Mr Barry Potton

Pennine Lodge

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection was unannounced and took place over two days on 18 and 21 August 2014. When we inspected the service in January 2014 we found the provider had breached regulation because they had not regularly sought the views of staff in order to come to an informed view as to the standard of care and treatment provided to service users. They sent us an action plan and told us how they were going to make improvements. We also said the provider may find it helpful to review people's sleeping and resting preferences and assess how these were recorded and monitored. During this inspection we looked to see if these improvements had been made.

Pennine Lodge is a care home providing personal care and accommodation for 40 older people living with dementia. Thirty-six of the bedrooms are single and two rooms are double. At the time of our inspection there were 38 people living in the home.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At this inspection we found the provider had a system to monitor and assess the quality of service provision although this was not always effective. They had introduced more measures to seek the views of staff but they needed to make some further changes to the way they monitored the service to ensure people received safe quality care.

Although we did not find the provider was in breach of regulations at the last inspection we recommended they should look at people's sleeping and resting preferences because we were concerned that the morning routine was not personalised. At this inspection we found staff were getting some people up very early on a morning and were task centred rather than taking account of people's welfare and individual preferences.

People were involved in activities within the home and the local community. People received good support to make sure their health needs were met. Care plans gave staff information about the best way to support people and assessments had been completed where areas of risk were identified in the care plans. However, it was unclear how the level of risk was determined because the service was not using evidence-based risk assessment tools which help to identify the level of risk and appropriate preventative measures.

Comments from people who used the service included, "They are good they will do anything for you." "They're really lovely." "Wonderful people these are." A relative said, "As soon as I came in here I had the feeling that this was the right place. You know when something is just right and it felt good, home from home. I could move in here myself." One relative said overall they were happy with the care but on occasions they had noticed their relative wearing clothes they didn't recognise.

People were supported by sufficient numbers of staff to keep them safe. Checks were carried out prior to the staff starting work to make sure they were suitable and they completed an induction when they started work. The provider had a programme of training, supervision and appraisal, however, we were concerned that the training provided may not equip staff with the knowledge and skills because staff sometimes completed up to ten training sessions in one day.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Staff we spoke with said people received safe quality care. Staff knew how to report a concern about abuse and were confident the registered manager would treat any concerns seriously.

The staff we spoke with were aware of their responsibilities under the Mental Capacity Act 2005. We saw that people's capacity to make decisions about different aspects of their care and treatment had been assessed and recorded in their individual care plan.

People lived in a clean, comfortable and well maintained environment and were protected against the risk of infection. People were able to move around most of the home freely although bedrooms were locked during the day which meant people were unable to return to their bedrooms unaided.

We noted that staff had used small bedside cabinets to prop doors open when we first arrived, which is not a safe mechanism for keeping doors open.

People received a choice of suitable healthy food and drink ensuring their nutritional needs were met. At meal times appropriate assistance was provided.

The provider worked effectively with health professionals and made sure people received good support when they moved between different services.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. Medicines were not administered safely. Staff sometimes failed to follow the prescribers' direction fully and people were not given their medicines properly.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and how to ensure the rights of people with limited mental capacity to make decisions were respected.

The provider could not demonstrate how they were identifying and managing some risk because they did not have any environmental risk assessments.

People said they felt safe and the staff we spoke with knew what to do if abuse or harm happened or if they witnessed it. There were enough staff to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had a programme of training, supervision and appraisal. Multiple training sessions were provided on one day which raised concerns about the depth of learning for staff.

People enjoyed the meals and were supported to have sufficient to eat and drink and to maintain a balanced diet. People received appropriate support with their healthcare and a range of other professionals were involved to make sure people's healthcare needs were met.

The home was well decorated and furnished although we noted some people's bedrooms were not personalised.

Is the service caring?

Good

The service was caring. Throughout the inspection there was a pleasant and relaxed atmosphere. We saw caring interactions when staff provided assistance. Staff knew the people they were supporting and chatted to them about family and friends.

Staff were confident people received good care. The registered manager and deputy managers carried out random checks and observed how staff supported people.

The home accessed support from the district nursing team when people reached end of life. The management team were introducing end of life care planning to help people prepare for the future.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not receive personalised care on a morning. Staff were getting some people up early to suit the convenience of staff so the delivery of care was not provided at the time that suited individuals and did not meet their needs or preferences.

At other times of the day people received appropriate care. Care plans generally identified how care should be delivered and contained good information about the person. People enjoyed different activities in the home and within the local community. Activity staff were developing a project to help build up people's life histories.

None of the people who used the service we spoke with raised concerns about their care. The provider had not received any formal complaints about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led. The service had systems in place to monitor the quality of service provision although these were not always effective. Staff understood their roles and responsibilities although there was some confusion about who was managing the service.

The provider had informed CQC about a number of significant events that had occurred, but they had failed to inform CQC about all reportable events.

We received positive feedback from health professionals who said the provider worked very effectively with them to make sure people received joined up care.

Pennine Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was carried out over two days. On the first day the inspection team consisted of three adult social care inspectors, a pharmacist inspector, a specialist advisor in governance and an expert by experience in older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the inspection team consisted of three adult social care inspectors.

Before the inspection we reviewed all the information we held about the home, which included information of concern we received just before the inspection from an anonymous source. The provider had completed an Provider Information Return (PIR). This is a document that provides relevant and up to date information about the home that is provided by the manager or owner of the home to the Care Quality Commission.

During our inspection we used different methods to help us understand the experiences of people who lived at the home. We spent time observing care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people who used the service, four relatives, two visiting health professionals, and 16 staff including care workers, ancillary staff, deputy managers, the registered manager and the deputy chief executive. We looked around the home and looked at 14 people's care records, 24 people's medication records, staffing rotas, staff training and induction records and the quality assurance records that the management team had completed.

Requires Improvement

Is the service safe?

Our findings

We looked at records about medication for 24 people who were living in the home and found there were some concerns about medicines or the records relating to medicines for 23 of the 24 people.

We found that most medicines were stored safely in lockable cabinets in locked rooms. However, we found that creams were not stored safely in people's bedrooms because they were not locked away. We saw one person had been into another person's bedroom and had taken a large tub of cream. If creams are not locked safely away people's health could be placed at risk.

We found appropriate arrangements had not been made in relation to obtaining medicines. People ran out of some medicines, such as Paracetamol for periods of up to a week.

We found that medicines were not administered safely. The morning medicines round started at 10am and on the day of our visit was not completed until 11:30am. This meant that people had to wait a long time between getting up in the morning and having any medicines including medication for pain relief, which may have caused people to be in unnecessary pain. We also found that bedtime medicines were given at 10pm; some people did not want to take their medicines so late which resulted in them missing doses. We found that arrangements made to give people their medicines as directed by the manufacturers, especially with regard to food were poor. We saw that medicines which needed to be given half to an hour before food were given with medicines which should be given with or after meals. Medicines must be given at the correct times to make sure they work properly.

People were prescribed medicines to be taken when required and we found that most medicines prescribed in this way did not have adequate information available to guide staff as to how to give them. We found there was no information recorded to guide staff which dose to give when a variable dose was prescribed. It is important that this information is recorded to ensure people were given their medicines safely and consistently at all times.

We found there was clear information recorded to guide staff as to where to apply creams which ensured people are given the correct treatment. However, we found that no records were made when creams were applied to people early in the morning. We found that appropriate arrangements were not fully in place in relation to the recording of medicines. We saw the records about medicines were generally well completed and medicines could be accounted for and the records could show if they had been given properly. It is important that a record is made about all medicines so that people are not at risk of having too much or too little medication given to them.

Staff sometimes failed to follow the prescribers' direction fully and people were not given their medicines properly. We also found that appropriate arrangements were not in place to ensure people did not miss doses of their medication when they were on trips or outings away from the home which meant their health could be at risk. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff we spoke with were able to describe emergency fire procedures and the actions they may need to take to protect people in the event of a fire. Personal Evacuation Plans (PEEPS) were in place for people who used the service. We also saw emergency evacuation equipment was available on the stair wells.

The registered manager said they did not have any environmental risk assessments but carried out visual checks and took action where appropriate. We noted that during our visit in one of the corridors there was an area that was uneven and a potential trip hazard. The registered manager and deputy chief executive said the unevenness was structural and had in the past been investigated but they were unable to find a solution, however, this was not recorded. This meant the provider could not demonstrate they were identifying and managing risk. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The deputy chief executive said they would look into this again and ensure a formal risk assessment was completed. They also agreed to look at other areas of the premises that may need risk assessing.

Bedroom doors automatically locked when they were closed, however, we saw one person was in their bedroom and unable to unlock the door so could not get out; we could not find a risk assessment for this in the person's care plan. Staff said doors were often kept locked to protect people's belongings and stop others from entering bedrooms. We looked around the home when we first arrived and noted that staff had used bedside cabinets to

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Is the service safe?

prop doors open. This is not a safe mechanism for keeping doors open. The deputy chief executive said they were aware the locks were not ideal; they had considered other options in the past but agreed to review this again.

Each person had a care plan that identified how care should be delivered and assessments for areas of identified risk. However, it was unclear how they determined levels of risk because the service was not using evidence-based risk assessment tools which help identify the level of risk and appropriate preventative measures. This puts people at risk of receiving inappropriate or unsafe care. The registered manager said they had recognised this was an area they needed to develop and were reviewing a range of risk assessment tools before they decided which they would implement. The registered manager said they had already recognised they needed to introduce a falls risk assessment and were planning to introduce this in the next month. We saw people's weight was regularly monitored and where concerns were raised advice was sought from other health professionals.

People we spoke with told us they felt safe and that staff were kind and gentle and did not handle them roughly or hurt them. One person said, "It's nice here they are good to you." A relative said, "It's good here, there is always someone about, I feel happy to leave him and I know he is safe."

Staff we spoke with said people were safe. They said systems were in place to protect people from bullying, harassment, avoidable harm and potential abuse. We looked at the provider's log of safeguarding incidents and found referrals to the local authority had been made where abuse or allegations of abuse were made. We saw each incident had been documented and action had been taken to prevent repeat events.

We were told that the staff had undertaken adult safeguarding training within the previous 12 months and the training records confirmed this. The registered manager and deputy managers had recently enrolled on an externally assessed 'safeguard' course. Staff could describe the types of abuse people may experience in residential care settings. The staff we spoke with understood how to report a concern about abuse and were confident the registered manager would treat any concerns seriously.

The staff we spoke with were aware of their responsibilities under the Mental Capacity Act 2005. We saw that people's capacity to make decisions about different aspects of their care and treatment had been assessed and the recorded in their individual care plan. Staff told us that where people lacked capacity decisions about their care and treatment were made according to "best interest" principles and wherever possible this included the involvement of family members.

Staff told us they had not received training in the use of restraint and had not found it necessary to use restraint in order to provide care and treatment. They said that they were able to manage any behaviour that challenges or altercations between people using calming language and distraction techniques.

We noted that key pad security controls were in place at the main entrance to the home and between the individual residential units although, at times, the interlocking door between the ground floor units was open and some people accessed both units. None of the people living at the home were permitted to leave the building unaccompanied. The home however did encourage people to go out with friends or relatives. Staff also told us they responded to individual requests and assisted people out for walks or to have a cigarette whenever possible.

We were told that three people living at the home were subject to Deprivation of Liberty arrangements to ensure they were kept safe and received appropriate care and treatment. The registered manager told us that following a recent court ruling on the interpretation of the Mental Capacity Act 2005 people who used the service were being reviewed to assess whether they were subject to restrictions on their liberty. We saw the provider had copies of the Deprivation of Liberty Safeguards (DoLS) procedures.

The registered manager told us that staffing levels were determined by the deputy chief executive and were based on the levels of dependency of people living at the home. The deputy chief executive oversaw the management of the service and spent time at the home most weekdays.

Staff were visible and present in all three units during the inspection and regularly checked to make sure people were safe. For example a care worker kept popping into the lounge where people were sitting. She explained she was not allowed to leave the unit while on duty.

Before we inspected the service we received information of concern that suggested staff did not have time to wash and take people to the toilet and people were going to bed

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Is the service safe?

early. At the inspection some of the staff we spoke with felt there were not always enough staff on duty to meet people's needs in a timely way although staff told us people were safe. We observed that in one of the three residential units there were 12 people. Staff we spoke with said at least ten of the people from this unit required assistance from two members of staff. We looked at six people's records from this unit and these confirmed all six required two members of staff to provide personal care and/or carry out any moving or handling procedures.

During the night there was one member of staff based in this unit with a 'floating' member of staff to provide assistance if required. The night members of staff we spoke with said people generally didn't get up during the night so they were felt staffing levels were adequate. We saw that there were two care workers working on each unit during the day with the option of calling on a third member of staff at busy times to assist in meeting the needs of all 12 residents. An activity co-ordinator also spent time with people and worked at the home five days a week. The registered manager said she was also available to assist at busy times. We concluded there were sufficient staff to keep people safe although there were times when staff were extremely busy and unable to spend quality time with people.

Staff we spoke with said they had gone through a recruitment process before starting work at the home. The registered manager told us the recruitment process was robust and this included carrying all the relevant checks and interviewing all staff prior to employment.

We observed staff assisting people with restricted mobility throughout our inspection and saw they were given reassurance, handled appropriately and at their own pace when being assisted to move around the home.

Staff told us they had received training in the correct use of equipment, for example hoists, and were confident they could carry out procedures such as moving and handling appropriately. There was an annual service programme for hoisting equipment and routine maintenance was carried out by the home's handyman.

The registered manager said she carried out random observations to ensure staff were using the appropriate equipment and manual handling techniques. The registered manager told us checks and services were carried out on the premises to make sure they met safety requirements and this included internal checks and servicing from external contractors. When we looked around the home we saw the premises were well maintained and measures were in place to help keep people safe. For example, doors and gates leading to staircases and to the outside of the home were locked and required a fob to open them.

There were effective systems in place to reduce the risk and spread of infection. We looked around the home which included all communal areas and a number of bedrooms and saw the home was clean and hygienic. We noted a bath chair and grab rails in one of the shower rooms had patches of rust. This is a potential infection risk and the registered manager said they would replace these pieces of equipment. The local authority had inspected the kitchen area in January 2014 and awarded the home a five star rating, which is the highest rating that can be awarded.

Staff told us there was always a supply of personal protective equipment (P.P.E) which included, gloves, aprons and sanitising hand wash. When we looked around the home we saw P.P.E was available.

Requires Improvement

Is the service effective?

Our findings

Staff said they felt well supported and were able to ask for advice from the registered manager or raise concerns at any time. Staff had a programme of training, supervision and appraisal. The provider sent us information before the inspection that showed all staff received regular supervision and those who had been employed for over 12 months had received an appraisal.

Staff told us that following appointment they underwent a minimum two day or shift induction at the home. We were told the induction period could be extended if necessary, for example, when the member of staff had not previously worked in a care home. The induction period involved working with an experienced member of staff, observing procedures and gaining knowledge of people who used the service and their individual needs. Staff we spoke with told us they followed an induction checklist and had to demonstrate their competence before being formally "signed-off" to work unsupervised. We saw induction checklists which confirmed this.

Records showed a range of training courses had taken place throughout 2013/2014. The registered manager said the external training provider asked staff to complete a knowledge test at the end of each session. However, we were concerned that the training provided would not equip staff with the knowledge and skills because staff completed several training sessions in one day, sometimes up to ten and these could include dementia, safeguarding, first aid, health and safety, moving and handling and infection control. This meant staff may not have spent sufficient time to fully understand how to deliver care safely and to an appropriate standard.

We recommend that the service considers the workforce development body 'Skills for Care' guidance for developing the skills, knowledge and leadership of the workforce.

We observed lunch in all three units and found, in the main, people received good support and their nutritional needs were met. The atmosphere during the meals was relaxed and informal and there was no sense of people being rushed. People were offered a choice of hot meal with a selection of vegetables and pudding. In one unit staff used the pictures to help people make their choices. In another unit staff showed people the options when they were serving the meals. Food looked appetising, portions were generous and people were offered more.

Staff encouraged people to eat and offered support where people needed assistance. One person indicated they did not like their meal and staff replaced this with the alternative option. Another person was upset because they were given a large plate of food. The care worker comforted them and brought another smaller plate of food. People enjoyed the food. One person was not asked if they wanted more to eat even though their care plan stated they should be offered a second portion. This was discussed with the management team who said they would remind staff that additional portions should be offered. Comments from people who used the service included, "That was lovely." "It's always very tasty and they fill you up." "It's not bad." "I don't like it." "We're fed pretty well." A relative said, "Its good and he's put weight on."

Hot and cold drinks were served with lunch and during the day, however, outside of the routine; cold drinks were not readily available. Jugs of water were not available in people's bedrooms or in the lounges. A water dispenser in the dining room was empty. This meant people did not have access to fresh water.

The menu was varied and included at least two choices at all meal times. A cooked breakfast was available every day. The deputy chief executive advised the menus were under review and a consultation was commencing.

Staff were knowledgeable about people's dietary needs and were able to name individuals and their specific requirements, for example whether people were diabetic, gluten intolerant or required their food to be blended. They told us that all staff had a responsibility to ensure people were well nourished and report any concerns that a person was not eating well. Staff told us concerns about anyone who was not eating well were raised at shift handover meetings and noted in their daily records.

The registered manager told us they observed how people were supported with their meals. People at risk underwent risk assessments and if appropriate were placed on weekly weight programmes with the support of the dietician and in some cases the nurse practitioner. A visiting health professional said, "The standard of nutrition is very high.

Requires Improvement

Is the service effective?

They regularly offer people smoothies and have protected meal times. Referrals come through at appropriate times if people are losing weight or if they notice and deterioration in their condition."

People aged over 75 years had a named GP and the advanced nurse practitioner from a local doctors' surgery visited the home every week. The provider had also made arrangements for a dentist and optician to visit the home on a regular basis to assess people's need and provide any treatment required. The district nurse visited the home three times each week.

We looked at people's care plans and these contained information about visits from health care professionals, for example GPs and the district nurses. Where advice was given we saw this was implemented and followed by staff at Pennine Lodge Care Home. During the inspection we spoke with two visiting health professionals. They both said the home ensured people's health care needs were met. One health professional said, "The standards here are very good. I have absolutely no concerns." Another health professional said, "I'm in several times a week and think they are very good. They always follow advice given if people need pressure relieving equipment."

The home was well decorated and furnished. The registered manager told us that people who used the service and their relatives were invited to be involved in deciding how their rooms should be decorated. Some of the bedrooms were personalised with trinkets, photos etc. Staff told us family members often brought items and helped people personalise their rooms. However, we noted in some bedrooms there were bare surfaces and blank walls.

We observed people in communal areas where they appeared relaxed and comfortable. People were able to move around areas of the home freely. This included moving between two of the units and accessing various communal areas. However, we noted people's bedrooms were locked during the day which meant people were unable to return to their bedrooms unaided. Some people had assessments which said, 'unable to manage a door key due to poor short term memory'.

Some communal areas were spacious but others were quite small. Two dining areas were small and staff struggled to support people at lunch because there was limited space. Staff also had difficulty getting the hoist and wheelchairs in and out of one lounge.

Good

Is the service caring?

Our findings

Comments from people who used the service included, “They are good they will do anything for you.” “They’re really lovely.” “Wonderful people these are.” A relative said, “As soon as I came in here I had the feeling that this was the right place. You know when something is just right and it felt good, home from home. I could move in here myself.” One relative said overall they were happy with the care but on occasions they had noticed their relative wearing clothes they didn’t recognise.

We did not receive any negative comments about the staff and throughout the inspection there was a pleasant and relaxed atmosphere. We saw caring interactions when staff provided assistance. Staff provided physical and verbal assurances if people were confused or distressed. Staff spoke kindly and knelt down to speak at eye level with people sat in chairs. The affectionate manner was easy and natural and in some cases this was reciprocated by people who used the service.

Some people who had complex needs were unable to tell us about their experiences in the home. We spent time observing the interactions between staff and the people they cared for. Some observations were done using the Short Observational Framework for Inspections (SOFI) tool and others were done without using the tool.

During our observations we found people responded in a positive way when staff engaged with them. People were watching and engaging with other people who used the service although this was mainly the same two people. Staff were calm and patient and explained things well. They were busy but at every opportunity interacted with people and checked people were comfortable. Staff knew the people they were supporting and chatted to them about family and friends.

Staff were confident that people received good care. They said care plans were sufficiently detailed to enable them to provide appropriate care and treatment. The registered manager and deputy managers carried out random checks and observed how staff supported people. These included observing how people’s dignity was maintained, for example during hoisting.

Staff told us they encouraged people to do things, such as dressing and eating, for themselves, where possible but time was sometimes an issue. We observed one person sat in a lounge chair, who had been walking unaided earlier in the day, attempting to stand up. A member of staff stood by them, ready to assist if necessary, but allowed them time to try several times to gain their balance and stand up on their own.

The registered manager said they had systems in place to make sure people received appropriate care at the end of their life. For example they accessed support from the district nursing team. The registered manager was confident when people reached this stage in their life they received appropriate care although they had recognised people’s care plans did not generally cover end of life. They had identified that the planning stage needed to be carried out at an earlier stage and were developing these. The provider had an end of life care planning policy and procedure which the registered manager said they were implementing but at the time of the inspection had not introduced. They had gathered information which included a ‘preferred priorities for care’ document and were starting to make arrangements to talk with people who used the service and relatives so they could prepare for the future. Staff told us they had received end of life training, and policies and procedures were available.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in January 2014 we told the the provider they may find it helpful to review people's sleeping and resting preferences and assess how these were recorded and monitored.

This was because the arrangements that were in place did not provide assurance that people's morning routines were personalised. When we arrived at 7.30am we found all but four of the 36 people who had stayed overnight were dressed and sat in the lounges waiting for their breakfast to be served at 8.00am. Some people appeared to be asleep in their chairs. In May 2014 concerns were also raised about times people were getting up and these were shared with the provider.

On the first day of our inspection we arrived unannounced at 7.10am and found 23 of the 38 people were up; 21 were dressed and sitting in the lounges. We could not establish from speaking with people if they had chosen to get up but a number were asleep. We saw that people's beds had been stripped by the night staff and were ready to be remade by the day shift staff. The night staff we spoke with told us it had been a typical morning, and people had chosen to get up or were up because their beds were wet. Two night staff said they started getting people up around 5am. They said the majority of people who were up required assistance from two staff. Staff also confirmed that even though some people were up at 5am by 7.30am people had still not been offered a drink.

We looked at care records but could not determine the times people usually got up because they were not always recorded. Most care plans were standardised and did not identify when people liked to get up. They usually stated people liked to 'get up at various times' but no further information was provided. We concluded that staff were getting some people up early to suit the convenience of staff. People's individual needs or preferences were not met because staff had not given people the care they needed and the delivery of care was not provided at the time that suited individuals. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although the times for getting people up were not specific, care plans generally identified how care should be delivered and contained good information about the person. This included an overview about the person and their health needs. Pre-admission assessments and care plans covered moving and handling, personal care, eating and drinking, continence, communication and weight monitoring. Care plans gave staff information about the best way to support the person. For example, in one person's care plan we saw that when sitting down to a meal 'everything apart from their plate and spoon should be moved away from them' because too many items' caused the person to be confused.

Care plans were reviewed monthly. We were told they were fully updated every three months and staff were asked to share their observations and contribute to the reviews. Many people living at the home were unable to express their views about their care and support. Staff told us that where people had capacity they were encouraged and support to be involved in their assessments and care planning. And where people could not plan their own care their relatives were welcome to contribute. There were however no formal arrangements for this and it was unclear how relatives were notified or informed about the timing of reviews.

During the inspection we noticed some people spent time in a different unit to the one where they lived but it was not clear why. We received different feedback from different staff about the reasons for this. For example, one member of staff told us a person was spending time in the downstairs unit because there were tensions with another person they lived with and it was safer. Another member of staff said it was the person's preference. Staff told us another person had been brought to the upstairs lounge because she was prone to wander and could more easily be supervised there. We looked at the relevant care plans and risk assessments but these did not contain any information about spending time in an alternative unit which meant this aspect of their care was not formally assessed and planned to ensure it met their identified needs.

People were involved in activities within the home and the local community. People who used the service made the following comments: "I like the sing songs and sometimes we go out." "I like to go out in the garden, I turn the soil over and sit and have a chat" and "I have no family, have made friends here, I can have a chat." Two people had enjoyed

Requires Improvement

Is the service responsive?

gardening before they moved into the home and were able to continue with this. One relative said, "He loves to garden, we had a lovely one at home, he goes out here and does a bit."

An activity co-ordinator worked at the home five days a week. A timetable of weekly activities and planned entertainment sessions were displayed on a notice board for information. For example, a concert was being held in the home in September 2014.

On the first day of our visit an activity session took place in the morning and ball games were in the afternoon. We were told people were encouraged to suggest activities, including external entertainers. On alternate weeks people were able to visit a dementia café, where there were opportunities to talk with other people and also visits to "singing for the brain" sessions in Halifax. On Tuesdays people had access to a hydrotherapy pool. Risk assessments had been carried out to ensure people's safety when using the pool. Staff told us people enjoyed using the pool, particularly those with limited mobility, and the psychological and physical benefits such as improving their muscle tone.

We saw examples of 'life histories' which included family photographs and special events in the person's life. These files were kept in the person's room for them to look at and for staff to spend time with them talking about the pictures. The activity coordinator was expanding this project to gather more background information to help build up the life histories. We saw that records were kept to show what activities people had taken part in and identify who had not engaged with planned activities.

None of the people who used the service we spoke with raised concerns about their care. One person said, "They know you so well here, pretty good, if there was anything wrong they would know." We spoke with visiting relatives who told us they could talk to staff and members of the management team if they had any concerns. One relative said, "I've spoken out a few times if ever I've been worried and they've always listened and sorted things out." Relatives said they could visit anytime and were welcomed.

The complaints policy was displayed in the home. The registered manager said they took appropriate action to deal with any concerns raised which helped prevent them escalating to formal complaints, and they had received not received any formal complaints in the last two years so had not needed to carry out a complaints investigation.

The registered manager talked to us about the arrangements in place to ensure people received a positive experience when they moved into the home. She said they completed an assessment prior to admission, visited the person and encouraged them to visit Pennine Lodge Care Home. We looked at an assessment for a person who had recently moved into the home. This was very detailed and included good information about the person's needs and health professionals involved in the person's care. They had considered how the person would continue to receive important health care support to ensure their needs were met. The registered manager also provided examples where people had experienced well co-ordinated care when they had transferred between services, such as hospital. The registered manager said people who used the service had a document called 'this is me' which helped other professionals support them in an unfamiliar place.

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Our findings

At the inspection in January 2014 we found the provider was in breach of regulation because they were not fulfilling their responsibility to seek the views of staff and assess these in relation to the standard of care at the home. The registered manager and deputy chief executive talked about changes they had made since the last inspection. They said the frequency of staff meetings had increased since our previous visit and individual supervision had also improved. Staff we spoke with said they felt able to raise concerns and they would be considered. Staff were aware of whistleblowing procedures and said they would report their concerns to either CQC or the local safeguarding authority if necessary. One member of staff told us things hadn't changed and they did not feel staff could come forward to question practice for fear of being bullied and ignored.

The registered manager and deputy chief executive discussed the systems for monitoring quality and safety. At the time of the inspection they had records of accidents and incidents, including safeguarding incidents but they did not have a system to look for any patterns and trends. The registered manager said they had completed an audit about medication but this had not picked up the concerns we found with management of medicines during our inspection visit. The registered manager and deputy chief executive said they had identified that they needed to develop their auditing processes and introduce additional data checks to ensure they had an overview of the service.

The provider had informed CQC about a number of significant events that had occurred but they had failed to inform CQC about all reportable events. They should have reported two safeguarding incidents but had failed to do so. The registered manager said this was an oversight and assured us all future inciodents would be reported.

We looked at the 'registered provider's visit to the care home' reports which showed the proprietor had visited and reported on different aspects of the service. They said they found the home was clean and tidy; people were engaging in a good range of activities. Health professionals had visited and this had been recorded in people's care files. The proprietor had reported that they had found out about the experiences of people working at the home through 'the interview stage, going through their application, looking at their past history of employment, training courses attended and qualifications'. The proprietor had written the same in both July and August 2014 reports about what people working at the home had told them. The report stated 'staff were pleased with the outside CCTV (Close Circuit Television) especially the night staff with the added security to their cars and the home. They enjoy the multiple choice of training courses and the support they get for training and development and all the training courses being paid for'. Although this was positive feedback there was no information about which staffthey spoke with and if this was the same feedback used for both reports.

In May 2014 the home received information of concern about the morning routine at the home which suggested it was not personalised and responsive to peoples' needs. The concerns were discussed at a staff meeting. We looked at the staff meeting minutes but these indicated the concerns were dismissed and blamed on a disgruntled member of staff. They read, 'The complaint was fully discussed. The manager said we believe it is not true. All staff were asked individually …each one said it was totally untrue. None of the residents were got up at unreasonable times and they were given drinks and snacks if they wanted one and they had a choice of clothes. The staff were appalled at the allegation'. The concerns raised were similar to those found during our inspection. We therefore concluded that the investigation carried out by the home was not thorough, questioning and objective. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were asked to comment on the quality of care through surveys. The provider had completed a survey in June 2014 and asked for feedback from relatives. We looked at the returned surveys and saw comments were very positive. One relative had stated, "As a carer I have been amazed at the care and consideration for (name of person). She believes she's in a four star hotel. Visitors are always welcome and their views and comments are well received."

At the time of our inspection the service had a manager in post who was registered with the Care Quality Commission in May 2013. Staff we spoke with said the registered manager was doing a good job and was popular with staff. They said the registered manager was approachable and

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would listen to concerns and ideas for developing the service. The registered manager said they had a good relationship with other agencies and implemented any recommendations and suggestions to improve the service.

During the inspection we spoke with two visiting health professionals. They told us the home worked very effectively with their service. One health professional said, "We work very closely and very well together. They always accompany us when we visit people if it's appropriate. Referrals always come through at the appropriate time if they require support, whether this is for someone losing weight or a general deterioration in their health." We looked at returned surveys from health professionals which were sent out by the provider in June 2014. Of the ten on file, seven assessed the service as 'excellent' and three as 'good'.

Staff we spoke with said they understood their roles and responsibilities, and the role and responsibility of colleagues. When we spoke with people about the service there was some confusion about who was managing the service. A member of staff and a relative both referred to the deputy chief executive as 'the manager'. We talked to the registered manager and the deputy chief executive about the confusion and they acknowledged this was historic. The deputy chief executive had been actively involved in the management of the service for many years and even though they were no longer managing on a day to day basis some people still referred to her as the manager. They both said there had been a gradual recognition of the management structure and the registered manager was seen by most as the person in charge. The deputy chief executive was not planning to spend as much time at the home from September 2014 so they believed the managerial roles would then be much clearer to everyone.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate by means of planning and delivery of care in such a way to meet the service user's individual needs and ensure the welfare of each service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect service users and others against the risks associated with unsafe use and management of medicines.**