Canterbury Care Homes Limited

Pennine Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection of Pennine Care Centre took place on 5 and 6 May 2015. It was unannounced. The home provides care and support for up to 64 older people, including people living with dementia. On the day that we visited forty nine people were living there. The home was divided into two units, Pennine Unit and Moorland Unit . People in both units have access to communal areas and gardens.

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

We spoke with six people who used the service, two visiting relatives and a visiting professional. We also spoke with members of care staff. We observed care and support in communal areas, spoke to people in private and looked at care and management records.

Our last inspection on 5 August 2014 found three breaches in legal requirements. These were in relation to care and welfare of people who use services,

Summary of findings

safeguarding people from abuse and assessing and monitoring the quality of service provision. We found the service had made improvements in their safeguarding procedures but the requirements of the other regulations had not been met.

We found that the provider had still not fully ensured that the planning and delivery of care met people's individual needs. Quality assurance systems were in place but they were ineffective as risks to people had not been monitored or responded to. People had not been fully protected from the risk of cross-infection because areas of the home were unclean and the provider's infection control policy was not being followed. Medicines were stored and administered safely. However, failures in ordering systems meant that some people had not received their prescribed medicines.

Staff had been recruited safely and received training. However, staff did not always put their training into practice, particularly with regard to meeting people's dementia care needs. There were sufficient numbers of staff to meet people's personal care needs, but staff did not always have time to speak with people on an individual basis

People had individual care plans in place but these were not always based on how people would like their care to be delivered. People were not always involved in decisions about their care and how the home was run. Activities took place at the home but some people told us they were bored. There was limited evidence that staff supported people to engage in meaningful activities and interests.

Staff understood how to safeguard people from the risk of abuse. We saw that mostly, people were treated with compassion and respect from the care staff. However, on a few occasions we observed care practices that fell short of this.

People had a choice of meals and vegetarians in the home were catered for. People's health needs were monitored but some people had not received dental care in a timely manner.

Requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards were met.

We found three breaches of the Health and Social Care Act and you can see what actions we told the provider to take at the back of the full version of this 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?
The service was not always safe.

People did not always receive their prescribed medicines due to issues with the ordering system. People were not prevented from the risk of cross-infection as areas of the home were unclean.

Staff had been safely recruited and there were sufficient numbers to meet people's needs. However, staff had limited time to interact with people.

People were protected from the risk of abuse due to improvements in the providers safeguarding procedures.

Requires improvement

Is the service effective?
The service was not always effective.

Staff had received training but this was not always put into practice.

People were supported with their needs in relation to eating and drinking and there was a choice of food available.

Requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards were understood.

People's health had been monitored but there was a delay in people receiving dental care

Requires improvement

Is the service caring?
The service was not always caring.

Most people's privacy and dignity was respected and promoted but we saw examples of where this was compromised.

People's independence had not been consistently promoted.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's experience of care did not meet their individual needs.

There was a lack of stimulation around the home for people with dementia.

Care records were completed and up to date but there was limited evidence people had been involved in decisions about their care and support.

Requires improvement

Is the service well-led?
The service was not well-led.

Requires improvement

Summary of findings

There were systems in place to assess the quality of the service provided in the home; however we found that these were not effective. The systems used had not ensured that people were protected against the risk of infection or appropriate and timely administration of medicines.

Staff and people living at the home were not always asked for their views about how the service could improve.

Pennine Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on the 5 and 6 May and was unannounced.

The inspection team was made up of two inspectors 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.

Prior to the inspection we looked at the previous inspection report, information we had received from the local authority and statutory notifications sent to us by the service. A notification is information about important events which the service is required to send to us by law.

During our inspection we spoke with six people who used the service and two people's relatives. We also spoke with two care staff, two senior care staff and the registered manager, area manager and a visiting professional.

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

During our inspection we looked at a number of records including six people's care plans and records in relation to the management of the service such as policies and procedures.

Requires improvement

Is the service safe?

Our findings

At our last inspection in August 2014 we found that the registered manager was aware of the correct procedures to prevent and respond to allegations of abuse. However, staff were not aware of how to record and respond if concerns arose about possible abuse or neglect**.** This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**.** Following that inspection the provider told us what action they were going to take to rectify the breaches and at this inspection we found that improvements were made.

We saw that people were cared for in a safe way. Discussions with staff and a review of records showed that staff were trained in how to safeguard people and how to recognise signs of abuse. Staff we spoke with were aware of their duty of care to people and knew how to report any incidents or allegations of abuse, including contacting the local authority if they needed to. Staff all said that they would challenge their colleagues if they observed any safeguarding concerns, as well as reporting to a senior member of staff. This meant that people were kept safe from the risk of harm.

The home did not have appropriate systems in place for returning medicines to the pharmacist. For example we saw some medicine that should have been returned to the pharmacist but was still in the medicines cabinet, this meant that out of date medicine could have been given to people and so their therapeutic purpose may have been compromised.

Some medicines were not ordered in a timely manner leaving people without their prescribed medicine. For example, one person had not had some of their medicines for two days because there was no stock available. In addition, the service had run out of aspirin for another person. This had been raised by the registered manager with the GP and advice from the GP was followed. However, this meant that people had not received their prescribed medicines and so could be at risk from a recurrence of their medical condition or suffering unnecessary pain. It also meant that medicines were not managed in a way that ensured people were given their medicines as prescribed.

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

However, we saw that medication administration records (MAR) had been completed appropriately and that medicines were stored according to national guidance.. We saw that staff checked the temperature of the medicines store and when there was a fluctuation it was addressed.

One relative told us that they felt that the cleaning needed to be improved and that they had cleaned the toilet in their relatives' room themselves. They also told us that there were stains on the bedding and that the bedding had not been changed.

The provider did not have processes in place to ensure that the home was hygienic. The home was visibly dirty and there were parts of the home that had malodours. There was a cleaning rota in place, however this was not followed. The fridge in the Moorland suite was chipped and the interior was dirty. Tea, coffee and sugar were stored in open containers that were not clean and the sinks that staff used to wash up in after meals were stained and had ingrained dirt around the taps. This meant that people were at risk of cross infection as the equipment used to prepare food was not clean.

The provider had a policy on infection control, however this was not followed. For example the provider's guidance stated that 'the commode pans should be put through the bedpan washer disinfector' a machine that washed commode pans at 80 degrees, however a machine was not available in the home and staff were hand washing pans in hand hot water which meant that the provider could not be sure that they were free from infection. Commode pans were hand washed with water at less than 47 degrees Celsius which was not at a sufficiently high temperature to kill bacteria. This put people who lived in the home, and staff, at the risk of cross infection.

There were no systems in place to ensure that mops used to clean the floors throughout the home were left hygienically clean. The cleaning equipment storage rooms and the sluice rooms were chaotic and unclean; therefore staff could not be sure that the equipment they used eliminated infection in the home. We were concerned about the lack of cleanliness in the home and showed the regional manager and registered manager those areas of the home we had concerns about. Our second day of inspection we found the cleanliness of the home had improved slightly but people were still not fully protected from the risk of cross-infection.

Requires improvement

Is the service safe?

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Most people said that the care staff were kind and caring and very helpful. One person told us "I'm safe here, there's no bullying or anything like that". A relative we spoke with us told us they thought their family member was safe in the home.

We saw that staff were skilled in recognising when a person's behaviour could put a person, or other people, at risk from physical harm and that they intervened. This was done in an appropriate way to diffuse the situation to ensure all people in the home were kept safe.

We saw that risk assessments had been carried out on the environment and that the provider had recognised that some parts of the home were showing signs of dampness. Action had been taken to remedy this and this helped to ensured that the physical environment was safe for people to live in.

People told us that mostly there were enough staff to help them when they required assistance. One relative told us that there was always someone around if their family member needed any medicine and that they were watching, observing and reacting to their needs.

We saw that there were sufficient staff on duty to meet people's needs. However, staff did not always have the time to talk to people other than when they were providing care.. Staff told us that when people were off sick they were not always replaced and that this sometimes meant other staff were not always able to respond to people in a timely manner.

There was a recruitment process in place to ensure that staff who worked at the home were of good character and were suitable to work with people who lived in the home. The provider carried out identity and security checks on staff prior to them starting work at the home.

Staff confirmed with us that they did not take up employment until the appropriate checks such as proof of identity, references and satisfactory Disclosure and Baring Service (DBS) checks had been obtained which ensured that the suitability of the care staff who worked in the home was thoroughly checked.

Requires improvement

Is the service effective?

Our findings

Due to people's complex needs, some were not able to tell us their views about the skills of the staff that supported them, however, those who were able to do so said that the staff supported them well.

A relative told us they felt care staff had the skills and knowledge to know when their relative had a restless night and if so, that they left them for a little longer in the morning to sleep. A visiting professional told us that the care staff quickly identified when they couldn't meet people's needs. They also told us staff were very good at persevering with people when they were anxious and took their time to understand them.

We saw that staff were trained to support people with their personal care. Staff had also received dementia care training, however we saw this was not always out into practice. For example, care staff did not always communicate with people in a way that acknowledged their dementia care needs. This meant that people living with dementia had very little stimulation and were not always supported to interact or engage with their environment and the other people living in it. Staff had not received training in mental health awareness despite people living at the home having mental health needs. This meant that people may not have received care which was based on best practice.

Staff told us that they attended formal supervision meetings but that these were irregular and not in line with the policy in the home. One staff member told us that they only had supervision if they had done something wrong which meant there was no collective learning from good practice.

The registered manager had a good understanding of the Mental Capacity Act (MCA). The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Care staff we spoke with were aware of the MCA and had some understanding of the requirements. Records showed that care staff had undertaken some training in this area. We saw that mental capacity assessments had been completed for people to assess whether they had the capacity to make informed decisions and that best interest decisions were recorded. We also found that five people had a Deprivation of Liberty Safeguard (DoLS) in place and that these were held within their care records. The DoLS are a law that require assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. The provider had recognised when people's care was being delivered in a way that may have deprived them of their liberty and followed the appropriate processes to ensure this was done legally and in people's best interests. However, care staff were unable to identify which people were subject to a DoLS authorisation and therefore unaware of how this may have impacted on the care and support they provided. People told us that they enjoyed the food and that they got three meals a day. There was a choice of food available, including a hot option at tea time. We also saw that vegetarians were catered for.

Care staff were, mostly, aware of people's needs in relation to eating and drinking and encouraged people when required. For example, we saw one person getting anxious at the table and walking away from their food. However, a member of care staff followed them, with their food, so they could eat in a place of their choice. People were assisted to eat in a pleasant, unhurried and patient manner and there was a pleasant ambience in the dining room. Salt and pepper was available on a side table but not on individual tables, this meant that the people who did not have the skills to ask for what they wanted were left without. We saw one person at the dinner table who was unable to help themselves to a drink and struggled for many minutes, the care staff did not notice this until we pointed it out to them, this could have meant that this person did not have appropriate fluid intake.

People who could make their own snacks did not have the facilities to do so and snacks were not freely available. This meant that staff had to leave the area to go to the kitchen which left fewer care staff available to meet people's needs. It also meant that people were not supported or encouraged to be independent in maintaining their own nutritional needs.

People did not always have access to appropriate health care professionals. For example, we saw that a significant proportion of people who used the service had tooth decay and we found no systems in place to ensure people had access to dental care in a timely manner. This may have resulted in people being in pain before access to treatment

Requires improvement

Is the service effective?

was arranged. When we discussed this with the registered manager they told us that dental practitioners were unwilling to visit the home and it was difficult to send personal escorts with people to the dentist.

People had access to a GP and district nurses and people's mental health was promoted in some instances. For example, the local mental health team visited the home regularly and left direction for staff to assist them to meet people's needs and to recognise when their mental health was at risk. One person told us that their mental health was promoted and they said "I've just had my review with my psychiatrist and, it has been decided, that this is the correct place for me" they went on to say that they felt that care staff could recognise any change in their mood and act accordingly.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us that they felt well cared for and made positive comments about the care provided, we were told that the carers were helpful, polite, friendly and respectful. One person said “they’re all very friendly”, another said “they’re polite, friendly and respectful, they’re good that way”. One relative told us that staff were very kind and compassionate and showed consideration to their relative. A visiting health professional told us that they had seen that staff were caring and committed. We saw that the care staff were kind and caring; they knew the people they were caring for and had a good rapport with them. When we looked at care plans we saw that they encouraged positive caring relationships between the care staff and the people in the home.

Some people were supported to maintain their independence and were able to come and go from the home as they chose. Care plans encouraged care staff to support people to be as independent as possible. However, we saw that people who needed assistance to go outside of the home were not supported to do so and some people who should have been able to had not left the home for many months.

However, people who were living with dementia were not always supported to maintain their independence. For example, the physical environment did not have sufficient signage to assist people to find their bedrooms, the toilets, or other facilities in the home. This meant that people living with dementia were not supported to be independent.

During our inspection we saw that most care staff endeavoured to treat people with respect, promoted their dignity and made them feel that they mattered. For example, they knocked and waited for permission to enter people’s rooms. We saw two care staff using an electric hoist to lift a person from their armchair to a wheelchair and this was done in a caring and careful manner. The person was addressed by name throughout the process along with explanations of what was being done and why.

However, people’s privacy and dignity was not always respected in the home by some of the care staff. Care staff did not have enough time to spend ensuring that people were cared for in the way that they wished and the focus was on tasks to be completed. For example, one member of staff who was assisting a person with eating was called away to deal with something else and only returned to continue to assist the person with eating some time later which meant that their food was likely to be cold. On another occasion care staff were trying to complete two tasks at the same time and were unable to focus on the person they were assisting. This resulted in the door to the toilet being left open when a person was using it which meant their dignity was not maintained.

Requires improvement

Is the service responsive?

Our findings

During our last inspection we found the provider had not ensured people received care that was individual to their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We found sufficient improvements had not been made.

People who were living with dementia were not always supported to maintain their independence and we saw nothing to stimulate or to offer comfort to them. People living with dementia need extra support in their day to day life to express their preferences, wishes and aspirations and we saw that the support in place in the home for this was not adequate. People were not offered stimulation or comfort when required and staff were not responding to people in a way that recognised their specific needs. We saw that people were sitting in front of the television all day and this meant that people living with dementia were not receiving care that was personal to them.

Some people we spoke with told us they were bored and would like more to do. There was limited evidence that people were supported to spend time doing things they were interested in or which were important to them as individuals. Their likes and dislikes in their daily lives had not been explored in any depth and, though there was some evidence of people's likes and dislikes in the care plans, we could not see how this was put into practice. We discussed this with care staff and they did appear to understand the likes and dislikes of people but there was insufficient time for them to focus on this. This meant that people were inactive during most of the day. People's wishes and aspirations were not identified and they were not supported to follow their interests.

People had pre-admission assessments to ensure that the home could meet their needs and this information was recorded in care plans. However, some of the care plans had not been updated for several months which meant that care staff could not be sure that they were working with up to date information. On the day of the inspection we did not see any evidence of people being actively supported to express their views about how they wanted their care and support delivered or being asked to give their consent to care and treatment.

We saw that there was an agency member of care staff working in the home but they had not had an opportunity to look at the care plans to enable them to work with people in a way that was responsive to their needs. When we discussed this with the registered manager they told us that they would only work alongside more experienced members of staff. However, we saw them working alone at some points during the day. This meant that people were receiving care from care staff who were not aware of people's preferences and wishes in the way that they received their care.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with were aware of the complaints procedure in the home and they told us that they knew how to make a complaint and would do so if they wanted to. Visitors we spoke with told us that complaints were responded to but the cause of the complaint was not eliminated. We saw that the registered manager kept a record of complaints but there was no record of how complaints had been resolved. Some complaints were about the quality of the linen and towels but this situation had not been resolved as the bed linen and towels were in very poor condition. This showed that the home were not responding to complaints or respecting views and wishes as they continued to live with poor quality linen.

At our last inspection in August 2014 we found that the risks to people's health and safety had not been adequately assessed and action had not been taken to mitigate such risks. Also, that Systems designed to protect people from inappropriate or unsafe care were ineffective and poorly managed.

Requires improvement

Is the service well-led?

Our findings

At our last inspection we found that the systems designed to protect people from inappropriate or unsafe care were ineffective and poorly managed. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager told us about the improvements they were going to make. When we visited again for this inspection we found that the registered manager had systems in place to assess, monitor and improve the quality of care people received. However, these were ineffective. Throughout our inspection we found several shortcomings in the quality of service provided in relation to cleanliness of the home, medicines management and the effectiveness of staff training. The management systems had failed to detect and respond to these issues. For example, audits were in place but they had not identified that the home was not hygienically clean and that staff were not following the provider's policy on infection control.

Care was not always delivered in a way that met people's individual needs and the systems in place to assess, monitor and improve the quality and safety of services provided were inadequate. Staff had not always recognised and responded to people's dementia care needs and there was limited evidence of people being involved in making decisions about how they would like their care or support to be provided.

The provider had conducted a quality assurance audit which identified a number of additional issues. Although a development plan with date for action was in place, the action required had not always been taken. For example, as outlined in the providers action plan, further training for staff in challenging behaviour had not happened and this meant that the home had not achieved what the provider had identified as areas to be addressed.

Although the provider had audited accidents and incidents to ensure the health and safety of the people in the service, there was no evidence that this had resulted in any learning or improved practices as a result.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not have a clear and visible presence in the home. One person told us, "I don't know the manager". We saw that the home was not managed in a transparent and open manner that allowed people and staff to have input into how the home was run. Staff felt that supervision was only used when they had done something wrong and not to support them. Due to the lack of supervisions there was little opportunity for care staff to ask questions so that they had a better understanding of how the home was run and managed. This meant that they were not given an opportunity to input into any improvements in the home.

People told us that they had not been asked to be involved in giving feedback to the home and that the current methods used to consult with people were ineffective. Residents meetings were regularly held but poorly attended. For example, a meeting held in January 2015 had no attendees and one held in April 2015 had three attendees. When we discussed this with the registered manager they were unable to tell us why or what they had put in place to encourage more people to attend. Discussions with people showed that they would like changes in the home but the registered manager had failed to capture these opinions or make changes that would improve the social lives of the people who lived there. This meant that there was no drive for improvement in the quality of the care in the home and the registered manager was not taking responsibility for continuous improvements in the service delivery.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Person-centred care **People did not receive care and support that was personal to them, that met their needs and reflected preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People had not been protected from the risk of infection. Medicines not managed safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes were not sufficient to ensure people's health, safety and welfare had been monitored and responded to.**