Turning Point

Pemdale

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 inspected this service in January 2016 and rated the home as Good overall. When we inspected the service on 14 March 2018 we rated the home as Requires Improvement overall. This is the first time Pemdale has been rated as Requires Improvement. This inspection was announced the day before we visited. This was to ensure a member of staff would be present to let us into the home.

Pemdale is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Pemdale provides personal care and accommodation for people who have a range of learning disabilities and physical disabilities. Pemdale can provide care for up to 6 adults. At the time of the inspection 5 people were living at the home. Pemdale comprises of accommodation over one floor.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some issues with the upkeep and maintenance of the home. The landlord was not maintaining the home to a reasonable standard. The landlord was separate from the provider. But the provider was responsible under their registration to provide accommodation to people living at Pemdale. We found walls were chipped and marked; bathroom furniture was chipped and rusty in places. This had the potential to trap dirt which could increase the spread of infection.

The service was not testing for the virus Legionella and there was a build of lime scale in parts of the home

which could support the growth of this virus. This had the potential to make people unwell.

The home looked tired and uncared for. The land lord had not invested in the up keep of the building. The provider had not resolved this investment issue. This was a historical matter and had not been resolved for some time. The provider had not taken any timely action to resolve this issue and improve the day-to-day quality of lives of the people at the home. As a result of this the registered manager had to rely on charity funding to repaint people's bedrooms and the communal parts of the home. This lack of investment connects with how the provider values the people living at Pemdale and how they promoted people's rights.

People were also not given the opportunities to go on trips, attend events or go on holiday.

Staff training had been cancelled by the provider and some staff's training was out of date. Staff competency checks were not robust and did not evidence how a member of staff was competent in their work. We identified some shortfalls in staff practice and knowledge which had not been identified before. There were no on going staff checks to ensure staff were competent in their work and that they had the knowledge to do their job well. There was no system to check the training had been effective.

There was a lack of robust quality monitoring checks. The quality monitoring checks completed by the provider had not identified the issues which we found during this inspection.

The registered manager was not fully aware of all the important events that they must notify us about by law. A person had sustained a serious injury and we had not been informed about it.

These issues constituted a breach in the legal requirements of the law. There was a breach of Regulation 12, 17, 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a breach of the Registration Regulations (18). You can see what action we asked the provider to take at the back of the full version of the report.

People received their medicines as the prescriber had intended. The management of the home had taken recent advice about how to improve the administration of people's medicines. However we found that some medications were not stored safely.

People had robust assessments in place which outlined the risks which they faced. Guidance was given to staff about how to reduce the risks to people. There were safety checks taking place to ensure the service was safe.

We found that people had sufficient to eat and drink. But people were not fully involved with their food choices on a daily basis. One person had complex needs with eating and drinking. Not all the staff were following the recommended guidance, in order to support this person to eat and drink in a safe way.

People had access to health services when they needed this support. Professional's advice was sought to meet people's needs. However, information relating to this advice and guidance from health professional was not always fully recorded in people's care documents.

People were being supported by staff who were kind and caring towards them. People and their relatives spoke positively about the staff at the home.

We saw evidenced that people went out locally for lunch and went shopping or on errands with staff. The

management of the home made efforts to meet people's daily social needs.

People had person centred care assessments and care plans in place. People, their representatives, and staff had been involved in planning people's care needs. People also had detailed and thoughtful end of life plans in place.

The registered manager showed a commitment for the service to improve. They told us about the changes which had taken place as a result of their input.

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.

There were areas of the home which were damaged and poorly maintained which could increase the spread of infection.

Some people's medicines were not stored in a safe way.

People received their medicines as prescribed

There were sufficient numbers of staff.

People had comprehensive risk assessments in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff training had not taken place and was out of date.

Staff competency monitoring was not effective or well evidenced.

People were not always given choices with what people they ate.

Staff were not always following professional's guidance when people had complex needs with eating and drinking

People had access to health care support when they needed it.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed some interactions between people and staff which were not always respectful.

People told us that staff were kind and caring to them.

People's private information was stored securely.

People were involved in the planning of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not getting the opportunity to go on planned trips which they wanted to.
and social day to day opportunities were not always utilised.

People enjoyed going out locally for meals and went shopping.

People had personal care plans relevant to them as individuals.

Staff knew people well.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider was not ensuring that the home was being maintained to a good standard.

The service was relying on charity funding for basic redecoration and maintenance of the home.

The provider's quality monitoring audits were not effective. They did not challenge or always promote improvements.

The registered manager had not informed us of all the important events which they must do by law.

There was limited community involvement at the home.

Care Quality Commission

Pemdale

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 checked 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.

The inspection site visit was undertaken on 14 March 2018. We gave the service 19 hours' notice because the home was small and people could be out during the day. So we wanted to ensure a member of staff would be present to let us in.

The inspection team consisted of one inspector and an inspection manager.

Before the inspection we made contact with a representative from the local authorities' contracts team and safeguarding team. We asked them for their views on the service to aid with our planning. We looked at the notifications that the registered manager(s) had sent us over the last two years. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with three people who lived at the home, two people's relatives, three members of care staff, a member of staff supporting the management of the home and the registered manager. We looked at the care records of four people, and medicines records of people at the home. We also looked at the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and, safety records completed at the home.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Requires Improvement

Our findings

We inspected Pemdale in January 2016 and found that people were safe. When we visited in March 2018 we found some areas where improvements were required.

During our visit we identified some issues in relation to the maintenance of the building. The service was not testing for the water born virus Legionella and the management of the service was not aware of this. In the bathrooms and laundry room we found a significant build-up of lime scale. The service should be responding to any development of lime scale when this occurs. Legionella is a water born virus which can cause people to become unwell. A build-up of lime scale can support the growth of this virus. The service should have had an on going system to treat this lime scale.

We also observed potential concerns with infection control. Walls and doors within the home were chipped, a toilet seat was significantly chipped and a commode was rusty. These exposed surfaces increased the risk of bacteria being able to grow. There was some discolouring in the corners of the bathroom near the pipes, which was a rusty colour. Toilet brushes were sitting in water, faecal matter was attached to the brushes. These were all potential hygiene issues.

Parts of the communal spaces were not clean. For example, areas of the home's bathroom and shower room were very dusty. The radiators had a film of dust on them. The plastic white window frames were discoloured with dark matter on them. Some people's toiletries, including two tooth brushes were stored in plastic drawers which were not clean. Two people's tooth brushes were lying on the bottom of these drawers. One person's drawer had a bar of soap laying on the bottom of it, which had a hair in it. Another person's flannels had an odour of stale water to them. This meant that there was an increased risk of the spread of infection and there were hygiene issues at the home.

We observed a member of staff washing some floors. They were not wearing disposable protective clothing such as an apron and gloves to aid with good infection control practices. After they performed this task they went into the kitchen where we saw them making a person a drink, and give them a snack. This increased the risk of cross contamination. We also noted that the buckets used for cleaning the floors were dirty with a thick layer of dusty matter on them. All these issues were potential infection control issues.

During the inspection we found that the cupboard under the sink which contained detergents that could cause people harm if ingested was left unlocked. This was despite a key pad lock being available on the

cupboard door. We also saw that one person's medicine to prevent them from choking was left on the side in the kitchen in an area used by people, their visitors and staff. This is not a safe way of storing this prescribed medicine. This could cause people harm if ingested incorrectly. We raised this with the registered manager; we needed to explain to them that this was not safe practice. They said that they would remove this straight away.

In the main bathroom there was an electric item attached to the wall. It had discoloured over time. It was being used by staff to pump air into a person's inflatable bath matt. It sat above the bath. It had not been tested to ensure it was safe to use. The registered manager confirmed it was still in use. We advised the registered manager of our concerns with this piece of equipment.

At this inspection we checked people's medicines. We found one person's medical product, which stated it was highly flammable, in the person's bedroom. This was not stored in a safe way. We told the registered manager about this.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had had their medicines as the prescriber had intended. The registered manager had recently worked with health professionals to ensure people received their medicines in a safe way.

Some people were prescribed some medicines which controlled their behaviour. The registered manager told us how this was monitored to ensure it was not excessive. However, the process followed was not adhering to best practice guidelines. There should be a 'best interest' meeting with professionals, relatives, and staff involved in people's care. We suggested to the registered manager that they speak with people's GP's to formulise this process and to evidence this.

When we spoke with staff we asked them how they protected people from experiencing potential harm and abuse. Staff were able to tell us what abuse could look like and what the potential signs could be that indicated that a person was potentially experiencing harm. All the staff we spoke with said they would inform the registered manager straight away. However, all the staff we spoke with did not know of the local authority safeguarding team who they could also report their concerns to. The staff we spoke with said they would also contact the provider to raise concerns. But they did not know who they could speak with and how they could contact the provider.

These members of staff did not have a clear understanding about what discrimination could look like and how the service should promote people's rights in this way. Staff had not heard of protected characteristics such as age, disability, or sexual orientation, and what this meant. There was no information about the service about what a hate 'incident' was and what action should be taken if this occurred. We found that this did not have a negative impact on people, but this had the potential to in the future.

We looked at a sample of three people's records and saw that these people had detailed risk assessments in place. These people had plans to try and reduce the risks which they faced. When we spoke with staff they were able to tell us what these plans were.

There had been limited accidents at the home. Actions had been taken to respond to accidents when they happened. We did note that one person had experienced a serious injury. The registered manager told us what action was taken to discover how this had occurred as a way to try and prevent it from happening again. A relative told us that this was investigated. However, conversations with health professionals had not

been fully documented. This person's risk assessment with an accompanying plan had not been updated. The registered manager told us what staff needed to do to prevent this injury from potentially happening again. This involved placing a pillow or cushion near the affected area. But we noted this was not always happening. We told the registered manager about this and we later saw staff following this practice.

Some people could not communicate with us in ways which we could understand, but some people could. We asked one person if they felt safe, they said, "Yeah." Another person said, "Like it here." A person's relative told us their family member was, "Absolutely (safe)."

At this inspection we looked at records of various tests that took place to ensure that equipment used by people was safe to use. With one exception, electrical items were being tested regularly and there were various fire safety checks taking place. For example the service had had a visit from a fire officer who had found no concerns. The fire alarms were being tested weekly and there had been fire drills this year. Each person living at the home had an emergency evacuation plan. The home also had a robust contingency plan with detailed practical information for the person in charge to follow.

Some people who lived at Pemdale could express behaviour which others found challenging. People's records which we looked at identified these behaviours and what staff could do to calm the person and deescalate the situation. The registered manager and staff were able to tell us about this information.

We saw that there were appropriate levels of staff to support people and keep them safe. The staff we spoke with had no concerns regarding staffing levels. Agency staff who were familiar with the home and the people living there were used, if there was a reduction in staff availability. Two new members of staff had recently been recruited. The home had a clear plan of what action to take if there was a sudden reduction of staff able to work at the home.

Recruitment processes were in place to ensure that people were safe when they were around staff. New staff had completed Disclosure and Baring Service (DBS) checks in place. One member of staff told us how before they started working at the home they had a new DBS in place from a previous employer, they said, "But they asked me to do a new one, and I had to wait until it cleared, until I could work here." This is the correct practice. New staff had two references in place and full employment histories. When staff had any gaps in their employment histories, this was checked at their interviews and recorded on their files.

Requires Improvement

Our findings

We inspected Pemdale in January 2016 and found the service was providing effective care to people. When we visited in March 2018 we found that improvements were required.

Staff spoke positively about their induction when they started working at the home. New staff had a period of observing staff and reading people's support plans. Staff said they were introduced to the people at the home. One member of staff said, "I spent time with people to help me get to know them." New staff then shadowed more experienced staff working in a team of two. The staff we spoke with said they felt supported in their new roles.

We were told about the training programme that new staff completed. This included face-to-face classroom training in areas such as moving and handling, safeguarding, first aid and epilepsy awareness. After this training staff completed e-learning (computer based) training. New staff also now completed the 'care certificate.' This is a national training course about what good quality care looks like. Some staff told us they were supported to gain a further health and social care qualification. One member of staff said, "It's great they [provider] help us do this."

Despite this positive information we found some issues with staff training. Recent induction face-to-face training had been cancelled and not rescheduled by the provider. This meant that staff who had recently started to work at the home to deliver care to people had not received training in key areas of their work. We spoke with the registered manager about these issues. They later told us that following the inspection they had asked the provider for the induction training to be arranged, but the registered manager did not have confirmed dates of this training.

When we looked at the training programme we also noted that some long term staff had some out of date training. We were also sent information which said that refresher training was arranged for later in the year. However, this training should have been arranged before it had expired. Two members of staff had not received training on mental capacity and promoting people's freedoms, despite working at the home since early and mid-last year.

The provider's policy was to 'refresh' staff training every three years. The registered manager and provider did not have a system of checking staff had retained this training during this time.

When we looked at staff competency checks which were completed after people had completed their inductions these did not evidence how individual members of staff were competent. There were no on going competency assessments taking place or checking staff's knowledge. When we spoke with staff we identified shortfalls in their understanding of safeguarding, mental capacity, and discrimination. The provider and the registered manager were not testing the effectiveness of the training staff received.

Some people had been placed under a Deprivation of Liberty (DoLS) by the local authority. We looked at one of these people's DoLS authorisations and saw that the service was following the local authority's recommendations. However, none of the staff we spoke with were aware anyone at the home had been placed under a DoLS. Two members of staff out of the three we spoke with did not know what a DoLS was.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We considered how the management of the service ensured that people did not experience discrimination. We saw staff had training about equality and diversity but staff had limited understanding about what this meant in practice. The registered manager and provider were not monitoring or checking staff's awareness or understanding of this area as a way to help prevent people from experiencing discrimination at the home.

Technology was being used to enhance the delivery of effective care. Some people were being supported in pressure reliving mattresses and were being hoisted in their beds and into the bath. However, there was no consideration about people accessing their interests or social opportunities via the use of technology and the intranet. We identified issues with the provider's level of investment into the service. This issue is potentially linked to this shortfall.

We saw people being supported to have lunch and as we were leaving staff were preparing the evening meal. We noted that people were supported to have hot drinks and snacks. We asked how people were involved with what they ate and drank. People had one-to-one meetings where they were asked about the menu for the week ahead. This was on the notice board in the kitchen, but it was not accessible. The pictures were small and the board was high on the wall in front of a table. There was no other information about the menu around the kitchen or the home.

We noted that one person's record identified food they liked and did not like to eat. However, in another person's record it said for staff to make their food appetising, and to give them food which they liked. But it did not say what this food was, or how to make it appetising for this person. This meant that there was an increased risk for this person of not receiving food that they liked.

One person was asked, "What do you fancy for lunch?" The member of staff who asked this question stood behind this person some distance away from them. This member of staff then said, "Cheese?" This person was not being given other options to have for lunch. They were then asked if they wanted tomatoes with their sandwich. The sandwich appeared with cherry tomatoes on the side of their plate. This member of staff later told us that the tomatoes were a replacement for crisps. The issue here is that staff had not engaged with this person to involve them in what they wanted to eat. They did not give choices and involve them in this process.

A member of staff talked us through the food menu and told us how the service tried to promote healthy eating. They said that people only had takeaways twice a month. We looked in the kitchen where people

came to eat their meals. There was some fruit on the side. When we looked in the fridge there was only one vegetable. No shopping was planned that day.

One person had complex needs with their eating and drinking and was at risk of choking. Specialist support had been involved to support this person to try and prevent them from choking when eating and drinking. We spoke with staff who told us how they supported this person in this way. We checked this against the health professional's advice. However, one member of staff's response was not correct, which had the potential to put this person at risk. We raised this with the registered manager who said they would talk to all members of staff that week.

We concluded that people were having enough to eat and drink and there were some efforts made to involve people. However, there were areas where improvements were needed in order to fully promote choice, people's involvement in what they ate, and to provide healthy options and alternatives.

We looked at people's health care records and found that people were being supported to access health support when they needed to. People had involvement from the dentist, optician, and chiropodist. Specialist health care referrals had been made via the GP.

The registered manager had recently acquired charity funding to renovate a room which people could access if they wanted to relax. We saw one person wanting to use it when we were visiting the home; they called it the "Snooze room." However, the provider had not considered the design; layout or the decoration of the room to ensure it met people's needs and enhanced their experiences at the home. There were no comfortable chairs or other soft furniture to make this a more fulfilling experience.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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.

When we spoke with staff they told us how they promoted choice when they were supporting people to manage their personal care needs and helped them to make choices about what clothes they were wearing that day. We looked at people's care records and we could see that people had capacity assessments which were relevant to specific decisions, important to their day-to-day lives. 'Best interests' processes had been followed in relation to particular decisions when this needed to happen.

We concluded that the service was compliant with the MCA. However, staff's knowledge and awareness of DoLS was not sufficient and needed to be improved. This is important because it is another way in which people's liberties can be promoted and protected.

Requires Improvement

Our findings

When we visited Pemdale in January 2016 we found that the service was caring. When we visited in March 2018, we found improvements were needed.

During our inspection we did observe two practice issues. One member of staff was talking with another member of staff in the presence of a person who had some cognitive issues. One member of staff started to talk about a person's continence care, the tone of their voice was 'light hearted.' This was not respectful. Eventually a member of staff indicated that this member of staff should not continue with their conversation as we were present in the room. It was not made clear to this member of staff that it was not appropriate to talk about another person's care needs in the public space of the home.

One person was watching a recording of their favourite music artist on a DVD. This person had limited communication. Later two members of staff started to joke with one another in front of this person about this particular musical artist. This was not thoughtful or respectful. This person could not and did not contribute to this joke and what staff were saying. It was not reciprocal banter. It was being said in front of the person and in their own home.

Alternatively we observed positive interactions between members of staff and people at the home. We saw staff being kind, patient, and gentle with people. One person's relative said, "From what I have seen staff are kind." We concluded that the staff in these situations did not intend to be unkind or disrespectful. This highlighted a practice issue and lack of understanding about the promotion of people's respect and dignity among some members of staff.

Staff knew people's likes and interests and we saw staff taking practical action when people indicated that they needed support.

People who we could communicate with us said staff were friendly and kind to them. One person said, "Yeah." When we asked this question. Another person told us how their key worker was on holiday and they were looking forward to them returning to Pemdale. A person's relative said, "I think [name of relative] really likes it there."

People and their representatives were involved in the planning of their care. The registered manager had arranged for independent advocacy support organisations to support some individuals. This is to advocate

for them in relation to some specific important decisions in their lives.

When we spoke with staff and looked at people's records we could see how the service was promoting people to be as independent as they can be. Staff gave examples of how some people completed elements of their daily routines independently and how they promoted this. We saw one person making themselves a drink and then staff walking behind them in order to carry their drink for them.

People's private information was being stored correctly and safely in the home. Staff also told us how they did not share people's private information outside of the home.

The relatives we spoke with told us how they were supported and encouraged to visit their relatives at Pemdale. Relatives told us that they visited when they wanted to and staff were always friendly and welcoming. One person's relative said, "It's a home, when we visit we get tea for two."

Requires Improvement

Our findings

When we visited Pemdale in January 2016 we found that people were receiving Good effective care. When we visited in March 2018 we found some areas where improvements were required.

Staff, relatives, and pictorial information told us that people were going out and a having social experiences which they wanted to do. Often this involved staff taking people shopping or out for lunch. We could see from these pictures and from what we were told that people enjoyed these moments and these happened on a regular basis. However, there were no planned trips or events or holidays. We were told about one person who had said they wanted to visit Norwich and stay one night. We spoke with the registered manager about this who said the provider will not commit to spend the additional money required for such events. The registered manager said they were now considering using funds donated by a charity to fund trips and holidays.

We concluded that the staff within the home were working creatively to meet people's social interests. However, the provider was not fully promoting people's social needs and ambitions.

During our visit we also saw how staff responded to people's daily social needs. We saw one member of staff regularly chat with people and try and engage with people in a social conversation. We heard one member of staff sitting with one person who had said they wanted to watch a particular film. During parts of this film they were having a conversation about the film. We saw two members of staff with one person helping them arrange their music collection. However, there were other times when staff did not engage with people in conversation and utilise this social opportunity. One person was watching their favourite pop singer on a DVD. There was no social contact and engagement during this time with this person, even though the member of staff sat with them during this time. Another member of staff was supporting one person to make a desert. They did not chat and engage with this person about this. At one point the member of staff looked through a magazine and spoke with another member of staff. This meant that there were missed opportunities for staff to engage with people in a social way.

There was a complaints process at Pemdale. There had not been any complaints for the last two years. The guide about how to make a complaint was in a pictorial form. However, this information was not in an accessible format about the home as a way to promote this option of making a complaint to the people living at the home. The guide and home's policy about making a complaint also did not tell the potential complainant what they could do if they were not happy with the outcome of their complaint. Such as contacting the local government ombudsman and highlight how they can do this.

We looked at people's care records and we could see that people had had person centred assessments. Some people faced communication challenges. In one person's record it detailed how this person expressed their views and the ways they wanted staff to communicate with them. How people wanted to spend their days and what their routines were and how they wanted to be cared for, was identified and recorded in people's care assessments.

These records also detailed what was important to people and what upset and irritated them. We could see that people's interests and what they liked to do had been identified in these records. People's assessments were also in a pictorial form to involve them and to make their assessment their own personal document. Throughout people's records there were different photos of them performing certain activities which they enjoyed doing. Personal information had been gathered about the individual person to support staff to know and meet people's needs. These people's records stated what particular type of films they liked to watch and artists they liked to listen to. One person liked gardening and helping in the kitchen and there were pictures of person doing this.

People's life histories, their important relationships and religious and spiritual needs were also identified and explored in people's care assessments and records. Again we saw photos of the people who were important and special to the people living at the home and involved in their lives. This also included staff.

We were shown people's one-to-one records. This is where a person's key worker or another member of staff would sit with a person and discuss their week. How the week had gone and what they wanted to do and achieve in the following week. We looked at a sample of people's one-to-one documents and their weekly activity plan. We could see that what people had asked to do, was in their following weeks plan.

People would also have a monthly review where their key worker would look at their needs to see if there were any changes to these and update their care assessments. We saw where applicable information had been updated and changed in people's care assessments. People's monthly reviews were person centred. Although on one person's review some information was consistently lacking. This person had communication issues and was not engaging as they had previously due to a change in their health needs. Their review stated that, staff would continually find ways to stimulate this person, but it did not say what these 'ways' would be. Their key worker had not discussed the various options with their colleagues and this person's relatives to look at other ways to promote this person's wellbeing.

When we looked at people's care records people consistently had end of life plans in place. These were person centred and staff had clearly consulted with the individual person, and their representatives. When some people could not communicate these wishes staff had also been consulted with. These plans contained personal information such as where they wanted to be cared for if they become very unwell. What music they wanted playing at their funeral and other personal details. The service had made efforts to know people's wishes and how they wanted to be cared for at this part of their lives.

Requires Improvement

Our findings

When we visited Pemdale in January 2016 we found that the service was well-led. However, when we visited in March 2018 we found there were areas which required improvements to be made.

When we spoke with the registered manager they told us that the land lord was reluctant to invest into the home. At this inspection we found that the home looked like it was in need of redecoration. Paintwork and equipment was chipped and marked and rusty in places. There was a significant amount of lime scale in the laundry. We identified some hygiene issues. There had been limited investment into the appearance and up keep of the home. This was evident from what we saw. However the provider had not addressed and resolved this issue with the landlord. This issue was not new it was historical. This situation had led the registered manager accessing local charity funding to fund basic redecoration of people's bedrooms. At the time of the inspection this money had also been used to clear a storeroom area which had been painted to make it a chill out room for people. However, the room was not furnished with furniture that people could relax in.

The provider was not investing in supporting people to access social opportunities outside of the home. Some people had aspirations of short trips involving a night away, but the provider since the last inspection had not funded these requests. The provider's quality monitoring visits did not highlight these issues. No attempt was made to challenge this situation following these quality audit visits.

We concluded that the provider was not investing into the service and fully promoting and enabling people to have an improved quality of life.

Training had been cancelled for some staff and the provider had not resolved this issue despite new staff being appointed and people needing support. We were told that the provider was having a senior management restructure which could have affected this. During this time it was unclear how the registered manager was being supported. The provider is a large national provider and should have put systems in place to ensure training and the support of the management of the home, during this time, as part of their organisational oversight.

There was a lack of robust quality monitoring or systems to identify certain short falls at the home. Such as the lack of cleanliness around the home and that staff on occasion were treating people with a lack of respect.

We identified some shortfalls of staff practice and knowledge. In infection control, safeguarding, DoLS, discrimination, promoting choice, and being sensitive to always being respectful to people. We found that these issues did not have a negative impact on people when we visited. But it had the potential if these issues went on unaddressed. There was a lack of evidenced robust competency monitoring of staff and ensuring training was effective, up to date, and being put into practice. The management of the home needed to improve the systems and how they monitored staff practice to promote continuous learning and best practice. At the provider quality monitoring checks staff observations and checks into these areas were not taking place. This area had therefore not been identified, with a plan of action to make improvements.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was not fully aware of all the important events they need to notify us about by law. One person had experienced a serious injury and we had not been notified of this. We spoke with the registered manager about this and advised they reviewed the information on our website, about what events they need to notify us about.

The above issue constituted a breach of Registration 18 Regulations 2009 (Part 4).

People and their relatives where applicable were involved in reviewing and giving their views about the care and support they received. Relatives said that the management responded positively to their feedback or when they raised issues about the care of their relatives. The registered manager told us their plans of how they wanted to involve people, staff, and people's relatives about how to spend the recent charitable funds the service had received. These would be used to improve people's experiences living at the home. However, there had not been any prior engagement with these individuals about the development of the home. The provider had not identified this issue or promoted it.

There had been involvement from a local religious group but there had not been any further involvement or efforts to involve the local community, despite the home being situated in a residential area. Again this had not been identified at the provider quality monitoring visits.

From looking at a sample of quality monitoring reviews completed by the provider we could see that some improvements had been identified and acted upon. The local authority and Clinical Commissioning Group (CCG) had visited and made recommendations to improve how people's medicines were managed. We could see that the management of the home had acted upon these recommendations and made timely improvements.

The registered manager told us about the improvements which they were making since having been in post. The registered manager and the staff were open with us which was a positive reflection of the culture at the home. However, the provider was not supporting the development of this culture.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 HSCA (Registration) Regulations 2008 (part 4): Notifications of other incidents. The provider had failed to notify the commission about all the important events they must notify us about by law. Regulation 18 (1) and (2) (a) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that all aspects of the environment were always safe for people to live in. People's medicines were not always stored safely. Regulation 12 (1) and (2) (d) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider had failed to have effective systems and processes in place to monitor and improve the safety and the quality of the service provided. Regulation 17 (1) and (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The provider had not ensured that staff always had the training and knowledge to do their work effectively. Regulation 18 (1) and (2) (a).