Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Pendlebury Court Care Home

St Marys Road, Glossop, SK13 8DN

Tel: 01457854599

Date of Inspection: 12 October 2012

Date of Publication: November 2012

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✖ Action needed
Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Safety and suitability of premises	✖ Action needed
Requirements relating to workers	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Pendlebury Care Homes Limited
Overview of the service	Pendlebury Court is a care home for up to 39 older people, some of whom have dementia. The home is situated in the town of Glossop, Derbyshire.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 October 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

People told us, "I like the staff here", and we observed that staff treated people in a respectful and sensitive manner. However, we found that people were not always informed and involved regarding their care. We also found that consent was not always being obtained for people's care, especially if they could not make decisions for themselves.

People were generally happy with the care at Pendlebury Court. One person told us that staff were caring, and another that, "the meals are really nice". We found that people's needs were assessed, and that care plans were in people's files. However, we found that the planning and delivery of care did not always meet the person's individual needs and or ensure the welfare of the person. For example, we found that care plans did not include details of people's health needs, and that information was not always accurate.

We found that the building was large and had been purpose built as a care home. However, the layout and decor was not fully suitable for the needs of people with dementia, and some areas of the building had flooring that were slippery and not fully safe.

We found that staff were properly recruited and trained, and that people were protected from abuse. We also saw that people were asked for their views, and that the quality of care was monitored at Pendlebury Court.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 21 November 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's views and experiences were not fully taken into account in the way the service was provided and delivered in relation to their care.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People we spoke with were generally happy with their care at Pendlebury Court. A family member told us there was, "a nice bunch of staff, who take time to speak to people." We observed that staff spoke to people in a respectful and sensitive manner.

We spoke to the manager at Pendlebury Court, who was applying for registration with CQC, about how people were involved in their care. We also spoke to people and their relatives and staff at the home.

We saw that there were some opportunities for people to discuss their care, and that residents' and relatives meetings had been held recently.

We looked at care files for three people and saw that details of people's preferences were recorded, for example food and their hobbies. This was particularly important for people who might not be able to express their views.

We found that the care plans did not, however include detailed information about how people preferred to receive their support We saw that care plans did not include the person's preferred gender of staff, or how to ensure their privacy and dignity when helping with personal care. Staff told us that if they were aware of people's preferences, they would respect them, but also that they were not aware of everyone's views.

One care file we saw included a detailed communication profile describing how the person could be encouraged to express their views. Two files we saw, however said only that the people had dementia and could not communicate their needs. We found that information in care files did not ensure that staff were fully aware of people's preferences, particularly where they may not be able to express their wishes.

We found that care files did not always show that people or their representatives had been involved in planning their care. The family member of one person with dementia told us they were did not know what care their relative actually received, for example if they dressed themselves, or had help with medication.

The manager told us they were aware of the importance of involving people in their care, and that they planned to make care files more individualised. We saw that new care plans were being completed that were based on people's individual choices and needs. The new plans contained more personalised information to guide staff, although the ones we saw were not dated and signed.

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider did not have arrangements in place to act in accordance with legal requirements.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with the acting manager about how people were giving consent to their care at Pendlebury Court.

We found that consent was not always being sought from people about the content of their care plans, their wishes regarding their valuables, keys to their room, medication or other aspects of their care.

We saw that files did not contain evidence that people had been asked for their consent, and the acting manager said they had identified that this was an area for improvement.

The manager told us said that they had attended training about the Mental Capacity Act 2005 (MCA). This law provides a system of assessment and decision making to protect people who do not have capacity to give consent for care or treatment themselves. Staff we spoke with also told us that they had attended courses about the MCA, and the training matrix we saw confirmed this.

The manager told us that of the 34 people living at the home, around 80% had dementia. Three care files we saw stated that people were unable to administer their own medication due to dementia. We spoke with the manager about this, who told us that people would also probably not be able to consent to other aspects of their care because of the level of their dementia. We found, however that the required MCA assessment process for people without capacity was not being used at Pendlebury Court. This meant that decisions might have been made that were not in the person's best interests.

The managers showed us a new policy that was to be implemented within the next few weeks about capacity and consent. We saw that it included guidance about capacity and the MCA, and also a form to complete to make assessments and decisions.

We found that currently, however, appropriate consent was not always being obtained for people's care at Pendlebury Court.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their welfare and safety. This was because care files and risk assessments did not contain adequate information about risks, health conditions and individual needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the care files of three people, and spoke with people living at Pendlebury Court and their families. People were generally happy with their care, and one person's relative told us, "the staff are wonderful."

We found that although care files were completed, the planning and delivery of care at Pendlebury Court did not always meet people's individual needs and ensure their welfare.

We saw that people's needs were assessed on referral to the home. Files we saw also contained care plans about various aspects of people's care. We found that risk assessments had been completed for people in a number of areas, for example about the risk of falls, pressure sores and moving and handling. However, files we saw did not always include important information, for example risk assessments regarding people's health conditions and what support they needed. This meant that staff did not have guidance about particular conditions; how to recognise symptoms or what to do in an emergency.

We saw that information in care files was not always consistent, and this could put people at risk of receiving inappropriate or unsafe care. One person's file contained conflicting information about what support they needed with continence and also about their diet. Another person's file had an assessment that said they had no dietary needs, but we also saw they had a care plan that said they could eat only soft foods.

We found that because of the lack of accurate and detailed information in care plans and risk assessments, people at Pendlebury Court were at risk of not receiving safe and appropriate care.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People at Pendlebury Court were protected from the risk of abuse, because reasonable steps had been taken to identify the possibility of abuse and prevent abuse from happening

Reasons for our judgement

People we spoke with and their families told us that they felt people at Pendlebury Court were safe from abuse. We saw a training matrix confirming that staff had completed training in safeguarding vulnerable adults, including refresher courses.

Staff we spoke with were able to describe different kinds of abuse and how people were protected. Staff also told us about how they would report and record any concerns about abuse or neglect. We also saw records of referrals that had been made to social services previously, and that any concerns had been followed up.

The managers and staff we spoke with demonstrated an awareness of the Deprivation of Liberty Safeguards (DoLS). This is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. Staff we spoke with were aware of the importance of people's freedom and rights. We saw that no restrictions were currently needed to keep people safe at Pendlebury Court.

We found that level of awareness demonstrated by staff at the home helped to protect people against the risk of abuse.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

The premises were not fully suitable for people receiving care at Pendlebury Court.

People who use the service, staff and visitors were not fully protected against risks at the premises.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that Pendlebury Court was a purpose built care home on three floors, with a lift between each floor.

The manager told us that they were trying to make the environment more homely, and wanted to help people with dementia see Pendlebury Lodge as their home. We saw that some rooms had been re-decorated and pleasantly furnished in the style of a domestic home, and also saw plans for the replacement of some carpets and furniture.

We found that the premises did not fully promote the well being of people at Pendlebury Court. We saw that the design and decoration of parts of the home were not fully suitable, particularly for people with dementia. One person's relative told us that though the care was good, they felt the building was "not nice really, more like a hospital". Another person we spoke with said some areas were "not homely", particularly the lounges. We found that some communal areas had a clinical design, and a lack of comfortable domestic fittings. Some lounge areas, for example had large areas of fireproof glass that had not been made less clinical, for example by adding blinds or curtains. We saw that other areas also looked bare and clinical, for example a long corridor that was painted white, and with identical doors leading to people's bedrooms. This could be confusing for people with dementia, and did not help them to recognise Pendlebury Court as a home, and the place where they lived.

We saw that people were not helped to recognise where they were in the building, for example what kind of room was behind each door. Also, where the bedroom doors were identical, this did not help people to know which door led to their own room.

We also found that flooring in some areas, including the third floor consisted of a polished, laminate type material and was slippery. We found that this could present a risk of falls to people at Pendlebury Court.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We found that staff at Pendlebury Court were recruited using effective procedures.

We saw two staff files containing application forms that included a full employment history, two references, and health declarations. Files we saw also contained confirmation that criminal record bureau checks had been done.

There was also a recent photograph in each file and relevant identification documents. We also saw that staff had a contract of employment and a record was kept of their training and qualifications.

We saw that the manager had a Registered Manager's Award qualification. This is a management qualification especially for people running services that provide care and support.

The recruitment procedures and records we saw helped to ensure that suitable people were employed to work at Pendlebury Court.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

We found that staff at Pendlebury Court received regular training in subjects relevant to their role.

Staff were also supervised regularly by the acting manager

Reasons for our judgement

Family members we spoke with said they felt the staff were well trained at Pendlebury Court.

We spoke with two staff and also looked at their files. We saw that staff had three or four supervision sessions with the manager, and also that six team meetings had been held in 2012. This meant that staff had the opportunity to discuss the care they delivered, and to receive support about their role at the home.

Staff we spoke with had completed an induction with external training courses, and also an internal induction specific to the home. We saw that staff were also observed by the acting manager staff delivering care, to ensure that they were fully competent. This helped support staff to deliver safe care to people at the home.

We saw the home's training matrix, and staff training was up to date. Staff we spoke with had completed training about dementia, and were knowledgeable about how care for people. The acting manager had arranged for further training courses to meet people's individual needs, for example about supporting people with swallowing difficulties and also Parkinson's disease. Staff told us that they felt supported by the manager, and that they were able to discuss any training needs in supervision meetings.

We found that staff received relevant training and support to enable to them to carry out their role at Pendlebury Court.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

Effective systems were used to regularly assess and monitor the quality of care that people received at Pendlebury Court.

Reasons for our judgement

We did not speak to people at Pendlebury Court about how the service was monitored, and our judgements are based on other evidence.

We found that a new quality manager had recently been appointed, and that improvements had been made to assessing and monitoring quality at Pendlebury Court. We saw that monthly quality checks were completed, and an action plan recorded any improvements that were needed. The quality manager completed regular medication checks, and we saw that an infection control audit was completed by the primary care trust in August 2012 achieving a high rate of compliance.

We found that people were asked for their views about the service. We saw that quality surveys were available at the home to get the views of people, their families and staff. The manager told us that the results of the latest survey were then published and sent out to everyone involved. The manager also planned to send out surveys to other professionals and families who were not able to come to the home regularly. We also saw that complaints were recorded with details of the action taken and the outcome.

We saw that an incident reporting system was used at Pendlebury Court. The manager told us that information about accident and incidents was analysed as part of the monthly quality checks. This helped to identify any underlying patterns or risks to people at Pendlebury Court.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Arrangements were not always made for people to express their views (Regulation 17(2) (c) (ii))
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Arrangements were not always obtaining the consent of people, or person(s) able lawfully to consent on their behalf (Regulation 18 (1) (a)) Where there was lack of capacity, arrangements were not being made to establish and act in accordance with people's best interests (Regulation 18 (1) (b))
Regulated activity	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Planning and delivery of care did not always meet people's individual needs. (Regulation 9 (1) (b) (i)). People were not fully protected against the risk of receiving care that was inappropriate or unsafe. (Regulation 9 (1) (b) (ii)).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The premises did not have a design and layout that was fully suitable, and it did not fully protect people against risk (Regulation15 (1) (a)).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 21 November 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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