Community Integrated Care

The Peele

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Peele is a nursing and residential care home. The Peele provided personal and nursing care to 86 people aged 65 and over at the time of the inspection. The service can support up to 108 people across nine separate households. At the time of our inspection one household was not being used and another household was at 50% capacity.

There is one intermediate care household, for people who need short term rehabilitation support after discharge from hospital before returning home. On this household, CIC provide the nursing and care staff and the NHS provide the physiotherapists and occupational therapists.

People's experience of using this service and what we found
Care plans were not always person-centred and varied in the level of detail and guidance they contained about people's care and support needs. People's advanced wishes for the end of their life had not been discussed. There was a lack of information about people's life history, likes, dislikes and communication needs.

Most people and relatives said they had not been involved in reviewing their care plans. The registered manager acknowledged this and said that the new monthly reviews prompted staff to discuss the care plans with people and their relatives and record their views.

People and relatives said there was a lack of activities for people. Three activity co-ordinators were employed across the home, but we did not see any plan of the activities available. Care staff did not have the time to engage in activities with people.

The provider had not had sufficient oversight of the home. A succession of registered managers had managed The Peele. The provider had not had robust quality assurance, recruitment or training systems in place during this time.

Information the inspectors requested was not always available for us to view or was not readily available.

The new registered manager had recruited more staff, reducing the reliance on agency staff and ensured staff completed their training and induction. New audits had been introduced, including for the intermediate care household, although these did not always identify the issues we found at this inspection, or actions identified were still to be completed.

A range of information, for example falls, pressure sores and people's weights were not currently analysed by the registered manager. They told us they had prioritised other issues, such as recruitment and training and now planned to start analysing the available information for trends and patterns to improve the service.

Medicines on the intermediate household were not always safely managed. Medicines were well managed on the other households.

Not all pre-employment checks had been completed, with gaps in staff employment history not being explained and references not always being from the staff members previous employer.

There were now fewer agency staff used at the service, although agency staff were still used at night. Agency staff inductions had not been completed. Profiles for the agency staff to ensure they had the training and experience to meet the needs of people living at The Peele had not been obtained from the agency.

People and relatives were complimentary about the staff supporting them, saying they treated them with dignity and respect. Staff said they enjoyed working at the service and felt well supported by the residential and registered managers. They said the availability of training had improved and there were more permanent staff employed.

People were supported to maintain their health and nutrition. Referrals were made appropriately to GPs, district nurses and other health professionals.

The Peele was visibly clean and the layout, decoration and signage supported people to orientate themselves within the households.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection (and update)
The last rating for this service was requires improvement overall, with one domain being rated as inadequate (published 19 February 2019) and there were two breaches of regulation. After the last inspection we issued two Warning Notices.

At this inspection not enough improvement had not been made and the provider was still in breach of regulations. The service is now rated inadequate. This service had been rated requires improvement for the last five consecutive inspections.

This service has been in Special Measures since November 2017.

Why we inspected
This was a planned inspection based on the previous rating. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement

We have identified breaches in relation to four regulations at this inspection.

Care plans were not person-centred and did not contain sufficient information about people's support needs, life history or communication needs. There was a lack of activities for people to take part in.

The provider had not had robust oversight of the home during a period of changes in the registered

manager. Information was not analysed to drive improvement at the home. Information requested by the inspectors was not always readily available.

Medicines were not always safely managed on the intermediate care household.

Not all pre-employment checks had been completed prior to staff starting work.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Peele

Detailed findings

Background to this inspection

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

Inspection team
On the first day the inspection was carried out by four inspectors, an assistant inspector, a pharmacist inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Four inspectors returned for the second day and two inspectors for the third day.

Service and service type
The Peele 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.

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

Notice of inspection
This inspection was unannounced. The registered manager was unavailable on the first two days of our inspection and some information was not available for us to view. Two inspectors arranged for a third day of inspection to meet the registered manager and review the outstanding information.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 15 people who used the service and 15 relatives about their experience of the care provided. We spoke with 24 members of staff, including the registered manager, residential manager, the providers lead nurse, the providers quality assurance manager, nurses, team leaders, care workers and visiting health professionals. 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.

We reviewed a range of records. This included 15 people's care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality assurance were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection medicines had not been safely managed on the nursing and intermediate care households, including medicines being out of stock. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst some improvements had been made, with medicines now being available when they were needed, not all medicines were safely managed on the intermediate household and the service continued to be in breach of Regulation 12.

- Staff administering medicines on the intermediate care household did not always ensure the medicines were taken before signing the Medicines Administration Record (MAR).
- On the intermediate care household, packaged vacutainer needles and expired urinalysis sticks were on top of the medicines trolley in the lounge area. Both were in easy access to people living in the intermediate care household. We informed the residential manager and quality assurance manager of this. The vacutainer needles were still being stored on the trolley in the communal area of the household on the second day of the inspection. We discussed this with the registered manager on the third day of our inspection who said they would check that the vacutainer needles were stored safely in future.
- The home did not record the time when regular doses of medicine's containing paracetamol were given on the intermediate care household.
- Medicines in the fridge on the intermediate care household were stored outside the recommended temperature range and we could not be assured they were safe to use. Medicines fridge temperatures were being recorded, however, the temperature exceeded the recommended temperature and no action had been taken to rectify this prior to our inspection. The maximum and minimum fridge temperatures were not being recorded, however, this was in place by the third day of our inspection.
- The intermediate care household did not record when a person's fluid was thickened to reduce the risk of choking, making it unclear if drinks were thickened correctly.
- The intermediate care household did not always have people's photographs in their medicines file and people did not wear identification wrist bands. Therefore, staff were unable staff to check if they were giving the medicines to the correct person. This was important on this household as people only stayed for a short period of time during their rehabilitation.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines on the residential and nursing households were safely managed.

Staffing and recruitment
● Staff files we viewed showed that not all pre-employment checks were completed prior to staff starting work at The Peele. The reasons for any gaps in previous employment had not been provided and not all references were from the candidate's previous employer. References had not been verified as being accurate.
● The recruitment process was managed by an external recruitment agency. Recruitment information was not readily available to the inspectors when requested. For example, further information was requested on the last day of the inspection and this was not provided.
● The use of agency staff had reduced at The Peele, which improved the continuity of care and support people received. However, agency staff continued to be used, mainly at night. From the rota we saw some night shifts, especially at a weekend, were predominantly staffed with agency workers. We were told agency staff were given an induction to the service; however, there were no completed agency induction forms since January 2019. Profiles of the agency staff, detailing that they had the experience and training required for the role, had not been received from the agency supplying the staff.

This was a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Five people lived on Dove Meadow. There was one staff member on the household to support them. We were told that the staff would ring another household when they needed assistance, for example with moving and handling. However, a member of staff told us they sometimes left the household, for example to go to the laundry, meaning there were no staff present on the household during this time.

This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered manager told us this should not happen and said they would speak to staff to ensure there was always at least one member of staff on Dove Meadow at all times.
● People and relatives told us that the staff were very busy and raised concerns about staffing levels and the use of agency staff. Our observations verified this, with staff being task orientated to meet people's needs, but they had no time to try to engage people in activities or general conversations.
● Generally, members of care staff told us that whilst they were busy, they felt there were enough staff to meet people's needs. One told us, "At times we are busy, but we manage it well. The use of agency has greatly reduced over time." However, we were also told that the three ground floor households should have two team leaders on shift during the day. We were told that when a team leader was off, for example on annual leave, their shift was not covered, leaving one team leader across the three households. Care staff said this made the shifts very busy, especially on the Brinkshaw household. We discussed this with the registered manager, who said that the residential manager or an advanced carer would cover a team leader shift if required.
● The Peele used a recognised dependency tool to calculate staffing levels, which was not fit for purpose. We saw the calculations resulted in a very low number of staffing hours, with the home using around 70% more hours than the dependency tool indicated.

Assessing risk, safety monitoring and management
● The risks a person presented had been identified. However, the information and guidance available for staff to manage the risks, varied in detail and quality. This meant we could not be assured; the staff team

were aware of the risks and how to manage each risk.
● There was some information in care plans to assist staff in supporting people who became anxious or agitated and gave details of how staff should distract and reassure people.
● Equipment was serviced and maintained in line with guidance and regulations.
● One person was at high risk of falls and had had 10 falls in the last 16 months. A referral had been made to the physiotherapy team, however the care plan had not been updated to show they now used a frame when mobilising instead of sticks.
● Each person had a personal emergency evacuation plan (PEEPS) in place, stored by the main entrance so it was accessible in the event of an emergency.

Learning lessons when things go wrong
● Incidents and accidents were recorded, and the incident forms forwarded to the registered manager. These were reviewed, and actions taken to reduce the chance of a re-occurrence noted.
● Each incident was added to a provider computer-based system. This produced information at the home level for the time of the incident and the location, for example in a bedroom or communal area. The registered manager told us they planned to start analysing this data to look for patterns but had not had chance to do so up to now.
● We also saw the provider had a number of falls preventative documents to track falls, but these were not being used.

Systems and processes to safeguard people from the risk of abuse
● Staff understood safeguarding, how to report any concerns and felt able to raise any issues with either the residential or registered managers.
● Staff had completed safeguarding training.
● People and their relatives thought they were safe living at The Peele. One person told us, "I was really worried about coming here, but this is much better and safer than in hospital" and a relative said, "Dad is safe here, no worries whatsoever."

Preventing and controlling infection
● The Peele was visibly clean, although the carpets on some households were stained. The service improvement plan stated quotes were being obtained to replace the carpets on one household.
● A local authority infection control audit in April 2019 had rated the home as Amber. Actions from this audit were seen on the Peele service improvement plan and were ongoing at the time of our inspection.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now been rated as requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff were positive about the support provided by the new registered manager and the residential manager, who were visible within the home and approachable.
- Staff received the training they required to carry out their roles. New staff completed a formal induction workbook, including observations of their practice.
- The registered manager acknowledged that staff inductions hadn't been robust prior to her appointment. They had actioned this and ensured all new staff now completed their initial training, shadowed experienced staff and completed their induction workbook.
- Staff had regular supervision meetings with team leaders or nurses. Staff found these useful to discuss their performance and any training they needed.
- As stated in the safe domain, since January 2019 agency staff had not completed an induction to the home when they covered a shift.

Supporting people to eat and drink enough to maintain a balanced diet

- Most people's nutritional needs were being met. People said they enjoyed the food and had a choice of meals. One person said, "The food is brilliant; three main meals and drinks and snacks whenever you want."
- We observed lunch on five households. People were encouraged and supported to eat their meals, although they sometimes had to wait for support as the staff team was busy serving food and supporting other people.
- The main meals were bought pre-prepared and re-heated within the home. These were nutritionally balanced and were of the correct consistency, for example soft and bite sized or pureed to reduce the risk of choking.
- People at risk of losing weight were referred to dieticians or the speech and language team as appropriate.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People were supported to maintain their health. Medical professionals we spoke with were complimentary about the service. One said, "They (the staff) follow any guidelines they're given. They're very good like that." For the intermediate care household we were told, "The care staff follow through on the advice they're given; encouraging people's mobility and safely following the guidance for how the person mobilises, which can change quickly with their rehab."
- Appropriate referrals were made to other services, for example district nurses and GPs. Notes of professional visits and multi-disciplinary team meetings were made in people's care files.

● Eight people did not have oral healthcare assessments. This meant we could not be assured people were receiving the correct support to manage their oral healthcare.
● Care records did not always contain information about people's communication needs. For example, one person did not speak English. They therefore could not understand and be involved in decisions about their health care without their family being present to translate, which was not always possible.

Adapting service, design, decoration to meet people's needs
● The Peele has nine small households, with up to 13 people living in each household. All bedrooms led into the communal lounge and dining area. This made it easier for people to orientate themselves within the home.
● Bedrooms had people's photographs on the door to assist them to find their own room. Memory boxes were situated outside each room; however, not many were used.
● Dementia friendly signage was used to help people identify different rooms within the household, for example bathrooms or toilets.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● At the time of our inspection The Peele was not accepting new admissions. One household was closed and another was half full. The operations director told us it was planned for both these households to be refurbished before new people were admitted.
● An initial assessment of people's needs was completed prior to them moving to the service. This enabled the service to ensure they could meet the person's needs.

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

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

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

● The service was working within the principles of the MCA. DoLS applications were made where people lacked the capacity to consent to their care and treatment.
● Decision specific capacity assessments and best interest decisions, for example for the administration of medicines and the use of sensor mats.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives were positive about the care and support they received and the staff team. One person said, "Quite simply, they treat you like you would want to be treated" Relatives told us, "All you hear is negative stories about Care Homes, I think the carers in this one are brilliant" and "The staff are really friendly and hardworking."
- We observed and heard positive interactions between people and members of staff throughout our inspection.
- There was very limited or no information at all about people's life history or family. This information is useful for staff to engage in conversations with people and build relationships with them. The operations director told us life history information was planned to be discussed during the initial assessment of people's needs so that it was available for staff to read when people first moved to the service.
- Care plans we saw did not contain a section to record a person's cultural needs, for example if they followed a religion or had any preferences for cultural food.
- One person's family, who had lived at The Peele for two years, brought all their meals into the home for their relative. Their care plan did not have any information about their cultural diet but stated the person 'was a fussy eater.' Their relative said, "I visit the home daily to bring in food for mum, the service have never offered to help with this, so we just get on with it." The registered manager told us they had offered to provide culturally appropriate meals, but the person wanted their family to continue to bring them in for her. We spoke with the chef, who confirmed that they had not been given any details of this person's cultural dietary needs, but was aware that their family provided meals for them.

Supporting people to express their views and be involved in making decisions about their care

- Care records did not always contain information about people's communication needs. For example, one person had lived at the service for two years and did not speak English. The service had not worked with the person's family to translate or write out on cards key words for the staff team to use and efforts had not been made to use an internet-based translation service to assist communication. The staff relied on the person's family to translate on their behalf when they visited. This had an impact on their ability to access the care and support they needed.
- People or their relatives were not always involved in reviewing and agreeing their care plans.

The lack of information about people's life histories, cultural needs, communication needs and inconsistent involvement of families in reviewing people's care was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us that they were kept informed about any changes in their relative's health or wellbeing by the staff on the households. They also said the staff were approachable and would address any issues they raised.

Respecting and promoting people's privacy, dignity and independence
● Staff explained how they maintained people's privacy and dignity when providing personal support, including explaining to people what they were doing throughout the support.
● Relatives were very complimentary about the staff and how they interacted with people. One told us, "I am made to feel so welcome and they really do listen."
● Staff told us they prompted and encouraged people to complete tasks they were able to themselves. We observed staff supporting people to mobilise and encouraging them to eat independently. However, care records did not always identify what people were able to do for themselves to guide staff.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care plans were not always person centred and did not always contain enough information or detail about their needs and how staff should meet these needs. Some people had comprehensive care plans reflecting their support needs, likes, dislikes and personal preferences, whilst others lacked meaningful information that would enable staff to provide a responsive, person-centred level of care. There were two different versions of care planning documentation in use at The Peele. Which one was used depended on when the person moved to the home.

● For example, one person stayed in bed. Their pressure area care plan did not give guidance about the frequency they needed to be re-positioned to reduce the risk of pressure sores or the equipment used to stabilise their position in bed. A care plan review in July 2019 stated that this care plan was up to date and had not identified the lack of detail and guidance. At the time of our inspection the person's skin was intact. Records showed the person was being repositioned and staff we spoke with knew their needs. The lack of guidance for staff meant that new staff or agency staff would not know the person's care needs, increasing the risk of the person developing pressure area sores.

● The care plans contained a section to outline people's usual routines for getting up and in the evening. These were not always completed and varied in their detail.

● Daily records were used to monitor the care and support provided. These were not always completed. Daily notes were very brief and did not always provide any detail of the support provided that shift. For example, we saw daily record entries that just stated, "[Name's] been fine today, I have no concerns."

● People did not always receive the care and support as stated in their care plans. For example, one person's care plan stated they needed to be re-positioned every two hours. Over a period of five days from the 2 August to 6 August we found 12 occasions when this person was not turned within the recommended two hours, increasing the risk of developing pressure area sores.

● Records were not kept of welfare checks made by staff. The residential manager told us the staff used the call buzzer in the person's room to identify they had checked the person. However, the call buzzer data was not analysed to verify these welfare checks were taking place. We discussed this with the registered manager who said they would look at a different system to monitor the welfare checks were being completed as planned.

This was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The care plans on the intermediate care household contained enough information for staff to meet

people's needs. A white board in each person's room was used by the physiotherapists to provide up to date information about a person's mobility needs. One person told us, "The staff don't do anything without referring to the (white) board. They always go by the book."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care records did not contain information about people's communication needs. As described in the caring domain, one person had lived at the service for two years, who did not speak English. There was no information in their care plan about how staff could communicate with them.

This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People and relatives told us there were not many activities for them to participate in. One person said, "It is such a shame that there is no proper activities plan." Our observations during the inspection confirmed this.
● The home had recruited three activity coordinators. However, we did not see a plan of the activities arranged throughout the week or month. At the time of our inspection one coordinator was on annual leave.

● We saw a breakfast club and afternoon tea sessions were arranged for the second day of our inspection; however, this activity was limited to those people who were able to leave their households safely.
● The registered manager told us that activity boxes had been provided for each household. The aim was to move the activities from the separate communal rooms that most people could not access to each household. Staff were also to be encouraged to engage in activities with people, not just the activity coordinators. However, as previously stated in the safe domain, staff were very task orientated and did not have the time to engage with people outside of their support tasks.

The lack of organised activities was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● People's advanced wishes for the end of their life were not known by the service. Conversations had not been held, with people or their relatives, what their wishes were, for example if they wanted to be admitted to hospital or stay at the home or their preference for their funeral.
● Where people's care file or the handover sheets indicated there was a do not attempt cardiopulmonary resuscitation (DNACPR) in place, these were not always readily available in their files. This meant the home could not give the DNACPR form to a paramedic and therefore they may attempt to resuscitate the person against their wishes. Following our inspection, the registered manager contacted us to advise, a missing DNACPR had been located and we would be supplied with a copy. We did not received the copy as advised.
● The operations director told us end of life wishes were due to be included in the new pre-admission assessment procedure, so this information would be captured when people moved to the home.
● The registered manager told us they were engaging with the regional Six Steps for end of life care co-ordinator to provide training in end of life care for the staff team.

This was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy in place. Complaints received, had been investigated and responded to in a timely way.
- The outcomes of any complaints were shared with team leaders and nurses at a daily huddle meeting if appropriate and with the complainant.
- There was no information on the households or in the reception area of the home about how people or relatives could make a complaint.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection there had been a lack of stability within the management structure and the provider did not have effective quality assurance monitoring and oversight of the whole service. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst some limited improvements had been made at this inspection, the quality monitoring systems were still not effective and the service continued to be in breach of Regulation 17.

- A new registered manager had been appointed since our last inspection. They had successfully recruited more staff, re-introduced staff inductions and reduced the out of stock medicines. The intermediate care household was now included in audits within the service.
- However, the provider had not had sufficient oversight of the service over a period of time, which meant there were multiple issues for the new registered manager to action. The Peele had been rated as Requires Improvement for the previous five inspections since 2015, with well led being rated as inadequate in four of those since January 2017. For example in this time period, staff inductions and training had not always been completed, there had been a reliance on agency staff and a lack of staff recruitment, no analysis of incidents or accidents was completed, care plans were not always detailed or person-centred and staff were not adequately trained to write detailed person-centred care plans and risk assessments.
- The quality assurance system was not robust. Audits were completed but they did not always identify the issues we found at this inspection or where issues had been identified actions were yet to be completed. For example, the care file checks did not always identify the lack of person-centred detail. A care plan audit for the intermediate care household stated it was not applicable as the care plans were different due to the rehabilitation nature of the household. However, the audit was repeated, rather than being adapted to be meaningful and fit for purpose.
- The registered manager and provider did not currently have full oversight of the home. Accidents and incidents were not analysed for trends. A data collection audit for unplanned hospital visits, deaths, pressure sores, infection control, weight loss and falls was completed but no further analysis of this data was undertaken. Call bell response times were checked, however, there was no analysis of these or evidence that excessive response times had been investigated. Minutes from a clinical risk meeting in February 2019 were seen; however, there had not been further clinical risk meetings since this date.

● The service's improvement plan noted that a senior manager's audit in May 2019 had identified that care plans and risk assessments needed to be reviewed and updated to reflect people's current care needs. From our inspection care plans continued to lack person-centred detailed information.
● The operations director and registered manager told us that new care plans were due to be introduced at The Peele. There was an acknowledgement that the current care plans were variable in the content. We were told there would be training for staff in how to write these and they would be introduced gradually over twelve months. This would mean that there will be three different care plan formats during this implementation phase. There was no mention of how they would ensure the current care plans were updated to fully reflect people's needs, the risks they may face and how staff were to meet these needs.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others
● The registered manager acknowledged that not all information gathered, for example unplanned hospital visits or falls were currently analysed to enable any learning from these to improve the service. They said they had concentrated on staff recruitment, induction and training and now planned to start analysing the available data.
● Information regarding the service was not always readily available for the inspectors to view. For example, staff recruitment and training records.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service worked with medical professionals, community services and local authority social workers. Information was shared appropriately where required.
● Since the last inspection the clinical lead had left the service. At the time of our inspection the provider's clinical governance manager was supporting the home. However, they also had responsibility for all the CIC homes in the north west. We were told the provider was looking at introducing different roles on the households which would provide some staff with supernumerary time in order to complete care plans and audits. The current arrangements would continue until this had been established.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff said the registered manager and residential services manager were visible within the home. They completed a daily walk around to be updated on any changes and talk with the household managers and staff. A member of staff said, "Can't fault the management team. Changes are happening daily for the better here."
● Daily managers meetings were held, including team leaders, nurses, the chef, maintenance and the head of domestic staff. A member of staff said, "The new manager I believe is doing a good job here. They have introduced 11am team meeting huddles where we discuss a range of topics such oral hygiene. It's a lot better than the past, I've had many managers but really happy with how it is going."
● Staff said they enjoyed working at The Peele and thought there had been improvements at the home since the new registered manager joined. One member of staff said, "I like it here; the people I work with and the service users make it enjoyable."
● The service was not fully inclusive as different ways to meet the communication needs of a person who did not speak English had not been explored and the staff relied on the person's family to translate for them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager notified the CQC appropriately of any accidents and incidents at the service. All complaints were responded to within the timescales set in the providers policy.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives said they were able to talk to the staff, nurses, team leaders and registered manager as they were all approachable. However. Many did not know the management team at the Peele.

● There were residents and relatives meetings held every 3 months.

● Most people and relatives were not aware of their care plans We were told the service was introducing people's families being involved in a six or 12 month review of their relatives care and support. Relatives were kept up to date with any changes in their relative's health or wellbeing by the staff on the households. One relative told us, "Yes, they always call. I am satisfied with the communication."

● Staff told us that there were regular staff meetings. A night staff meeting had been held in May 2019; however, we did not see any minutes for any day staff meetings since March 2019.