Canterbury Care Homes Limited

Pennine Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 21 and 23 May 2018. Pennine Care is a 'care home'. People in care homes receive accommodation and 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.

Pennine Care is registered to provide residential care for up to 64 people in one building. Some of these people were living with dementia and mental health issues. At the time of the inspection 42 people were using the service. The service was divided into two distinctive areas Pennine and Moorland with Moorland being a male provision.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However a manager was in post and had applied for registration with CQC.

During the home's previous inspections in May 2015 and April 2017, we rated the home overall as Requires improvement. At this inspection we continued to find areas of concern. The overall rating continues to be 'Requires Improvement'. The details of the reasons why are explained in the summary below and in the body of the main report.

People felt safe living at the home. Staff understood the processes for protecting people from avoidable harm. However some staff did not always put the protection of people first. People's medicines were generally managed safely however they were not always stored in a manner that ensured they were safe to use.

The risks to people's safety had been assessed and care plans were in place to support people safely. There were enough staff to keep people safe. Although staff were trained to deliver person centred care, this did not always happen and some care was task led. This could place people at risk of poor care. Accidents and incidents were regularly reviewed, assessed and investigated by the registered manager. The home was clean and fresh.

People's physical, mental health and social needs were not always assessed and provided in line with current legislation and best practice guidelines. People were supported by trained staff who had their performance regularly assessed. People did not always speak highly about the food. People were not always assisted to eat in a manner that promoted their dignity.

The manager had built effective relationships with external health and social care organisations and people's health was regularly monitored. The environment had been adapted to ensure people who had

mental or physical disabilities were able, where possible to move freely. There was directional signage to support people living with dementia to orientate themselves independently around the home.

Staff mostly treated people with dignity and respected their privacy, however we saw occasions where people did not have their dignity supported. Some people felt able to make decisions about their care and felt the staff respected those decisions. People were encouraged to lead as independent a life as possible and some were prepared for a more independent life back in the community. People were provided with access to an independent advocate if they needed one.
People's care records were person centred and guidance was provided for staff on how each person would like to be cared for.

People did not have their social care needs recognised and met. Group activities were available but these were not suitable to everyone. People were not always encouraged to attend these and were planned a year in advance. They did not always include activities that were important to individuals. People felt able to make a complaint and were confident it would be dealt with appropriately. The service received many compliments. End of life care was not currently provided, however, systems were in place to support people with this if they needed it.

Care had not been taken to ensure there was a skill mix of staff on duty each day. We saw a marked difference in care provision between days. Records were not maintained appropriately and were not always contemporaneous.

The quality assurance processes that were in place to continually assess the quality of the service people received were not always effective. They had not identified the concerns raised during this inspection. Staff were not always held accountable for their actions.

People felt able to give their views about the service. Staff felt valued and able to give their views and formal team meetings were in place. The manager was supported by a knowledgeable and experienced deputy manager.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back 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?

Requires Improvement

The service was not always safe.

People's safety was not always promoted and some people in their rooms were left unattended for periods of time. Staff did not always follow instructions to protect people from risk.

Medicines were administered as prescribed. However, they were not always stored effectively.

Staff were recruited safely. People were protected from the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not happy with the quality of the food and their consent was not always sought. People's rights were protected under the Mental Capacity Act.

Staff were trained to care for people, they did not always put their training into effect. People's mental and physical health was promoted.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always promoted. Some staff did not respond to people.

Other staff were caring and kind. People's privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were activities in the service for some people but not for all. Care was not always personalised.

There was a complaints system in place. The service had many

compliments.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider did not ensure the service was managed in the best interest of the people who used it. Care was not always personalised.

Systems were in place to monitor and improve the quality of the service, however they were not robust and there was a lack of on-going monitoring for improvement. Staff were supported.

Pennine Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 23 May 2018 and the first day was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor with experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Derbyshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, three visiting families, one visiting healthcare professional, the infection control lead, a domestic staff member, three care staff, the assistant manager and the manager. We looked at the relevant parts of the care records of five people who used the service, three staff files and other records relating to the management of the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection carried out in April 2017 we found people were not protected from the risk of infection and medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act Regulations 2014 Safe care and treatment. At this inspection we found improvements in infection control and improvement had been made in the administration of medicines.

Staff administering medicines told us they had completed medicines training and received competency checks for medicines administration. We observed the administration of medicine; staff checked against the medicines administration record (MAR) for each person and stayed with the person until they had taken their medicines. MARs contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicines.

Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability. Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room on each unit. Temperature checks were recorded daily of the room and the refrigerator used to store medicines. The temperature of one room was above recommended limits on several occasions within the current month. When prompted staff responded to this and while we were there staff phoned the pharmacist to ensure the medication was still safe to administer. The medicines were then moved to the other medicines room where the recorded temperatures were appropriate. We saw staff administer medications to people. This was done with patience and care. People were not rushed and staff explained what the medicines were for. This meant people were offered their medicines as prescribed and were given ample time to take their medicines.

We saw the issues relating to infection control had been effectively addressed. We found the service to be clean and fresh. In response to these concerns the service had implemented an action plan to ensure the service was always clean and fresh. An infection control lead was appointed and we spent time with them as they showed us what they had done to ensure people were safe from the risk of the spread of infection and lived in a pleasant environment.

People were not always kept safe. Risk assessments had been completed to assess common risks such as falls, using bedrails, developing pressure ulcers and nutritional risk. There were also risk assessments for additional individual risks such as the use of a wheelchair or a hoist. Actions to reduce risks were identified and were in place. Risk assessments had been updated monthly to ensure they remained accurate. These gave staff clear directions on how to keep people safe. Discussions with staff showed they used the risk assessments to keep people safe. However, there had been a recent serious safeguarding incident involving care staff not promoting a person's safety and welfare. This is currently under investigation by the Local Authority and the police.

Staff told us they had undertaken adult safeguarding training. They were aware of the signs of abuse and said they would report any concerns to the registered manager or the provider. A safeguarding policy was in

place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety.

People told us and we saw there were sufficient numbers of staff on duty. However, on the first day of the inspection the skill set of staff on duty had not been considered and deployed in the best interests of people. The staff on the first day of the inspection staff provided task led care. Staff focused on the work they were doing rather than on the person they were caring for. This meant that although people had their physical needs met, staff walked past people who were trying to get their attention. In contrast on our second visit we saw staff were kind and friendly and cared for people in a person-centred manner. This lack of planning the delivery of care meant people did not get a consistent and balanced service.

People told us that they were not unnecessarily restricted. A person said, "I can go where I like in here. I've no restrictions really." Another person said, "I can plan my day, what I want to do and when I want to go to bed too." On the days of our visits we saw people sitting in the shade in the garden. They told us they really enjoyed getting out in the fresh air. Some people enjoyed their independence by taxis to pursue their hobbies and interests in the local community.

Pressure-relieving mattresses and cushions were in place for people at high risk of developing pressure areas and they were used correctly. We saw that people received support to change their position to minimise the risk of skin damage in line with their assessed needs as set out in their care plans.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals. Accidents and incidents were analysed to identify any trends or themes so that actions could be taken to reduce any risks of them happening again.

The service worked with local health care professionals including the falls team in order to assist those people who had a number of falls. People were seen by a falls assessor and where possible aids and adaptations were put in place to assist people. We saw alert mats and side bumpers were used to keep people safe.

Systems were in place to identify the levels of staff required to meet people's needs safely. The manager explained that they considered people's dependencies when setting staffing levels and monitored them closely to ensure that staffing levels remained at the correct level.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

To ensure people were safe, checks were carried out on the equipment used to assist people and premises. For example, hot water temperatures had been monitored as had emergency lighting. This minimised the risk of avoidable harm.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

The provider did not always ensure people had access to food they enjoyed and allowed them to maintain their nutrition. We received mixed feedback on the food provided by the service. A person said of the meat, "It's like shoe leather." Another said, "I wanted chicken but got beef." We saw they had not eaten the meat they were served, it was on the side of their plate. They said, "You can see it's just grizzle." We were assured people were provided with nutritious food, however if they were not able to eat it their nutritional intake was compromised.

People who chose to eat in their room could not be assured their food was served hot. One person said their lunch was cold when served and again they said they couldn't eat the meat as they had, "Teeth problems."

The dining room was set out nicely with the use of table cloths, napkins and condiments. Plate guards were used to assist people to eat independently. Some people said they enjoyed their lunch. One said, "The food is fine and we get plenty."

We observed when people were being assisted to eat lunch some staff did this is a task oriented manner. They did not engage the person in any way. Other staff were focused on the person and assisted them in a slow and caring manner making sure they had the opportunity to enjoy their lunch.

People told us that they had sufficient to drink. Drinks were available throughout the visits and staff encouraged people to drink.

Nutritional screening and assessment were completed and eating and drinking care plans were in place. We saw staff had made referrals to other professionals such as a speech and language therapist and dietician when there were concerns about people's nutrition or ability to swallow. When people required the consistency of their food and drink to be modified this was clearly identified in the care plans.

People told us that staff were trained to meet their needs. A person said, "The girls are great." A visitor said, "There is a big difference in staff some are really good and some don't see anything wrong."

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. Training records showed that staff attended training which supported them in keeping people safe and assisting people to move safely. They told us they received regular supervision and records we saw confirmed this. A person told us that staff usually asked for consent before giving care. They said, "Yes they usually ask and I can say if I am ready." However, we saw that staff did not always ask permission or explain what they were doing before assisting people to move or assisting them to eat. For example, at lunchtime we observed that not all staff consulted people before assisting them to move or putting on a clothing protector.

All the records we looked at showed people had a pre-admission assessment and had a plan of care to meet

their needs. A review of the records showed people's needs and choices were assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Assessment of people's needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans. For example, people's needs in relation to any physical or mental disability were identified, and staff were familiar with people's care plans and how to meet their needs.

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 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 DoLS. We checked whether the service was working within the principles of the MCA.

Mental capacity assessments were completed and best interest decisions documented when people were unable to make some decisions for themselves. When people were being restricted, DoLS applications had been made. Staff had an appropriate awareness of MCA and DoLS.

People were encouraged to have freedom of movement when they were safe to do so. For example, some people were encouraged to make their way into the local town to pursue their interests.

Care records contained guidance for staff on how to effectively support people with behaviours that might challenge others.

People's needs were met by the adaptation, design and decoration of the service. Décor throughout the home had been updated. There was good signage and rails on the walls to assist people with orientation and to move around. People rooms reflected their taste and had been personalised.

People's physical and mental health was promoted. We saw the service worked closely with local health care professionals such as GP and mental health care professionals. Where necessary people had access to social care provision, this included social workers. When people were preparing for a more independent life we saw the service worked closely with all professionals involved to ensure a seamless move to more independent living in the community.

Requires Improvement

Is the service caring?

Our findings

People said their privacy and dignity were respected by staff, however, one person said, "[Staff] knock before they come in, though I don't always get a chance to answer." Another person said, "They always knock on my door first." We saw staff knock on people's door, however they did not wait to be invited in they entered as soon as they knocked not giving a person a chance to prepare for a visit.

People's dignity was not always promoted. We observed some staff did not adjust people's clothing, during and after using a hoist to assist them to move, to maintain their dignity. There was one occasion when a person's underwear was clearly visible. On another occasion a female service user was sitting in the lounge where their clothing had moved and was exposing their underwear. We saw staff in the lounge had not noticed despite the person being in clear vision. This did not respect their dignity.

A person said, "Staff tell you they will sort things for you, but then they forget. I don't like to keep asking." We were told this person had been confined to their room due to upset stomach and we observed they were lying in bed in an uncomfortable position.? A staff member entered their room to remove a hoist. The person asked for assistance. The staff member was heard to say, "I'll be back soon." We checked on this person twice more and found they had not been attended to. We asked the manager to attend to them who arranged this.

We observed some staff speaking in a kind manner with people, making eye contact and on occasions holding people's hands. We also saw some members of staff had good relationships with people and involved them in conversation. They were attentive to people's needs and provided them with reassurance when they were anxious. However, other staff were less friendly and more focused on the task they were completing.

Where people could not communicate their views verbally their care plan informed staff how they should identify their needs. However, we observed that some staff did not always take time to clearly and effectively communicate with people. We saw they did not make eye contact with them, nor did they give them time to respond in any way.

Care records contained evidence of regular contact with people's close relatives, to keep them informed about changes to their relative. There was also evidence of involvement of a person and the relatives of two other people, in the review of their care plans. We spoke with a relative who was concerned about their relative's care and a meeting was arranged so they could have the opportunity to express their views. They told us the issues were ongoing and other meetings had been arranged.

People were encouraged to give their opinions on how they wanted to live. This was done through in a variety of ways including meetings and encouraging people to speak to the manager or the deputy manager about any issues.

Advocacy service was available for people if they required support or advice from an independent person.

An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. At the time of the inspection visits no one was using an advocate.

People had their independence promoted. Some people were preparing for more independent living. We saw this was done well and when we spoke with people who were ready to move or were working towards this they were complimentary about staffs' involvement. One person said, "The staff have been great, they took me shopping for everything I need."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection visit carried out in April 2017 the provider was not always responsive to people's needs and wishes. At this inspection we found this had not improved significantly.

Some effort had been made to establish people's interests and hobbies. A volunteer assisted some people to garden and they had established a garden.

The service is divided into two separate areas, Pennine and Moorland. Moorland is predominately for men with mental health issues. There are plans afoot to make this a male only unit. We found that some of the men who lived there did not always have their needs beyond their basic care met. They were left un-stimulated and told us they were bored.

There was an activities co-ordinator, however, they did not spend dedicated time on Moorland. Some people were left un-stimulated. We saw people there walk around aimlessly and when we spoke to them they told us they were usually bored. One person said, "I go out and about, but when I'm here there is nothing to do outside watching the television." We found people on Moorland were not offered the opportunity to explore hobbies and interests.

We spoke to the manager about this and we were told that activities such as football events like the FA cup were celebrated and that they would look at getting a sports channel. In addition the provider advised that the activities are available to people on both units. However, we did not observe this on inspection and not all activities were appropriate to those living within the service. One person said, "I don't require much help from staff and am happy here although there isn't much to do, they used to be entertainers but not anymore." When we asked about this we were told there was no budget for outside entertainers.

In the main lounge in Pennine we saw and heard two separate televisions on at either end of the room. There was a different programmed on each one making it impossible for anyone to follow a programme. This was not addressed until we asked.

People did not always have their needs responded to in a timely manner. For example, when people were nursed in their rooms there were not regular responsive checks on them. This resulted in people being left unattended leading to their distress. One person could be heard calling for assistance. Staff were unaware of this until we alerted them to the issue.

The provider was aware they needed to provide more person-centred care. We were told they plan to introduce a new part to their care plan that would give more personalised information on people. This had not yet been used. We will report on this at our next inspection.

The provider had a complaints policy, however complaints were not always resolved in a manner that was satisfactory for the complainant. For example, one family member told us of a complaint they made that they were awaiting a resolution to an issue they had raised. We looked at this and found it was under

investigation by an outside organisation and the timings were outside the control of the service. However, we found further examples where the complainant was not happy with the investigations carried out and were not assured by the complaints process.

The service had received many compliments from families who were very happy with the care that had been provided to their family member.

Where people were at the end of their lives the service worked closely with health care professionals to ensure people wishes and needs as set out in their care plan were met. At the time of our visits no one was receiving end of life care.

The manager had an understanding of the Accessible Information Standard (AIS). The AIS is a law that requires that provisions be made for people with a learning disability or sensory impairment to have access to the same information about their care as others, but in a way that they can understand. They told us they did not currently have people who required information to be presented in a different way but in light of this Standard, they would remind people that records were available in different formats.

Requires Improvement

Is the service well-led?

Our findings

The provider did not ensure the service was well led. This was the third consecutive inspection where we found the service was rated as requires improvement. The previous inspections were carried out in May 2015 and in April 2017.

The provider had a system to regularly assess and monitor the quality of service that people received, however it was not effective as it had not identified and addressed the issues we found at this inspection. We saw that regular audits had been completed by the manager and other staff, including a representative of the provider. These covered a range of areas including infection control, medicines, health and safety, kitchen, laundry, domestic and care records. However, these audits did not always identify shortcomings and clear plans were not always in place to ensure that action took place to address identified, issues such as staff not following risk assessments, resulting in an injury to a person and medicines being stored inappropriately. This meant that people's health, safety and welfare were put at risk.

The improvements made at Pennine Care were limited in scope. Issues raised by CQC had been responded to but improvements made were limited to responding to the last inspection rather than being proactive to ensure individuals received effective, safe person-centred care.

There was no registered manager at the service. However, a manager had been appointed and had applied for registration with CQC on the 11 May 2018.

There was not a clear management framework in place for staff to follow so they understood their role in keeping people safe and respecting their dignity. This resulted in some staff not following risk assessments and putting at least one person we identified at risk of abuse and injury. It also resulted in a breakdown in communications with one person's family.

The skills mix and experience of staff was not arranged in the best interests of people living at the service. The difference in the care delivery on both days of the inspection showed this. On the first inspection visit we noted people were not getting care that was person centred care and respected their dignity. While on the second day staff were engaged with people and cared for them in a person-centred manner. As result of this people were offered different standards of care. We found some people who were cared for in their room had become distressed and were not regularly offered comfort and care. We fed this back to the management team and there was an awareness of the issues but they had not been effectively addressed. This resulted in people receiving a service that was not always meeting their needs and wishes.

The activity co-ordinator was not directly managed and this meant there was a distinct difference in the way people were offered support for their hobbies and interests.

At the inspection carried out in May 2017 we found medication was not always administered effectively. We found at this inspection improvements had been made, but medicines were not stored effectively until we brought it to the attention of the management team.

The provider had not ensured staff recorded care in a contemporaneous manner. We saw paper records had been changed. We were told this had been because there was a change in a person's care. The record had been completed before the care was given. This meant record keeping was not contemporaneous and therefore could not be an accurate record of care given.

The provider did not have a clear vision on how to ensure the service would continuously improve nor was there clear direction for the manager to follow on improving the service beyond requires improvement. This had affected people's quality of care.

This was a breach of Regulation 17 of the Health and Social Care Act (2014)

The provider worked closely with the local authority to ensure the service is responsive to local needs. For example, they are working with the local authority to increase the facilities for men with mental health needs.

The provider included people, their relatives and staff in the running of the service. The manager held regular separate meetings for people, and their relatives and staff. We saw the minutes of these meetings and saw, and were told by staff, that their views were respected. Other meetings were poorly attended. The manager said they try a variety of ways of getting people's views including an open-door policy where they are available to people. Visitors confirmed this.

Staff told us that they felt supported by the provider. The current CQC rating was clearly displayed. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required.

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 17 HSCA RA Regulations 2014 Good governance There was not sufficient management process in place to ensure the safety and welfare of people.