V Gulati

Catterall House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced, which meant the provider did not know we were coming. It was conducted on 23 February 2016.

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

The last inspection of the service took place on 3 November 2015. During that inspection we found the provider was in breach of a number of regulations. The breaches were in relation to safe care and treatment, premises and equipment, need for consent, staffing, good governance and notification of other incidents. At that time the domains of effective, caring and responsive were rated as 'Requires Improvement' and the areas of safe and well led were rated as 'Inadequate', which resulted in an overall rating of 'Inadequate'.

We found improvements had been made across some areas of the service during this inspection. However, we identified areas where further improvements needed to be made and we still had concerns about the way risks to the health, safety and wellbeing of people were managed. These are detailed within each relevant section of the report. We have judged that the service still remains Inadequate for the key question of safe and the home will therefore remain in special measures.

On our arrival to the home on this occasion the inspection team waited approximately ten minutes for the door to be answered. We were greeted by a senior care worker, who told us she was leading the shift for the day, as the manager of the home was on a training course. However, the manager arrived shortly afterwards, having left the training course to attend to the inspection team. The manager of Catterall House was in the process of applying for registration with the Care Quality Commission. We were told that the provider was aware that the front door bell was faulty and was in the process of getting this repaired.

We found that the cleanliness of the premises had improved in some areas, but further improvements were still needed. Some areas were also in need of modernising and updating.

We looked at medication practices adopted by the home and found some improvements had been made, although several shortfalls were still evident in this area, which meant that people were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed.

Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use.

Areas of risk had not been managed appropriately. Therefore, people were not consistently safe.

Formal consent had not always been obtained before care was provided. Legal authority had not been sought for those whose liberty was potentially being deprived.
New staff were, in general appropriately recruited and therefore deemed fit to work with this vulnerable client group.

The three care staff on duty each day were responsible for laundry duties as well as the provision of activities. An additional cook had been employed since our last inspection and the provider was in the process of appointing a cleaner, which will help to ease the workload for the care staff.

Induction programmes for new employees were formally recorded. Supervision and appraisal meetings for staff were regular and structured. This meant the staff team were supported to gain confidence and the ability to deliver the care people needed. A wide range of training programmes were provided, in line with the nationally recognised care certificate, although the training matrix could have been more detailed. We made a recommendation about this.

Evidence was available to show that surveys and meetings for those who lived at the home were conducted. Information was readily available about the use of local advocacy services. An advocate is an independent person who can support people through the decision making process. We found that people's privacy and dignity was respected.

Guidance from community health care professionals had been consistently followed. The planning of people's care was, in general detailed and person centred. However, some records did not contain all the information about a person's needs and conflicting information was sometimes provided.

We made a recommendation around the provision of fresh vegetables, fresh meat and homemade dishes being served at meal times and these being displayed on picture menus, which would be beneficial for those who lived at the home. We also recommended that the provider consults The National Institute for Health and Care Excellence (NICE) guidance and Alzheimer Society guidelines related to dementia care environments.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and receiving and acting on complaints.

As one domain remains inadequate in accordance with our guidance the service will remain in special measures. We have placed a restriction on admissions. Where we have identified more serious breaches of regulation we will ensure that action is taken to keep people safe.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

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

Infection control protocols were not consistently being followed. Although it was noted that some improvements had been made in relation to the cleanliness of the environment, some areas of the premises were still in need of a thorough clean.

Although we were told that the number of staff on duty at the time of our inspection were sufficient for workers to adequately complete the duties expected of them, we would expect the provider to constantly review the staffing levels, in accordance with the assessed needs of those who live at the home. Recruitment practices, in general were found to be satisfactory.

Is the service effective?

Requires Improvement

This service was not always effective.

New employees had completed a formal induction programme when they started to work at the home. There were structured mechanisms in place for staff support, such as formal supervision and appraisal sessions. Mandatory learning programmes were provided for the staff team and additional modules were available, in relation to the specific needs of those who lived at the home. The training programme provided a wide range of learning modules, which were in line with the nationally recognised care certificate. However, the monitoring of staff training could have been better by the introduction of a more structured audit.

Freedom of movement within the home was evident and we did not observe this being restricted. However, we found several areas which were unsafe and
therefore this did not effectively protect people from harm.

Formal consent had not always been obtained through best

interest decision making processes before care and treatment was provided and legal authority had not been sought for those who were potentially being deprived of their liberty.

Is the service caring?

Good

This service was caring.

People were very complimentary about the staff team and the general routines of the home. Their privacy and dignity was consistently promoted. Staff were seen to engage with people in a kind and caring manner and most of those who lived at the home were well presented.

The care records we looked at contained some good, person centred information about people's likes and dislikes and things that were important to them.

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

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

When viewing the plans of care we saw some good examples of person centred information, which detailed how people wanted to be supported and their preferred daily routines. Care plans we looked at had been reviewed on a monthly basis. However, important information was sometimes missing and conflicting information was occasionally provided. Community professionals were involved in the care and treatment of those who lived at the home.

The provision of activities was evident, although one person we spoke with felt that there was not much going on. Complaints were not being well managed.

Is the service well-led?

Requires Improvement

This service was not well-led.

Records showed that annual surveys were conducted for those who lived at the home and their relatives. A staff meeting and a resident's meeting had been held, although the manager was intending to arrange these in a more structured way. There was

clear evidence that the providers husband interfered with the day to day running of the home, as he removed confidential records from the manager's office, without having the authority do so.

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

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

Catterall House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 23 February 2016 by three Adult Social Care inspectors from the Care Quality Commission (CQC).

At the time of our inspection of this location there were 13 people who lived at Catterall House. We were able to speak with nine of them. We also spoke with four staff members and the manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the care files of six people who used the service and the personnel records of three staff members who had been employed since our last inspection.

We 'pathway tracked' the care of five people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

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

Inadequate

Is the service safe?

Our findings

People we spoke with who lived at Catterall House told us they felt safe living at the home. One of them said, "I've always felt safe staying here. We get well looked after and the carers are lovely." Another commented, "I think there's always enough staff on duty. We don't need to wait, if we ask for anything." The manager of the home told us, "We have three carers in throughout the day and two overnight, which for thirteen people I think is safe."

When talking with one person who lived at the home they said, "There are only two of them [carers] this morning. They don't come and talk to us because they don't have time. If you are not well you don't like to bother them because they are so busy."

At our last inspection we found that people were not safe. We found that the registered person had not assessed risks to the health and safety of people and had not taken appropriate steps to mitigate such risks exposing people to a risk of significant harm. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.

On carrying out a tour of the home on this occasion we noted that several environmental improvements had been made, in accordance with the provider's action plan. However, some areas of the premises were in need of refurbishment. On the day of our inspection contractors were on site conducting some essential repairs. However, we observed a number of easily identifiable hazards within the environment. These included a very unstable table, a broken chair, an insecure fire exit door, a loose radiator cover and a heavy based lamp, which was precariously balanced on the back of a chair where a person who used the service was sitting. We also noticed that there was no call bell lead available in the conservatory, for those who used this area to summon help, should they require assistance. These hazards had not been identified by the provider or staff, which demonstrated that processes for environmental risk assessments and audits were not effective. We were told that a maintenance plan had not been developed, despite the level of work required following the last inspection. A structured programme of maintenance would help to ensure that work required is identified and undertaken within a reasonable time frame.

There were a range of risk assessments in place within each care plan we viewed, which were supported by a sample table of potential hazards. These covered areas, such as personal care, falls, fire, the environment and infection control. However, many had not been reviewed. Some were unclear and difficult to understand, often providing generic information, which was not always relevant to the individual concerned. For example, a risk assessment for one person covered domestic duties, which included the use of equipment, such as a vacuum cleaner, washing machine, tumble drier, iron, cleaning equipment, cooker, kettle, microwave and toaster. There was no reference in the care plan of this person to indicate that they utilised any of this equipment and it was confirmed that they did not.

We also noted some examples where risk assessments were required, but not present in people's care plans. For example, one person faced some specific risks in relation to infection control, but these had not been

assessed or appropriately planned for. The risk assessments we saw had a part entitled 'control measures required to remove or reduce the risk'. Against the domestic duties section was written, 'Dynamic risk assessments by staff'. We were told that the previous manager had entered this comment and the current manager was unaware of its meaning.

We found that the provider had not always assessed risks to the health and safety of people who used the service and had not done all that was reasonably possible to mitigate such risks. This was in breach of regulation 12 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that areas of the environment were dirty and unhygienic and therefore infection control was not being adequately promoted. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.

The provider told us that the environment had been deep cleaned by an external contractor and the appointment of a permanent cleaner was in progress. During this inspection we found that there had been some noticeable improvements to the general cleanliness of the environment, in that some areas viewed were visibly cleaner and more hygienic. However, we identified a number of areas where the improvements had not yet been made. For example, we noted equipment including a pressure cushion and hoisting sling were soiled. Some bedding belonging to one person was seen to be in an extremely unhygienic state. Some surfaces were thick with dust; particularly high areas like the tops of wardrobes, but also window sills and the tops of drawers were dirty. The ivy from outside was growing into one bedroom through the open window. We saw powder like debris on the floor in the kitchen. We asked the cook what this was and they said the handyman had just sprayed the front of the fridge. When we enquired as to what the fridge had been sprayed with the cook was unsure. This was of concern given that the fridge was in use and contained various food items. An electrical cupboard was thick with cobwebs and dead insects, which had been brought to the previous manager's attention at the last inspection. A store room was seen within the rehabilitation unit. This was found to be unclean. Perishable food, for example biscuits and cake, were stored in this room, which was found to be unsuitable for this purpose.

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

At our last inspection we found that people were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.

At this inspection we reassessed the management of medicines and although we found that some improvements had been made in this area there were still several shortfalls evident, which could have potentially placed people at risk.

We found the medicines trolley to be somewhat disorganised. We also found some medicines which had been discontinued, but were still present in the medicine trolley. These should have been removed from stock and returned to the pharmacy department. Some stock with a limited shelf life had been opened, but not dated. This meant that staff would not be aware when the stock was to be disposed of.

We did note a small number of unexplained omissions on Medication Administration Records (MARs). In

these circumstances it was unclear whether staff had failed to administer the medicines or if they had administered them and not signed to confirm they had been given. We also noted one example of a hand written amendment on a MAR chart, which was scribbled out and re-written, making it very unclear.

Records in relation to variable dose medicines, for example, Warfarin, were confusing and difficult to follow. The manager advised us that a new system had been put in place by community health workers, which meant the home were given information about changes to people's Warfarin in a different way. Whilst information about the changes were recorded in people's care plans, it was not clear on their medicines records, which could lead to errors being made.

Some records in relation to topical applications such as creams and ointments were not clear. There were blank body maps included with the medicines records, but these were not completed to show staff where the topical applications should be applied. In several examples the records stated 'apply as directed' without any further information, which did not provide sufficient guidance for staff.

Balances of variable dose stock were not monitored, which meant it was not possible to audit the tablets against the records of stock in the home.

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

Lunch time medicines were administered in a safe and appropriate manner. We heard the senior care worker ask people if they required any medicines for pain relief. Medicines, including refrigerated items were stored securely. The temperatures of the storage area and fridge were regularly monitored to ensure they remained within the correct range.

Medicines Administration Records (MARs) were generally completed to a satisfactory standard with important information such as any allergies included.
Some people who used the service were prescribed medicines on an 'as required' basis. We saw that where this was the case, there was information for staff about when these medicines should be given, known as PRN protocols. This helped to ensure people received their medicines when they needed them.

We looked at the records of one person who used the service and managed their own medicines. We saw there were suitable risk assessments in place to help ensure that any support the person required to manage their medicines safely was identified.

We were only able to carry out counts of a small number of mid cycle medicines, such as antibiotics. Due to the balances of loose medicines not being monitored or carried forward at the start of each cycle. However, all those counts we did complete were correct. This showed care workers had administered the medicines at the correct times.

At our last inspection we found that people were not protected against the risk of receiving inappropriate or unsafe care and treatment, because there were insufficient numbers of care staff deployed to adequately meet the needs of people, due to them being responsible for all other ancillary duties. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.

The provider told us that a second cook had been employed and the appointment of a permanent cleaner was in progress. On our arrival at Catterall House there was a senior care worker, a care assistant and the recently appointed cook on duty. There were 13 people who lived at the home. The manager was on a training course, but attended shortly after our arrival. We were advised by the manager that one member of staff had phoned in sick on the morning of our inspection and it had not been possible to cover their shift at such short notice. However, an additional member of care staff attended for duty later in the morning. One person who lived at the home required two care workers for personal support and for mobilisation. The senior carer told us that care workers were responsible for domestic and laundry duties, as well as providing some activities. She said the situation was not ideal but manageable, due to a reduction of people who lived at the home. We noted that call bells were answered within an acceptable time frame and that people did not have to wait for assistance to be provided.

A dedicated domestic was not employed at the time of our inspection, although the manager told us that, 'several people had been interviewed'. A cleaning schedule was in place, although the duties were expected to be completed by care staff until a dedicated cleaner was employed, which we were told was being organised. In some parts of the home, a deep clean was required within some communal areas and several bedrooms.

We looked at the kitchen area during our inspection and found it to be clean and tidy. All cooking utensils had been washed and stored away. Fridge temperatures were taken twice daily and had been recorded appropriately. Any opened food had been put in a container and sealed and dated to help ensure the health and welfare of people who used the service. Random food items were checked in the store room and found to be within the recommended use by date.

The Environmental Health Officer (EHO) had re-inspected the home shortly before our visit, as the last rating given was level 2, which showed the home 'Required Improvement' in the area of food hygiene. We were told by the EHO that improvements had been made in relation to the cleanliness of the kitchen and the replacement of catering equipment. However, the area of staff training in food hygiene was under discussion.

We looked at three personnel records of staff members who had been appointed since our last inspection, which contained contracts of employment, job descriptions specific to individual roles, completed application forms and interview notes. Two forms of identification, including photographic evidence were present in the files we looked at. Two written references were seen on two of the three records, but only one was available for one new employee. This was discussed with the manager at the time of our inspection, who assured us that the missing reference would be followed up straight away. Although confirmation was available to show that the manager had seen Disclosure and Barring Service (DBS) authorisations for new employees, it would be good practice to record the DBS number within the staff file.

Staff we spoke with confirmed they had undergone training in relation to safeguarding vulnerable adults and were fully aware of the whistleblowing procedure. They told us that should they have any concerns about the health, safety or welfare of someone who lived in the home, then they would use the whistleblowing procedure without hesitation. Records we saw confirmed that safeguarding vulnerable adults was a mandatory training module, which meant that all staff had to complete this course regularly. The employee handbook outlined some important policies and procedures. However, this could have been more informative, by including areas, such as safeguarding vulnerable adults and fire awareness.

We viewed the fire escape at the rear of the home, which we had previously found to be unsafe. We noted this area had been cleaned and moss and other debris causing a slip hazard had been removed. The door

leading into the home from the fire escape had been secured and emergency lighting in the area had been repaired and was fully operational.

We toured the premises and found some improvements had been made since our last inspection. There were no unpleasant odours around the care home. We looked at the toilet and bathroom areas and found them to be clean. One bathroom area had been completely replaced by a wet room which staff said 'had made a big difference'. We saw soap and paper towels in toilets and hand washing instructions in the staff toilet. One member of staff told us, "We have had a lot of work done, new floors and wet-rooms, so the home is better all round."

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

Accident records had been completed and these were retained in line with data protection guidelines, so that the personal information about people was retained in a confidential manner. Personal Emergency Evacuation Plans (PEEPs) and risk assessments had been introduced. The purpose of these is to provide guidance for any relevant party, such as the emergency services, about how each person would need to be evacuated from the building in the event of an emergency, should the need arise. For example, in the case of fire or flood. Certificates were available to demonstrate systems and equipment had been serviced, in accordance with manufacturer's recommendations, to ensure they were fit for use.

Requires Improvement

Is the service effective?

Our findings

One person we spoke with said, "The food is OK. I enjoy it and if you want some more you can ask." Another commented, "If I need a doctor's appointment, one of the staff will arrange it and go with me." And a third told us, "They [the staff] said I don't need the Doctor but I think I do. I don't feel right. I can't stop going to the toilet." However, when we checked the person's plan of care we found that staff had recently arranged for their GP to visit and carry out some checks, as they had reported feeling generally unwell and this had been done.

At our last inspection we found that the registered person had not always ensured people's rights were protected, because consent had not always been obtained through best interest decision making processes, prior to the provision of specific areas of care. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.
At this inspection we observed people who lived at the home being asked for their consent verbally before support was provided. For example, when assisting with meals or cutting up food. However, consent forms were present within the care plans we looked at, but these had not always been signed. One person whose records we saw had an authorised Lasting Power of Attorney (LPA), who visited regularly, so there had been several missed opportunities to get the care plan and consent forms signed.

Families may be consulted about the proposed care and support provided for their relative, and their views taken into account, but this is not the same as consent. They do not have automatic legal authority to provide permission for the proposed care or treatment. Only people who have an LPA, or have been appointed by the Court of Protection as a deputy, have legal authority to give consent on behalf of a person who lacks capacity to do so. One care plan we looked at contained evidence of a family member being granted an LPA.

Mental capacity assessments are a necessity when caring for people who live with dementia or any form of cognitive deficit. This process helps to determine if people are able to make decisions about specific areas and if they are able to consent to care and treatment being provided. We were told by the manager of Catterall House that two people, who lived at the home experienced cognitive deficit and, as such, we would have expected an assessment to have been completed to help ensure their wishes, choices and best interests were being respected. However, these had not been completed.

One care file we looked at showed that a relative had been granted Lasting Power of Attorney (LPA) and relevant evidential documents were retained on the person's file. The relative had been fully involved in various decision making processes, including those surrounding care planning, medication and recent resuscitation decisions. Some care files contained people's signatures, to show they had agreed with the contents of the care plan and that they consented to relevant information being shared with other professionals. However, at the time of this inspection we were concerned that one person who used the service had not attended a hospital appointment for some minor surgery, which would potentially help to improve their eye sight. When we discussed this with the manager we were told a family member had made

the decision that the person would not go through with the surgery. There was no record in the person's care plan to confirm that their capacity to make this decision had been assessed and there was no record of any best interest decision meetings or Lasting Power of Attorney documents.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

We asked a senior care worker about people who used the service who may not be able to consent to their care. We asked this staff member to tell us about any person who may be subject to a DoLS. It was clear that the staff member did not have a full understanding of this area and was unable to give us this information. We asked the staff member if everyone was free to leave the home. The staff member confirmed that some people were unable to access the key code and that there were some people who she would attempt to encourage to remain in the building, for their safety. However, the staff member was unsure if DoLS authorisations were in place for these people.

The manager told us that no applications for Deprivation of Liberty Safeguards (DoLS) had been applied for at Catterall House. However, it was confirmed that two people required a DoLS application to be submitted. The manager started to complete the applications during our inspection, but confirmed that no other staff members were able to complete an application. Staff members' knowledge of mental capacity and DoLS was limited. This became apparent during our interviews with care workers.

Records showed that authorisation had not been sought for those whose liberty was being deprived. Therefore, the home was not working within the legal requirements of the Mental Capacity Act. This was in breach of regulation 13(1)(2)(4)(b)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the registered person had not always ensured that the premises were suitable for everyone admitted to Catterall House. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.

We were informed at the time of our last inspection that a more suitable placement had been found for one person who had moved into Catterall House the day prior to our last visit. It was confirmed when this transfer had taken place. At the time of this inspection it was evident that those who lived at Catterall House

were able to freely access all areas of the home independently or with help, as was required.

Records we saw demonstrated that induction checklists had been completed for new employees. These contained a wide range of important topics, such as moving and handling, safeguarding vulnerable adults, care planning, health and safety and equal opportunities. However, all areas had been completed in one day, which was an extensive amount of information for any new member of staff to retain, or indeed be able to cover during the identified period. This was discussed with the manager at the time of our inspection, who assured us that she would review the induction period for new employees.

Staff members we spoke with confirmed that part of their induction included shadowing a senior staff member until they felt confident enough to work independently. One care worker told us, "I have worked in other homes before coming here, but I still had a good induction. Everything's been fine." Training certificates relating to emergency and safeguarding procedures, as well as food hygiene were seen on the personnel records we viewed.

The staff personnel records we looked at were for three new members of staff and therefore their supervision sessions and appraisals had not commenced at the time of our inspection. However, longer standing members of staff, who we spoke with, told us they received regular supervisions and annual appraisals. One of them said, "I have been here six months and I have had two supervisions, which I think is good."

Staff members we spoke with had a good understanding and knowledge of people's individual care needs and they were encouraged and supported to undertake training, including the care certificate, which is a nationally recognised qualification in care.

Several people at Catterall House had been diagnosed with a form of dementia, but we found the environment not particularly dementia friendly. Appropriate signage on bathroom, toilet and bedroom doors would have been beneficial and would have helped with orientation. No meal menus were available. Picture menus for those who were living with any form of cognitive deficit or dementia would have proved invaluable in encouraging a choice of meals and would have reflected a person centred approach to providing care and equal opportunities.

We conducted an observation at lunch time in the dining room. We noted ongoing pleasant verbal interaction between staff members and those who lived at the home, with support being offered as was required. People were able to eat within the privacy of their own bedrooms, should they prefer to do so. Appropriate music was played in the background. Twelve people who used the service and four staff members were present. Staff wore protective clothing, whilst handling food.

We saw beverages and snacks being served throughout the day. Staff members were patient with people. People were asked if they required any assistance and staff waited for a reply before assisting the individual. People were offered hot and cold drinks. We were told by one member of staff that soup and sandwiches were prepared for the evening meal each day, which 'residents seemed to enjoy'. One member of staff told us, "One of the staff will go around during the morning and ask people what they would like to eat for lunch and tea time. We give them a choice."

There was a choice of food offered and staff encouraged people to eat their lunch independently. However, the meals could not be described as wholesome and nutritious. For example, one choice of meal was frozen chips, fried egg and spam. The alternative on the menu was cottage pie and frozen vegetables. Fruit and ice cream was served as a dessert, but we did not see any alternative choice being offered. No serviettes were

provided and we saw one person wipe her mouth on the table cloth and her sleeve.

We recommend that the provider reviews the provision of meals. The introduction of fresh vegetables, fresh meat and homemade dishes would be beneficial for those who live at the home. It would also be useful to implement a picture style menu, to help people to select their choice of meal. We also recommend that the provider consults The National Institute for Health and Care Excellence (NICE) guidance and Alzheimer Society guidelines related to dementia care environments.

Good

Is the service caring?

Our findings

People we spoke with who lived at Catterall House were very complimentary about the staff team and general routines of the home. Staff were described as 'helpful' and 'caring'. Comments from those who used the service included: "The staff are very good. They can't do enough for you"; "They (the staff) are all very nice. They take good care of us"; "Some of the staff are really nice and take care of us very well. They often take time out for a chat" and "I choose what time I get up. If I want to have a sleep in, then I do. I have breakfast when I get up. I can have it in my room, if I want to."

We looked at the care plans of six people who lived at Catterall House and found that they contained some good information about people's daily preferences and the things that mattered to them. They also provided clear guidance for staff about how to support people to maintain their independence and how to promote choice, privacy and dignity. All care workers had signed each care file to indicate they had read and understood the full support plan.

A service users' guide and statement of purpose was available for those who lived at the home and their relatives. This provided people with information about services and facilities available at Catterall House. Information was readily available in relation to advocacy services. An advocate is an independent person, who will support people through the decision making process.

We noted that there were adequate numbers of staff in the communal areas of the home, including in the dining room at lunch time. Most of those who lived at the home looked well-presented and we observed staff interacting with them in a dignified way. We saw staff members knocking on people's bedroom doors and waiting for an invitation to enter before opening the door.

Emergency health care plans were in place for each person whose records we looked at. One care file we saw showed that the GP and a relative, who had been granted Lasting Power of Attorney (LPA) had been involved in the development of this plan of care. One member of staff told us, "We keep a close eye on the residents and if something is not right we will ask them if they need to see a nurse or doctor and if they do we will call them."

Requires Improvement

Is the service responsive?

Our findings

One person who lived at Catterall House told us, "I haven`t been to a meeting. I am not sure if they have them or not." Another said, when asked about the complaints procedure, "No. I have never had to make a complaint, but if I needed to do so I would speak to one of the staff or the manager." Another commented, "They (the staff) never have the time to speak with us. It would be nice to have a chat."

We looked at the care records of six people who lived at the home and 'pathway tracked' five of them. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

Staff members we spoke with were fully aware of a complex personal care routine for one individual and they were able to discuss the support this person required to ensure their care needs were being appropriately met. However, we noted that this important aspect of the individual's daily care needs was missing from their support plan.

Some care files provided the staff team with conflicting information. For example, the falls risk assessment of one person who lived at the home indicated that there was a history of falls, but the moving and handling risk assessment stated there was no history of falling. This information was unclear for staff and therefore inappropriate care and support could have possibly been provided.

When viewing the home's communication book we read a complaint written by a member of staff regarding a lack of medical history and a lack of information about current medical conditions in one person's care file, which the staff member had stated had caused her difficulties in passing important information on to staff.

We found that the registered person had not maintained an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. This was in breach of regulation 12(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A service user guide was seen, which contained a complaints procedure. The complaints procedure was also displayed within the home, so that people were aware of the process to follow, should they wish to make a complaint. A system was in place for recording any complaints received by the home. However, this complaints log was not sufficiently detailed. For example, a formal complaint had been made by a community professional two weeks previous to our inspection. However, the name of the person to whom the complaint referred was not recorded; the name and contact details of the complainant were not recorded; details of the complaint were insufficient and there was no evidence to show that a written acknowledgement had been sent to the complainant, despite the home's written complaints procedure clearly stating, 'Catterall House will acknowledge receipt of a complaint within five working days'.

We found that the registered person had not establish and operated effectively an accessible system for

identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When viewing the plans of care we saw some good examples of person centred information, which detailed how people wanted to be supported and their preferred daily routines. For example, one person's care plan described how they liked to have their breakfast in bed and have a lie in each morning. This person's plan also described how they enjoyed leading the way into the dining room at meal times and showing people where to go.

There had not been any new admissions to the home since our last inspection. Therefore we were not able to assess the pre-admission process on this occasion. One page profiles were incorporated in the care plans we looked at, which recorded the individual's likes and dislikes. The care files included documents entitled, 'More about me', 'Decision making' and 'How better to support me', which provided staff with 'pen pictures' of people's health and social care needs.

Care plans we looked at had been reviewed on a monthly basis. Community professional visits had been recorded within people's care files and any changes to needs had been recorded well. Weight monitoring charts were seen in the care files we examined, but these were not always up to date. Records showed that foot checks were conducted internally each month for all those who lived at the home. This helped to ensure that any foot problems were identified and reported quickly, particularly for those suffering from Diabetes Mellitus.

Systems were in place for recording end of life wishes, but these had not always been completed, because the individual's concerned chose not to discuss this delicate subject. We viewed the care plan of one person who had some mental health care needs. We saw that this person's needs were clearly described and there was a good level of information for care staff about what sort of events may trigger anxiety and how best to reassure them. We also noted that staff members and the manager worked closely with the community health team to ensure the person received the support they required.

Care plans we saw contained information about people's hobbies and valued pastimes. There was a poster displayed advertising various activities, such as movie days and chairobics. It was difficult to ascertain how staff were able to provide these activities, as the activities coordinator was on the rota to provide care. However, a sing-a-long was observed during the afternoon and arm chair exercises were seen to be provided during the day of our visit. When speaking about activities in the home, one person we spoke with said, "There is nothing going on. People just go to sleep. I can't bear to see them all asleep." One member of staff told us, we will have activities this afternoon. Once the weather picks up we will go out a lot more." The care plan for one person, who lived at the home stated, 'Goes out to the club in Fulwood every Sunday by taxi.'

Requires Improvement

Is the service well-led?

Our findings

One person who lived at the home, who we spoke with, told us, "The manager is around all the time and if I need to, I can speak to her or one of the carers if I have a problem." Another commented, "I like the new manager. She talks to us every day and asks how we are. She's very nice."

Staff members we spoke with also made positive comments about the manager of the home, telling us that she was 'easy to talk to'. One said, "As far as I am concerned the new manager is doing a very good job from our end." Another told us, "Things are a lot more organised now. The manager is so approachable."

At our last inspection we found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and monitor the quality of service provided or any environmental risks relating to the health, welfare and safety of those who lived at the home. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.

At this inspection we found that there were a wide range of written policies and procedures in place at the home, such as infection control, medication management and health and safety. However, these were not being followed in day to day practice, as we identified several failings in these areas. Records also showed that a range of audits had been undertaken. For example, medications, weights, infection control, bedroom facilities, hot water temperatures, call bells, light bulbs, accidents and falls. However, some of these systems were ineffective, as shortfalls in the service had not been identified and formally recorded during the auditing and reviewing processes. Therefore, this area was still in need of improvement, so that the service could be sufficiently monitored under a continuous assessment process and any improvements needed could be identified and addressed in a timely fashion.

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

We found a communication book was in place. At the time of our inspection this was located in the dining room of the home. It was not locked away. The book contained personal information about a number of people who lived at the home, which could have been accessed by anyone passing through the dining room. This did not meet data protection guidelines.

We asked for the care records of one person who had recently left the home, because concerns had been raised by a relative. The manager of the home was unaware of the location of these records, which had reportedly been removed from her desk. It was later established that the provider's husband had locked the records in his office within the home, without informing the manager of the home. We were told that he was unable to return to Catterall House with the keys in order for us to access these records. The manager of

Catterall House told us that she did not have access to this office.

We found that the registered person had not retained all confidential records in a secure manner. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Minutes of resident and staff meetings were seen. These meetings allowed people to discuss any topics of interest and to talk about any concerns or areas of good practice within an open forum. However, we were told that meetings for those who lived at the home and the staff team had not been well established. This was discussed with the manager at the time of our inspection, who told us this was in the process of being organised. She commented, "It's one of the things we need to arrange. More meetings for staff and the residents." We were told by staff that the manager was very approachable and she was always visible within the home. This we observed during our inspection at Catterall House.

The manager of the home told us that any equipment or resources needed were readily supplied by the provider of Catterall House. We saw that a regular newsletter was developed and circulated to everyone who lived at the home and their relatives. This helped people to keep up to date with any changes in the home and made them aware of any upcoming events or special celebrations.

We saw that the provider had displayed the current CQC rating in a communal area near the entrance of the home. We also established that no-one had been admitted to the home since our last inspection. This was in accordance with the Notice of Decision issued by the Care Quality Commission to restrict admissions following the outcome of our last inspection.

At our last inspection we found that the registered person had not always informed the Care Quality Commission of things they needed to know, such as serious incidents. We used our enforcement powers to keep people safe and ensure that the provider made improvements to the care of people who lived at Catterall House. We also asked the provider to tell us what they would do to make improvements.

Prior to this inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We found that the manager had informed us of things we needed to know.

Annual surveys were routinely circulated to those who lived at the home and their relatives, which covered a wide range of areas, such as the environment, food, staff approach and activities. This helped the provider to gather views about how the home was performing from those who used the service. In general, positive comments were received, the results of which were analysed and scored for easy reference. A suggestion box was also available within the reception area of the home, so that people could put forward ideas anonymously, if they so wished.

There was a staff training matrix in place, which covered a wide range of areas, such as infection control, food safety, safeguarding vulnerable adults, medication management, end of life care, diabetes, dementia awareness, fire safety, first aid, moving and handling and nutrition. However, this did not enable the manager to sufficiently monitor and audit the individual training programmes for staff members, as this record was a simple 'tick' list, which did not identify when modules had been completed or when they were next due. We noted that there was a good retention of staff at the home, as some had worked at Catterall House for several years. Staff members we spoke with had a good understanding of their roles and responsibilities towards those who lived at the home.

We recommend that the staff training matrix be updated to display the dates of when various areas of training were completed and when the refresher modules were next due.