conduct in previous employment had not been obtained for the volunteer who was due to be employed as an activity co-ordinator.
• For another two staff member files that we looked at we were unable to find evidence that DBS checks had been carried out. We were told that these checks had been completed but records of these could not be found. We asked the registered manager to send us confirmation that DBS checks had been completed following the inspection. We did not receive this.

Unsafe recruitment practices meant that the service was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People living at St Catherine's House told us that they felt safe living at the home. One person told us, "It's not too bad living here. I feel safe."

• Relatives that we spoke also told us that they were reassured that their relative was safe living at St Catherine's House. Feedback included, "He is kept very safe", "I feel safe living her here" and "I don't need to worry, they keep an eye on her."
• However, despite this positive feedback, based on our findings as stated above we found that people were at risk of harm or inadequate care.
• Staff that we spoke with were able to describe the different types of abuse, how they would recognise the signs and the steps they would take if they thought someone was being abused. One staff member explained, "I would report it straight away."
• However, two staff members that we spoke with did not believe people were safe living at St Catherine's House. Staff gave examples of why they felt this was which included poor medicines administration and poor monitoring of people's whereabouts resulting in people leaving the building.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience
• Staff working at St Catherine's House including the registered manager told us that they did not feel supported in their role. When we asked one staff member about whether they felt supported their reply was, "Not really!"
• Not all care staff confirmed that they received regular supervision. One staff member told us, "No, I never get supervision with [name of registered manager]. I did with [name of previous registered manager]." However, another staff member stated, "We have with [registered manager]. Anything we tell her she listens."
• However, records seen of supervisions that had taken place dated back to 2018. We did not see any recent records of staff members receiving a supervision and there were no records of an annual appraisal taking place.
• One volunteer who was working at the home and was due to be recruited as an activity coordinator had not received any training to support them in their role.
• Care staff had not received any refresher training since 2017 and early 2018. One staff member told us, "I haven't had any training recently. Just had one in medication. I heard we was going to have refresher but haven't had anything yet." Another staff member told us, "I had my training three years ago which included medication, safeguarding and another one." This left people at risk of being cared for by staff who were not sufficiently trained and skilled to do so.
• Staff had not been assessed to confirm their competencies especially when administering medicines to ensure practices were in line with any training that they had received. This meant that staff were not receiving the appropriate training and support to enable them to deliver safe and effective care and support to people.

The lack of appropriate training and support for staff meant that the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment with appropriate legal authority. In

care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• At the last inspection in June 2018, we found that the service did not record and document people's consent to care and where appropriate the involvement of relatives, next of kin or advocates. In addition, appropriate records were not in place for people who were receiving their medicines covertly. At this inspection we found that this had not been addressed and further issues were identified.
• Care plans documented where people lacked capacity, however, records were not available to confirm that the service had completed a mental capacity assessment. Furthermore, where specific decisions had to be made in people's best interest these had not been documented. This was especially the case where decisions had been made on behalf of people to administer their medicines covertly.
• The service had submitted applications to the local authority requesting the appropriate authorisations to be in place for those people where restrictions may have been applied on their liberty.
• However, these applications, which were to renew authorisations that had expired, had been submitted in March 2019. There were no records available of any previous DoLS authorisations that may have been in place, when they expired and if any conditions had been recommended. We were told by the registered manager that these records had been archived.
• The service had still not clearly documented whether people had consented to their care and where people lacked capacity, whether relatives, next of kin or advocates had been involved in the planning of their care.
• This meant that we could not evidence that the service was working within the principles of the MCA.

The lack of documentary evidence confirming that the service was working within the principles of the MCA meant that the service was in continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• All staff demonstrated an understanding of the MCA in relation to supporting people, asking their consent and giving them the opportunity and choice to make their own decisions about their care and support where practicably possible. One staff member explained, "We try to give people choices even though they aren't able to make decision. We don't take it away from them. We try to give them their independence. Let them try."

Adapting service, design, decoration to meet people's needs
• At the last inspection in June 2018 we found that people's individual needs were not always met by the adaptation, design and decoration of the home. At this inspection we found that the issues identified had not been addressed.
• No further improvements had been made to the decoration or design of the home to effectively support people living with dementia.
• There was no signage or direction available around the home, other than those signs indicating where the toilets were, which would enable people to find their way around the home.
• People's bedrooms still did not have any signs, numbers, pictures or names attached so that people could identify their bedrooms.
• The home continued to require modernisation. Some people's bedrooms remained very basic in terms of the decoration with poor quality bedding and curtains in use.
• The service did not consider a person-centred approach for people and did not take into account the support people required, their needs and preferences.

Supporting people to eat and drink enough to maintain a balanced diet
• During this inspection we found that the service had not addressed the issues that we found at the last inspection in June 2018.
• At the last inspection there were no menus on display and there was no evidence available to confirm that people were offered a choice of meal. During this inspection we found that nothing had changed.
• The chef confirmed that there was no formal menu in place as the previous menu did not work and meals were planned depending on the ingredients available within the home on the day.
• The chef also told us that people were asked what they wanted the day before, but choices were not recorded. The chef said that she was very aware of peoples likes and dislikes and any specialist dietary requirements as there were only 13 people living at the home.

The continued issues found with the adaptation, design and decoration of the home and the lack of menus and choice available to people for their meals, meant that the service was in continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

• People and their relatives, however, generally gave positive feedback about the food that they and their relative received at St Catherine's House. One person told us, "I love the food….stews cakes, ice cream." Another person stated, "The food is very good." However, one person did tell us, "I don't like the food. There is no choice and I don't like the crust on the chicken pie."
• Relatives comments included, "It looks okay, she [relative] says it is nice", "The food looks and tastes good. I have it here and there is a lot of choice" and "It smells good and there are choices."
• We observed people had access to drinks throughout the inspection. Snacks including fresh fruit were available upon request but were not easily accessible to people. Where people had specific dietary requirements these had been documented in the person's care plan and staff were aware of these. People's likes and dislikes had also been recorded.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• We saw records confirming that the service worked with other agencies to try and ensure people received the appropriate care and support. This included working with the local GP and district nurses.
• Where people required specialised intervention, referrals had been made on behalf of people to access a variety of services which included the dietician, continence service and speech and language therapists.
• The home also worked closely with the Care Home Assessment Team (CHAT), which consisted of nurses, occupational therapists and geriatric consultants, who supported the home with acute illnesses to prevent any unnecessary hospital admission.
• Relatives were assured that their relative had access to the appropriate health care professional when required. One relative told us, "They call me if they need to call the doctor. They know the residents well here and listen to them when they say they feel ill."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service had processes in place to complete an assessment of people's needs to confirm that the home could meet their needs and choices. However, there had not been any new admissions since the last inspection.
• Care plans in place for people were regularly evaluated, however, care plans were not updated to reflect any significant change. This has been further reported on under the 'Responsive' section of this report.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Inadequate: People were not treated with compassion and there were breaches of dignity. Some regulations were not met.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

• People and their relatives were complimentary of the care staff and support that they and their relative received. One person told us, "The carers are very good and I get the care that I need." Another person stated, "The carers are alright."

• Relatives comments included, "The carers are really caring. My [relative] smiles and everyone seems content", "They are really caring and they include me too" and "They are very kind and the care is lovely here."

• Throughout the inspection we observed some kind and caring interactions between people and staff. Staff knew people well and had established positive and caring relationships with them.

• However, despite the positive feedback and observations, our inspection found practices in place which did not promote people's dignity.

• People were not always supported with their personal care. On entering the home there was a mal-odour within the home that suggested poor personal hygiene. Daily records seen did not evidence that people were supported to have a bath regularly and as per their wishes.

• People were observed to have lengthy and dirty nails. People's hair was seen to be greasy. One person told us, "The nurses do my hair, but my nails are in dire need of cutting."

• Records seen for two people indicated that they had only been supported with a bath twice within a one month period.

• People told us that they did not get regular support with bathing. One person told us, "I rarely get a bath. I would like to have one twice a week." A second person stated, "I had a bath yesterday. That was a nice surprise. I usually wash myself." A third person said, "I have had problems with bathing. I think I can get a bath. I am not sure when."

• Care staff also told us that people did not always get the appropriate care and support with their personal care. One staff member stated, "People do get a bath or shower but its not regular. Some staff don't wash people properly." A second staff member explained, "Well I don't know what the baths are like for people, but I would say no they don't get it regular because when I come here I have to do so much. When I open the door you get an odour and there are those staff who don't do much."

• On the second day of the inspection we observed one person being transported into the lounge area on a commode. The person did not have a wheelchair which staff could use. Staff did not seem to think that this was possibly an undignified way in which to support people.

The above identified issues did not promote people's dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us that care staff were respectful of their privacy and dignity. Relatives confirmed this and told us, "She still has her dignity. They treat her like a person and not just another one to care for" and "They are good here. They are so respectful and we have the privacy and respect we need."
• Care staff gave examples of how they respected people's privacy and dignity which included knocking on people's bedroom doors before entering and protecting their privacy when supporting them with personal care.
• Care plans recorded people's cultural and religious beliefs and where appropriate how they wished to be supported. One relative told us, "I like it here because they continue her beliefs and celebrate that with her."
• People were supported to maintain their relationships with their partners, family and friends. Visitors were welcome to the home at any time. Care plans gave some basic background information on people's current relationships.
• People were encouraged to be as independent as they could be where possible. One person told us, "I am allowed to be as independent as I can." One staff member explained, "They [people] will try and do things themselves and we can help."

Supporting people to express their views and be involved in making decisions about their care
• People told us that they were always involved in making decisions about how they wanted to be cared for. Throughout the inspection, we observed care staff asking people about how they wanted to be supported. Choice was offered and people's responses were respected.
• Care staff knew people well and were aware of people's preferences and supported them accordingly.
• Relatives confirmed that they had been involved in the care planning process.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• At the last inspection in June 2018 we identified concerns with the lack of meaningful activities and stimulation available to people. During this inspection we found that these concerns had not been addressed.
• Throughout the inspection we observed very little meaningful activity and stimulation. People sat in the lounge with nothing to do. A television switched on in the background was positioned in a way which meant that most people could not watch it.
• The radio had also been switched on and was playing alongside the TV. Consideration had not been given to the music playing on the radio, which may not have been appropriate for the generation of people living at the home.
• There was no structured activity timetable available. During the inspection we saw a volunteer at the home, who tried to engage certain people with board games. We saw one person listening to classical music of their choice through their own personal headphones. Another person was given a mobile phone to watch music videos downloaded through the internet.
• However, other people were just left to sit in the lounge with nothing to do. We observed that due to the lack of any sort of available activity and stimulation some people had become quite unsettled and spent the day arguing and insulting each other.
• At different times throughout the day we also observed the volunteer blowing water balloons into the air without any meaning. People were not engaged in this activity.
• Activity records documented the activities that people participated in which included singing, watching TV, listening to music, walk to the toilet, bubble blowing and playing games. People were not supported on outings or to access the community.
• Feedback from people about the availability of activities was not positive. One person told us, "I don't bother about activities." A second person stated, "I am not interested in activities."
• Appropriate consideration had not been given to planning and scheduling of activities for people especially those living with dementia to stimulate them and bring them into positive wellbeing.
• People's care plans had been written on their admission to the home and detailed their needs and how they wished to be supported in areas which included personal care, continence, diet, mobility, communication and behaviour. However, despite monthly evaluations of the care plan, the main content of the care plan, some of which had been written as far back as 2014 and 2016, had not been updated to reflect significant changes in people's needs.
• This meant that care staff did not have access to information about people's most current support needs and requirements. Care staff would have to filter through monthly evaluation records to obtain the most current information about people. Therefore, there was a high risk that people may not have been receiving care and support that was responsive to their needs.

• At the last inspection in June 2018 we had noted that the registered manager was introducing a new format care plan and had written four care plans that were person centred and detailed. However, at this inspection we found that the new care plan template shown at the last inspection had not been used for the remaining care plans. Care plans in place were basic and lacked sufficient information about the person, their needs and preferences especially around social activity and interaction.
• Where people had behaviours that challenged the service, there was insufficient information available to care staff on possible known triggers to specific behaviours and how staff were to support the person into positive well-being.
• Important and relevant information was not always clearly available to care staff so that people could receive care, support and communication that was responsive and tailored based to their needs.

Issues around the lack of appropriate activities and stimulation and poor care planning meant that the service was in continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• No formal complaints had been recorded since the last inspection.
• People and their relatives knew who to speak with if they had any concerns to raise and were confident that these would be addressed appropriately and in a timely manner.
• Processes were in place to record and investigate complaints if they were received.

End of life care and support
• At the time of the inspection, the service was not providing end of life care.
• Relatives confirmed that discussions had been initiated by the service to obtain people's wishes on how they wished to be supported at the end of their life.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- In the June 2018 inspection, the provider was in breach of Regulations 9, 11, 12, 17 and 18. The issues found related to person centred care provision, consent to care, safe care and treatment, good governance and staffing. However, at this inspection we found that the service remained in continued breach of all these regulations.
- In addition, we found breaches of Regulations 15 and 19. Additional issues we found related to premises and equipment and staff recruitment practice.
- After the last inspection, the provider and registered manager submitted actions plans on how they were to address the regulations they had not been complying with. At this inspection, we found that the provider had not addressed or completed any of the required areas for action.
- The registered manager showed us a range of management checks and audits that had been completed to oversee and check the quality of care people received. Areas looked at included medicines management, care plans, infection control and health and safety. However, these checks were ineffective and failed to pick up any issues including those we identified as part of this inspection.
- Audits were seen to be a tick box exercise, where all areas checked were recorded as compliant. Issues or concerns were not identified by the provider or the registered manager.
- The registered manager or the provider had not completed any checks or audits since January 2019. We were informed by the nominated individual that new systems and processes were to be introduced to monitor quality.
- The service had failed to address issues and risks that had been identified by the environmental health department as part of a food hygiene inspection which took place in December 2018. The notice for this inspection had not been displayed within the home.
- Records of accidents and incidents that may have occurred within the home involving people and staff could not be located during the inspection. Care plans were disorganised and certain sections of some care plans were missing. The registered manager had to re-print the missing pages from the computer.
- Ineffective management oversight and the lack of accurate and complete records meant that people could be placed at risk of receiving care that was not safe, effective, caring and responsive to their needs.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider or registered manager did not plan, promote and ensure people received person centred and high quality care at St Catherine's House. Issues and failings identified have been detailed under each of the key questions within this report.

• The provider had failed to address any of the issues identified from the last inspection in June 2018. The provider did not engage with this inspection process despite being aware of the significant concerns that we had identified again.
• The provider had four other care homes as part of their registration with the Care Quality Commission (CQC). At three of these services, the CQC are undertaking significant enforcement action due to issues and failings that we have identified which are similar in nature to those found at St Catherine's House.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• People and their relatives knew the registered manager and all staff working at the home well and spoke positively of them. One person told us, "I know [registered manager] and can talk to her." Relatives told us, "I know her and if you need her she makes time or calls you back" and "I think she is approachable and knows what she is doing."
• Since the last inspection in June 2018 the service had not asked people or relatives to complete satisfaction surveys to get their feedback about the quality of care that they received.
• We asked people and their relatives what was good about the home and if any improvements could be made. People's responses included, "I don't know what is good about the home. Every day is the same", "I don't know what the home does well or could do better" and "The home is okay. The home could be better by taking me into the garden."
• Relatives feedback included, "They are very caring and kind to visitors and others as well as to the people who live here. Repairs could be done quicker" and "Maybe some different activities like a walk out to the shops or library or a film evening."
• We were informed by the registered manager that two weekly residents meetings were held. However, minutes from these meetings were not available and so we could not evidence the topics that were discussed.
• We saw records confirming quarterly staff meetings to be taking place. Agenda items discussed included activities, meals, cleanliness of rooms, wellbeing and general information.
• However, care staff, despite attending these meetings and receiving supervision were not positive about their working experience at St Catherine's and did not feel supported. Feedback from staff included, "Never had anyone who listened to me. I have been complaining about cleanliness", "Oh my god I work here but it's bad, I would never put anybody here. Nobody listens, nobody does anything. They don't take things seriously" and "I work here because I have to work but it's the very best of nothing."
• The lack of engagement with people, relatives and staff meant that there was a missed opportunity to obtain their feedback about the service they received, what was good and what could be done better.
• The service worked with a range of health care professionals to try to ensure that people using the service received timely access to health care services.

The issues identified above mean that the service is in continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not receiving appropriate care and support that promoted and respected their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of people was not always provided with their consent. Where people lacked capacity the provider did not act in accordance with the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Poor recruitment practices followed by the service meant that there was a lack of assurance that staff recruited were fit and proper for the role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff deployment and availability was poor. People's needs were not always appropriately and safely met. Staff did not receive the appropriate training and support to carry out their roles safely and effectively.

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 9 HSCA RA Regulations 2014 Person-centred care People were not in receipt of person centred care. Care plans were not current and reflective of people's needs. People's individual needs were not always met by the adaptation design and decoration of the home. The home had not been decorated and designed in a way which supported people living with dementia. The provider did not ensure that appropriate and sufficient activities were organised and provided to people which encouraged stimulation, interaction, independence and involvement.

The enforcement action we took:

We issued the provider and the registered manager with a Notice of Proposal to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed and administered safely. Risks had not been assessed or appropriately monitored to provide staff with guidance on how to mitigate these to keep people safe. Records relating to accidents and incidents could not be located. The service could not evidence learning or improvements from known accidents and incidents so that future re-occurrences could be prevented.

The enforcement action we took:

We issued the provider and the registered manager with a Notice of Proposal to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that all areas of the home used by the service were suitable for the purpose for which they were to be used and properly maintained.

The enforcement action we took:

We issued the provider and the registered manager with a Notice of Proposal to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not acted upon and made the required improvements to issues identified at the last inspection. Quality audits were ineffective and did not highlight concerns and issues around the home that were identified as part of this inspection. Service management and leadership was poor. The systems for improving the service were not pertaining effectively to identify and address issues with the quality and safety of the service. The provider had not mitigated risks highlighted by external safety professionals in order to keep people safe. The provider did not always act on people, relatives and staff feedback for the purposes of learning, continually evaluating and improving the provision of care and support. Complete records pertaining to people and the care and support that they required were not easily available and accessible.

The enforcement action we took:

We issued the provider and the registered manager with a Notice of Proposal to cancel the location.