Four Seasons Homes No.4 Limited

Pellon Care Centre

Inspection report

200 Pellon Lane
Halifax
West Yorkshire
HX1 5RD

Tel: 01422342002
Website: www.fshc.co.uk

Date of inspection visit:
02 November 2016
03 November 2016

Date of publication:
10 May 2017

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?	**Inadequate**

Summary of findings

Overall summary

Pellon Care Centre is divided up into three units and has a total of 100 places. Pellon Manor has 35 places and provides residential care for people living with dementia. Birkshall Mews has 30 places and provides nursing care for people living with dementia. Brackenbed View also has 35 places and provides nursing and intermediate care.

The inspection took place on 2 and 3 November 2016 and was unannounced. On the first day of the inspection 93 people were living in the home. At the last inspection in July 2015 the service was found to be compliant with our regulations and given a rating of 'Good.'

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

We found variations in the quality of care within the home with an overall higher quality of care experienced on the Brackenbed View and Pellon Manor units, where established unit managers were in place supported by stable and well organised staff teams. On Birkshall Mews we identified a number of care quality issues and lack of organisation of the staff team. A service improvement plan was in place to help drive improvement in this area. However we were concerned that the provider was unable to demonstrate a sustained, high quality service over time. During the inspection of February 2015 we identified five breaches of regulation, with improvements made during a follow up inspection in July 2015. At this inspection we found further risks demonstrating that the provider was unable to sustain this improvement.

Overall people and relatives provided positive feedback about the home. They said that people were safe, well looked after and that staff treated them well, with kindness and respect.

We observed some good medicines practice, although a number of inconsistencies meant medicines were not always managed in a safe or proper way, for example the management of topical creams.

In most cases, we saw risks to people's health and safety were assessed and plans of care put in place for staff to follow. However we had some concerns over the way behaviours that challenge were managed on the Birkshall Mews unit.

Staffing levels were suitable and sufficient on Brackenbed View and Pellon Manor however we concluded staffing was not always sufficient on the ground floor of Birkshall Mews to ensure people's safety. There was also a lack of nursing staff available at times to ensure robust oversight of people's nursing needs.

Recruitment procedures were appropriate to ensure that people were of sufficient character to work with vulnerable people.

The premises was generally managed in a safe way although there were some areas which required attention.

We found appropriate Deprivation of Liberty Safeguards (DoLS) had been made by the service, although two people's DoLS conditions had not been met by the service, demonstrating a lack of appropriate care. Where important decisions needed to be made for people who lacked capacity, best interest processes were followed in line with the Mental Capacity Act (MCA).

People provided mixed feedback about the quality of the food. We saw issues with the catering providers had been identified and action was being taken to address. The mealtime experience varied, with some good positive support observed, however breakfast and lunchtime lacked organisation on Birkshall Mews and some people did not receive appropriate support.

People's healthcare needs were assessed and we saw some good examples of how people were supported to maintain good health. People had access to a range of healthcare professionals.

In most cases, staff supported people in a positive manner and treated them with dignity and respect. Staff demonstrated a good knowledge of the people they were caring for. However on Birkshall Mews , we found some staff were less familiar with people's needs and requirements and observed some instances where people's dignity and respect was not always maintained.

People's views were listened to and wherever possible acted on to help improve the service.

People and relatives provided positive feedback about the quality of the care and said care needs were met. We saw some good examples of care and support being delivered in line with agreed plans of care. However on the Birkshall Mews unit there was not always a full assessment of people's needs and we observed some examples of inappropriate or unresponsive care.

Some activities were available to people, however we concluded there was at times, a lack of well thought out and personalised activities provided to meet people's individual needs.

People and relatives generally expressed a high level of satisfaction with the service. Complaints were logged, investigated and responded to. There was generally a low level of complaints with most recent concerns relating to Birkshall Mews.

We found an open and honest culture within the home. Staff on Brackenbed and Pellon Manor told us that morale was good and demonstrated these areas were well organised with staff having clear roles and responsibilities. This was less so on Birkshall Mews where we found the lack of unit manager had an impact on staff morale and the quality of care provided.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured a consistent high quality service across the three units or pro-actively identified all the issues we found during the inspection.

At this inspection we found several breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

Whilst we found some good medicines management practice, we identified areas where medicines were not managed in a safe or proper way, for example topical creams.

People told us they felt safe living in the home. We found risks to people's health and safety were appropriately managed on Brackenbed View and Pellon Manor but we had concerns that risk management was not always appropriate on Birkshall Mews.

Staffing levels were appropriate in most areas of the home; although we found people could not always be appropriately supervised on Birkshall Mews and at times there was a lack of nursing staff available here to ensure nursing oversight of people's care.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received a range of training and were mostly up-to-date with mandatory topics. Additional dementia care training was required for some staff. Staff received supervision and appraisals; however clinical supervisions for nursing staff were overdue.

People provided mixed feedback about the quality of the food in the home. We found the mealtime experience varied depending on the area of the home. Overall we found people were supported appropriately to maintain good hydration and nutrition.

People's healthcare needs were assessed and we saw appropriate care strategies were in place to meet people's healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We found staff were kind and well meaning, and overall knew the people they were caring for well.

We observed some positive interactions between staff and people who used the service, although this was not consistently the case on the Birkshall Mews unit of the home.

People were encouraged to maintain their independence wherever possible.

People's views were listened to, recorded and action taken to act on them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although we saw some good positive examples of person centred care and support this was not consistently the case on Birkshall Mews.

Detailed care and support plans were in place but these did not always offer solutions to people's care and support needs or behaviours.

Activities staff were employed, however people and relatives told us there was a lack of stimulation and person centred activities provided.

Is the service well-led?

Inadequate

The service was not well led.

We found inconsistencies in the overall quality of the service dependant on the area of the home .Birkshall Mews was missing a unit manager and was less organised with several areas of suboptimal care identified.

Systems were in place to assess, monitor and improve the service but these were not being operated effectively as they had not prevented the several breaches of regulation we identified from occurring.

The provider had been unable to sustain improvement found at the previous inspection.

Good systems were in place to seek and act on people's feedback on the quality of the service.

Pellon 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 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 2 and 3 November 2016 and was unannounced. The inspection team consisted of five adult social care inspectors, a specialist advisor in mental health 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, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support in the lounges and communal areas of the home. We spoke with 19 people who used the service, 12 relatives, 16 care workers, a domestic, four Care Home Advanced Practitioners (CHAPs), two registered nurses, the catering manager, a resident experience manager, a regional Care Home Advanced Practitioner, a pharmacy manager, two unit managers and the regional manager. We looked at a 22 people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned to us in a prompt manner. We reviewed all information we held about the provider and contacted the local authority to get their views on the service. We spoke with two healthcare professionals who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

We looked at the way people's medicines were managed. Whilst we witnessed some good practice and saw the majority of medicines were given as prescribed, there were areas which needed attention to ensure medicines were consistently managed in a safe manner. We saw the care workers administering medicines wore a red tabard denoting they should not be disturbed. Our observations on Birkshall Mews showed the tabard was of little use as carer workers were constantly being disturbed by colleagues, attending to people, who used the service, needs and visitors.

We found topical creams were not consistently managed in a proper or safe way. It was common practice to store creams and lotions in people's bedrooms on Birkshall Mews. Bedroom doors were open with creams on view and freely available for anyone to access. The application of creams showed poor adherence to the prescriber's instructions and poor practice in the recording of the use of creams. In some cases, we found there to be no topical MAR's in use meaning we could not confirm whether people received their creams as prescribed. Creams in use did not always have the date of opening recorded. We also found examples of poor recording of topical creams on Brackenbed View. On Pellon Manor we saw creams were managed in a better way, they were stored securely and topical MAR sheets were completed and complied with the prescriber's instruction.

Our observations of the medicine round showed medicines were administered with sensitivity. However, we observed some prescribed products were not being administered as required. We also saw evidence of poor recording. For example, our observations of MAR's showed gaps in signatures yet the dispensed items in the monitored dose pack was missing. On Birkshall Mews we found an instance where a nutritional supplement was not consistently signed as given meaning we could not confirm whether this person had received their supplement as prescribed. Along with the provider's pharmacy advisor we carried out a random sample audit of supplied medicines dispensed in individual boxes. We found there to be some discrepancies which suggested medicines were being signed for and not given.

We saw some people have been assessed by a speech and language therapist (SALT) and subsequently prescribed a thickening agent to add to drinks. During our observation of care we saw staff preparing hot drinks for people. We saw staff used one prescribed product for all people requiring thickeners. Each person should use only their prescribed product.

Our observations were witnessed by the provider's pharmacy advisor who undertook a review of our findings during the course of the inspection and commenced remedial action.

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

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We found these medicines were managed safely and robustly accounted for.

The provider had compiled protocols for the administration of certain medicines which required additional monitoring. For example, we saw protocols were available for the administration of warfarin where the dose is determined by periodic blood tests. We also saw people prescribed lithium were having appropriate blood tests. More complex medicine regimes were complied with.

We found medicines were stored securely and appropriately. Drug refrigerator and storage temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures. Where medicines were no longer required a robust system existed to record and dispose of the medicines safely.

People who used the service and relatives told us they thought people were safe living in the home and felt able to raise concerns without discrimination. A visiting health care professional told us they had no concerns about the safety of people living at the service. Staff told us they thought people were safe and one told us, "We look out for them." Care staff were able to demonstrate to us their knowledge of how to identify and report any suspicions of harm or poor practice. They gave examples of types of harm and what action they would take in protecting people and reporting such incidents. We saw evidence safeguarding procedures had been followed to help keep people safe.

Risk assessments were in place which considered areas of harm such as moving and handling falls, nutrition, skin integrity and choking. We checked whether risk control measures were being adhered to such as the use of pressure relieving cushions and sensor mats in line with plans of care and found they were. We saw the home used assistive technology, such as sensor mats which were placed on the floor next to the person or underneath the chair cushion to alert staff if the person mobilised. In most cases, we saw detailed information was recorded on the risks each person presented, although information on interventions was difficult to find due to the bulky nature of care records.

On Pellon Manor we saw observed some examples of behaviours that challenge and/or refusals or care and support managed well by staff and in a prompt manner. For example, one person had been assessed as being at risk of harm due to poor perception of risk. A recent incident report stated the person had been assaulted by another person following verbal exchanges. We saw care plans had identified the need for staff to distract and use diversion techniques when the person became distressed. The plan also instructed staff to ensure the two people concerned were closely observed when in close proximity to each other. Daily records showed no further incidents had taken place. Staff on the unit were able to tell us why risk assessments were in place and what measures had been taken to keep people safe.

We had some concerns over the lack of appropriate strategies adopted on Birkshall Mews to manage behaviours that challenge. When one person was brought into one of the lounges they were swearing and using offensive language for 10 minutes. This led to another person who used the service becoming distressed and becoming verbally abusive back. We spoke with staff who told us the person's swearing was usual for the person when they first got up. A manager agreed what we had witnessed was a safeguarding issue and accepted management measures needed to be put in place to reduce the risk. We therefore concluded more could have been done regarding managing this person's behaviour. We witnessed other instances of altercations between one person and three others on Birkshall Mews, staff fortunately were able to intervene before the incidents escalated. When we looked at incident reports we saw there had been previous unprovoked and unwitnessed incidents involving this individual and others. Staff told us the

lounge area needed to be supervised at all times to make sure people were safe, as well as other areas when the individual was walking around. We saw this was difficult for staff to achieve at times because of other demands. We concluded more could have been done to manage these risks especially in terms of exploring the causes of the person's behaviour and developing a therapeutic plan based on their history and interests.

We were also concerned one person who was diabetic was given two bowls of Eton mess on Pellon Manor for their dessert. We spoke with their relative who also expressed concern, saying, "I'm concerned [person's] not eating properly. Staff don't push him to eat main meals; [person's] more happy eating sweet things but [person's] a diabetic."

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

We received mixed comments from people and relatives about whether staffing levels were suitable within the home. We found staffing levels appropriate on Brackenbed and Pellon Manor with staff visible and able to provide prompt and attentive care when required. On Pellon Manor although staff were busy we did not identify any issues with staff not being able to meet people's needs and staff told us there were enough staff available to ensure timely care. Staff told us they felt there were enough staff on duty to ensure timely care. They told us the service had employed a lot of new staff and staffing levels were good

However we concluded due to staffing levels of Birkshall Mews ground floor area there was the potential for incidents to occur. One relative told us, "More staff would always make it better." Another relative said, "Downstairs [Birkshall Mews] needs an extra carer." A care worker told us, "If we had an extra carer we wold be able to spend more time with people and offer more baths or showers." Our observations of care and support on Birkshall Mews led us to agree with these comments given the complex needs of people living on this unit. Night time staffing levels on Birkshall Mews had recently been increased and staff told us this had had a positive effect on the unit. On Birkshall Mews we also identified nursing staff were not deployed effectively with a nurse being confined to upper floor of the unit with the lower floor run by the Care Home Assistant Practitioners (CHAP). We concluded there was a lack of nursing oversight on this unit as we found the nurses did not routinely review people's nursing care plans.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

Overall, appropriate recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people. We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references were requested and checks performed with the Disclosure and Barring Service (DBS) to establish whether potential applicants had any criminal convictions before they were offered the job. Application forms included full employment histories. Staff were required to provide references; evidence of any qualifications and undertake health screening. However, in one instance, we found a newly recruited member of staff had received a poor reference but there was no evidence that this had been discussed with the person and /or a plan of support/management put in place. We raised this with the regional manager who told us they would investigate

We found the home's environment was of variable quality. Pellon Manor had been recently refurbished, and we saw the main areas of the service were generally well maintained, well decorated and appeared clean. Corridors were brightly decorated with murals depicting nature and garden scenes. However, on Birkshall Mews we identified some areas which required attention. We saw damaged doors, stained flooring and

skirting boards which needed sealing and repainting and some damaged doors and doorframes throughout the home. One visitor told us ,"They could do with some new furniture and chairs." We saw a programme of refurbishment of these areas of the home was being undertaken. The service had an enclosed garden with seating areas. However, we noted the garden had not been recently maintained apart from the grass being cut which gave it an air of neglect.

Checks on the premises were undertaken by the maintenance worker. These included regular checks of window restrictors (in place to prevent the risk of falls) the temperature of water outlets, and fire systems. Lifting equipment, gas, fire and electrical equipment were serviced in line with statutory requirements by external contractors. Personal Emergency Evacuation Plans (PEEPS) were in place for each person who used the service. These provided information on the support people required should they need to be evacuated in the event of an emergency.

We received mixed feedback about the cleanliness of the home. We saw most areas including Pellon Manor and Brackenbed View were clean and hygienic. The home had dedicated staff for housekeeping and cleaning services. We saw staff used aprons and gloves when completing care and support tasks and when assisting with meals. Some relatives on Birkshall Mews told us they thought the home could be cleaner. One relative said, "It could be cleaner, some of the carpets are stained and there is a smell of stale urine." Another relative said, "There is an underlying smell of stale urine." A third relative commented, "A couple of times I have come in and found the bathroom dirty." We saw people's views regarding cleanliness had been identified through a recent survey of people who used the service and relatives and a plan had been put in place to address their concerns

Requires Improvement

Is the service effective?

Our findings

People who used the service and relatives praised the skills and knowledge of staff Staff were allocated to set units within the home to build knowledge of the people they were caring for. One relative told us "Usually the same staff, which is a good thing, they know what to do."

Staff told us they had received training to allow them to offer care and support to people living at the home. New staff were required to undertake induction training, a period of shadowing and those without previous care experience completed the Care Certificate. The Care Certificate is a nationally recognised study plan for people new to care to ensure they receive a broad range of training and support. Existing staff received regular training updates in topics such as manual handling and safeguarding. We looked at training records and found most key training was up-to-date. Staff had received basic online dementia training and some staff had received more in-depth face to face training. However, a number of staff we spoke with could not recall receiving dementia training. We concluded more face to face training was required in dementia and behaviours which challenge particularly for those working on Pellon Manor and Birkshall Mews, as they were specialist dementia units. We saw this had been identified by the provider and a plan had been put in place to implement a 'Dementia Care Framework' of which enhanced training formed a key part.

Staff received periodic supervision and support, and most staff said they felt well supported by their manager, although this was less evident on Birkshall Mews. Staff said they were able to request other courses of interest during supervisions. For instance, one staff member told us they had recently completed 'end of life' training and were completing Level 3 in Health and Social Care. Although nurses had previously received clinical supervision, this had not occurred since April 2016. We raised this with the regional manager who stated that due to a lack of management and prioritising high risk issues these had lapsed but would ensure they were brought up-to-date.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed issues regarding the MCA and DoLS on Pellon Manor. We saw 13 people had authorisation for DoLS in place. Without hesitation the unit manager was able to tell us of all these authorisations and accurately inform us of those authorisations with attached conditions. Staff and management on Brackenbed View had a good understanding of DoLS and applications and authorisations were being managed appropriately in this unit. We found staff on Birkshall Mews were less confident about who had an authorisation in place and the conditions attached.

We looked in detail at five people's care records where conditions had been applied to the DoLS. In three cases we saw conditions were being met or were in the process of being so. For example, a person with conditions attached to their DoLS had required the person to be referred to a falls assessment team. We saw the referral to and attendance of a physiotherapist had taken place within two weeks of the authorisation being granted. However, in two cases we saw they were not being adhered to. In one, a review of a Do not Attempt Cardio-Pulmonary Resuscitation (DNACPR) had not taken place in line with conditions specified four months previously. In the second case, a person had a DoLS authorisation which had a specific condition attached to it regarding exercises and keeping a diary. A regional Care Home Assistant Practitioner confirmed this had not been actioned. This meant the condition had not been complied with therefore care was not being delivered to this person in line with their assessed needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

During the inspection, the regional manager amended their system for monitoring who had a DoLS in place, when it would expire and the conditions attached to help ensure unit staff were fully aware of this information.

Where people were assessed as lacking the capacity to make specific decisions, a process of best interest decision making was undertaken and recorded, for example around the administration of covert medicines. We saw evidence of the involvement of a GP, pharmacist, family and carers. A pharmacist had conducted a medication review to advise the care home how the medication could be covertly administered safely. We saw a review plan existed and evidence reviews took place.

We found overall, people were asked for consent before care and support interventions, although we witnessed some inconsistencies which are discussed in the Caring section of the report. Where people refused care and support interventions we saw this was well managed by staff. For example, one person became distressed and refused care and support interventions despite requiring a change of clothing. Staff encouraged the person to change and although this was initially met with a high level of resistance, they persisted, adapting their approach until the person complied, in line with the instructions in their care plan, resulting in a good outcome for the individual. This demonstrated staff understood how to ensure this person's personal care needs were met whilst keeping distress to a minimum.

We found the use of restraint was kept to a minimum. For example, unit managers demonstrated a good understanding of how the inappropriate use of bed-rails may constitute unlawful restraint. Our discussion also showed the use of bed-rails was rarely used with staff relying on potentially less restrictive methods of providing a safe environment.

People we spoke with told us the food was okay, although some felt it could be improved. One person told us, "I like meals they suit me" and another person said "foods great." A third person said "I'm not all that keen on the food," and a fourth said, "Food is all right; not as good as it was when I first came. The quality and quantity is not as good, for instance, getting one sausage (only)." We saw from documentation that some concerns had been raised about the food, following an external contractor taking over the catering. We saw steps were being taken by the provider to solve this.

We reviewed menus and saw there was sufficient choice and variety of food. The main meal was served in the evening and there were always two choices. At lunchtime a selection of choices were also available. We saw people's preferences and dietary requirements were written on a noticeboard in the kitchen and the catering manager kept a file with special requirements such as diabetic diets in their office. As well as main

meals, we saw baking was done every day, such as scones for afternoon tea on the day of our inspection. Snacks were provided to people throughout the day.
We found the mealtime experience to be of variable quality dependant on the unit. On Pellon Manor we found it was a pleasant atmosphere. We observed breakfast and saw people were offered choice and given drinks throughout the day. We saw meals were nicely presented and staff who were assisting people with their meal told them what the components of the meal were.
However, on the downstairs unit at Birkshall Mews, at breakfast time we saw only six rashers of bacon and six hash browns had been sent for the eight people who received a normal diet. A care worker went to get extra, but only one slice of bacon had been prepared for each person. The bacon was served with one hash brown, baked beans and toast. One care worker told us, "There isn't enough bacon for people to have a bacon sandwich." On the same unit we saw one person did not eat their 'soft option' breakfast. At lunchtime we saw they ate all of the food on their plate and were scraping it clean with their knife. We asked the care workers if there were any second helpings and they told us there were not. We raised this with the regional manager who agreed to take action to address.

We also found breakfast to be disorganised on the upstairs unit of Birkshall Mews with people having to wait significant amount of time for food and drink in the morning. We identified no significant concerns with mealtime organisation in other areas of the home, although some staff we spoke with told us the catering arrangements were at times poor. For example, they said portion size was controlled by the catering company. They told us just to get simple things like tea bags, coffee and sugar they had to take the empty canisters to the kitchen to be filled instead of them being freely available on the unit. They also told us they had to buy ice creams from the supermarket during the summer months because the kitchen would not supply them

Overall we found appropriate action was taken to maintain people's nutrition. One relative told us, "When [Name] first moved in they put on weight, then lost weight but now its stable." One care worker told us, "We keep anything which is left over from mealtimes and keep offering people snacks throughout the day." Our review of records and observations of care confirmed this that people were offered a range of nutritious snacks throughout the day. We saw nutritional risk assessments were in place, people's weights were monitored and overall, where weight loss had been identified we found measures had been put in place to help them maintain good nutrition, including referral to the GP, dietician and increased monitoring of their food and fluid intake. Whilst we found appropriate steps were being taken, some documentation was not sufficiently robust. For example, one person's nutritional risk score had been calculated incorrectly and the advice from the dietician had not been incorporated into their plan of care. We saw two people were not being weighed at the frequency stated in their care plan, although we had no concerns their nutritional needs were not met.

Food and fluid charts were generally well completed showing people who had been identified as being at risk of malnutrition had been offered a variety of food and snacks throughout the day. However, we identified they were not always well completed on Brackenbed View.

People had access to health care professionals to meet their specific needs. Care records showed people had access to appropriate professionals such as GPs, dentists, district nurses, chiropodists, opticians and speech and language therapists. Care workers we spoke with told us if they noticed people were unwell or there had been a change in the condition of their skin integrity, senior staff were quick to involve the relevant health care professional. We found the Care Home Assistant Practitioners (CHAPs) we spoke with had a detailed knowledge of people's medical histories together with the medicines they were taking. We spoke with two healthcare professionals who told us they were happy with the way the service was managing people's healthcare needs. Relatives we spoke with told us they were kept informed about the outcome of

any medical visits.

We saw inconsistencies in the provision of a suitable environment for people living with dementia. On Pellon Manor, the environment had been adapted for people living with dementia. Bathroom and toilet doors had pictorial representations of the room attached. Most people's rooms had a 'memories' single page information sheet about them, their lives and memories in a photo type frame attached to the wall just outside their rooms. We saw one person's memories container had their wedding order of ceremony, a baby dress and booties which were special memories for that person. On the day of inspection the service had been decorated for Halloween. However some people we spoke with who lived at the service remarked on the decorations, particularly those suspended from the ceiling in the middle of the lounge area. One person was concerned and asked us, "What's that little girl hanging from the ceiling?" We saw the person was looking at a cut out figure of a ghost suspended on coloured paper. We were concerned these decorations may not have been appropriate for people living with dementia. Birkshall Mews showed a lack of environmental adaptions for people living with dementia; however, it was currently under redecoration to improve the environment. Some people's bedrooms had personal belongings but many were sparsely decorated. In one person's room we saw they had three or four family photographs but nothing else to reflect their interests or tastes. We commented it was a nice room and the person said, "It's a bit cold I think," it was evident from the context of the conversation they were not talking about the temperature but were referring to the bland décor.

Requires Improvement

Is the service caring?

Our findings

People provided mostly positive feedback about staff attitude and said people were treated with dignity and respect. One person told us, "The staff are very good. Just the odd one, you know." Another person said, "It's alright here. Staff seem not too bad. I can't grumble." A third person commented, "The staff are all right; I haven't had a problem with any of them." A visitor said, "The staff are lovely and really nice with people. They make sure people have dignity." A relative told us "You could not ask for better staff, my family and I are really happy with the progress [name of person] has made since admission and that is due to the professionalism of the staff." Another relative said, "The staff do a wonderful job and are kind and caring to everyone. When I leave I have peace of mind knowing [name of person] is being well cared for. A health professional we spoke with told us they had always observed staff were kind and caring and treated people well.

We saw some kind and caring interactions between staff and people who lived at the service. For instance, we saw staff spending time sitting and talking with people, laughing and joking with them, holding hands and kneeling down beside them to maintain good eye contact. We saw people were relaxed in the company of staff, with one person kissing and hugging staff, saying, "You are lovely." We observed staff respected people's privacy, for example, knocking on people's doors before entering and saying who they were, such as, "Hello, [person's name]. It's only me."

However, we saw some practices which showed a lack of respect for people on the Birkshall Mews unit. We saw one care worker put clothing protectors on people who used the service 'inside out.' They also moved one person in their specialist chair without telling them first, which made the person shout out. We saw and heard staff talking between themselves in one of the lounges and not trying to involve people in the conversation. The blue drinking mugs on this unit were very stained and unsightly. We also saw a resident experience manager change the music and television channels without appropriately consulting with people.

The breakfast time experience on the upstairs unit of Birkshall Mews did not demonstrate respect towards people. People experienced a significant delay in getting food and drink and staff did not promptly respond to one person's request for a drink. We observed people were not offered any clothing protection at breakfast time in this area. Another person was not offered appropriate support eating, the inspector noticed the person was trying to eat their cornflakes with a fork and had to intervene to suggest a spoon. When we looked in the person's care records we saw they were registered blind and had hearing difficulties. Their hearing difficulties were referred to a care plan review dated 18 October 2016 but the care plan had not been updated to reflect this fact or guide staff on what to do.

Another person had a care plan for communication written in May 2016 which stated they wore glasses. We observed the person was not wearing glasses and when we looked in their bedroom we found no glasses. We asked one of the care staff and they told us they did not know anything about the person having glasses. We concluded the service had failed to have due regard for the protective characteristic of disability as specified by the Equality Act 2010.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Overall, we found people looked clean and tidy and observed where one person had spilled some food on their clothes, care staff had noted this and changed these when they assisted them with a bath.

Staff we spoke with had a genuine regard for the people living at the service and most were able to tell us about the people in their care, including likes, dislikes and care needs. The information they gave us corresponded to the information contained in people's care records. One person we spoke with said, "I think the staff know me." This was confirmed by our observations. For example, during mealtimes we saw one care worker deduced by the person's facial expressions they did not like broccoli and did not persist with that element of the meal. Information on people's life histories was present within their care and support files or within their bedrooms for staff to consult. At a One page profiles had been developed to assist agency staff or those less familiar with people's needs. Staff were generally assigned to a fixed unit and floor within the home, this helped the development of relationships between people and staff and provided familiar faces for people.

We saw steps were taken to allow people to be as independent as possible. For example, staff encouraged people to leave the premises, by for example taking them to the shops. We saw where possible, people were encouraged to help out at mealtimes for example, in helping with the washing up. One relative remarked that they were impressed with the way staff encouraged people to be independent. Another person told us staff encouraged them to make their own drinks using the kitchenette area in the dining room. We heard staff encouraging people to mobilise themselves, saying, "That's it. Well done, [person's name]." Everyone who used the service was assessed as to their capability to self-medicate. Whilst at the time of the inspection, no people had been found capable of self-medication the process demonstrated the provider was attempting to maximise people's independence.

Relatives told us they generally felt welcome. One relative told us, "I am made to feel welcome but don't always get offered a drink." We saw that visitors arrived at various times thorough the day. Visitors were welcome in the home, although there were protected mealtimes to minimise disruption and distractions during meals. However relatives were able to dine with their relatives for a small fee.

We saw staff offering choices and being thoughtful and listening to people's opinions. We saw mechanisms were in place to listen to people's comments. For example, people had been listened to about their concerns around the food and steps were being taken to address this. The results of action taken following meetings and quality surveys was displayed in the reception area of the home which provided assurance that people's views were valued and acted on.

In the care records we reviewed, we saw people had detailed information about their end of life care, including details of interventions, funeral arrangements and contact information.

Requires Improvement

Is the service responsive?

Our findings

Overall people and their relatives spoke positively about the standard of care received. One person said, "They are doing a good job on my foot." Another person said they received "very good care" and added it was prompt and timely care. A relative told us, "[Relatives] needs are met, very happy with care and pro-activeness of [manager]." Another relative said "It's very good; if anything is wrong they tell me straight away and check him over. A third visitor told us their relative had settled really well at Birkshall Mews, having been at two different care homes before where staff could not manage to meet their needs. They said staff did not insist on anything which was not absolutely essential which helped to stop their relative becoming anxious. We saw this person become distressed and staff responded appropriately and settled them in their bedroom with drinks and played one of their favourite DVD's.

Throughout the inspection, on Brackenbed and Pellon Manor units we saw staff responded appropriately if people requested assistance and support. However this was not consistently the case on Birkshall Mews. During breakfast we observed one person who was trying to eat their cornflakes with a fork. The care worker put the cornflakes on the table in front of the person but did not support the person to select the right cutlery. There was an entry in the care records which stated staff should monitor the person's use of cutlery to reduce the risk of choking and another entry which stated staff should cut up the person's food. We observed the person's food was not cut up at breakfast time or lunch time. We asked the nurse in charge and spoke with the care staff on duty and they told us they were not aware the person needed to have their food cut up.

We saw one person wearing ill-fitting slippers and they nearly fell in one of the dining rooms. Staff told us they would get them new slippers but were waiting for the family to send some money. When we checked we found money was being held on their behalf by the administrator. However this information had not been effectively communicated to staff resulting in a delay. During our inspection we witnessed one person who displayed behaviours that challenge towards other service users and members of staff. We saw the person's behaviour was stressful and upsetting for other service users and in one case resulted in an attempt to retaliate. A female member of staff asked for help from a male carer as they were being hit. We saw no evidence of a care plan or staff reactions which suggested a causal factor or a plan of care was being explored or developed. We concluded their needs could have been better assessed in this area to offer an appropriate plan of care.

On Birkshall Mews we asked a care worker about the amount of nutritional thickener to be added to one person's drink as part of a plan of care for swallowing difficulties. They said the person required one scoop to a cup of tea , however care records recorded Speech and Language Therapy advice as 'one and half scoops to 200mls & ensure 200mls is measured,' demonstrating that this staff member did not have a full understanding of the required plan of care.

This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

We reviewed a number of care records. In most cases, relevant care plans were in place with appropriate

documentation and risk assessments. Care records also contained information about people's preferences, likes and dislikes. The majority of care records contained detailed and person specific information, such as up to date body maps where a person's skin integrity was a concern, information on their air mattress setting and turning regimes. When we checked this information with the daily records and information in the person's room and found these corresponded accurately. We saw repositioning charts and charts of daily care were well completed which indicated people received timely care and support interventions. However we found other care records were not fully up-to-date with the latest information about people's care needs for example pressure area prevention regimes or their hearing needs. In some care plans there was detailed information about people's behaviours but no clear instructions for how staff should respond.

Monthly and annual care reviews and risk assessments were up to date. Some care records had been signed by the person and others by their relatives. There was evidence of family involvement in decision making, particularly best interest decision making processes.

We received mixed feedback about the activities on offer and concluded more could have been done to ensure people were provided with stimulation and person centred activities. One person praised the activities and said they liked the quiz and puzzles provided on Brackenbed view. A visitor told us, "There are not usually any activities going on. Smooth radio is on all of the time, we used to listen to Radio 2 at home. When I come at the weekends there is nothing going on." Another relative told us that whilst the care was good, their only concern was the lack of stimulation for their relative living with dementia. Although we saw evidence of staff interacting with people on a one to one basis, for instance, giving someone a manicure, or sitting chatting and joking with people, we saw a lack of structured activities taking into consideration people's individual needs and interests. Part time activities organisers were in place, but people, relatives and staff we spoke with told us they didn't feel there were enough stimulation for people living at the service. We observed some people sitting in the lounge for long periods of time not watching the television which was showing daytime programmes. We spoke with one person who liked to spend time in the garden area. They told us they would be interested in helping to keep the garden tidy or planting flowers but no-one had asked them. A sentiment of a lack of activities and stimulation was also evident from reviewing minutes of relative meetings and surveys. We saw the provider had put a plan in place to address this. We also saw people's involvement in activities was inconsistently recorded in activities and journals making it difficult to establish what people had been involved in over recent weeks or months.

A number of events were held, for example a Halloween and bonfire party for the day after our inspection, a 'dress the unit for Christmas' day and a Christmas party. The unit manager told us people were encouraged to attend a weekly afternoon tea event at a local social club. Schools and nurseries were invited to the home and trips such as to the theatre were planned. One relative told us, "They take some people to the local Social Club on a Monday afternoon and arrange trips out. The last one was to Hollingworth Lake."

People generally spoke positively about how complaints were managed by the service.
One relative said, "I would raise any concerns with the nurse in charge and feel they would be dealt with." Another relative told us, "I would feel able to raise any concerns. When [Name] loses something I tell them." Complaints were logged, investigated and analysed. We saw there was generally a low number of complaints with people saying minor issues were resolved by unit managers. We saw that most recent complaints had been concerning Birkshall Mews where there was no unit manager. We looked at a sample of complaints and we saw appropriate action had been taken to investigate and resolve. Compliments were also logged by the service so it knew areas where expectations were exceeded. People were also able to provide views through a tablet in reception where surveys could be completed. If a negative survey was received, the regional manager told us they offered to meet with the person and relatives to discuss any concerns raised.

Inadequate

Is the service well-led?

Our findings

Systems were in place to assess, monitor and improve the service but these were not sufficiently robust. Prior to the inspection we were made aware that following the identification of significant risks on Birkshall Mews, the home had been subject to a period of increased monitoring and support by commissioners and agreed to restrictions on new admissions. However despite these measures being in place, we identified a number of risks which were not appropriately managed and five breaches of regulation. During the inspection of February 2015 we also identified five breaches of regulation, with improvements made during a follow up inspection in July 2015. However this demonstrated that the provider was unable to sustain this improvement and deliver a consistent, high quality service over time.

The breaches of regulation we identified should have been prevented from occurring through the operation of robust systems. We identified inconsistencies in the quality of care with documentation and care delivery of variable quality dependant on the area of the home. For example we identified some issues with risk management, topical creams, DoLS conditions not being adhered to, care documentation and a lack of assessment of people's needs in some areas of the home, as well as observing some good areas of practice. We found no recent dining experience audits had been undertaken and we found the mealtime experience on Birkshall Mews required improving and a number of issues with how food was managed now that it was provided by an external contractor. We also found a number of deficiencies with the premises such as three damaged radiators on Pellon Manor, some hygiene issues and a lack of hot water in one room on Birkshall Mews. Daily walkarounds and other quality checks in areas such as care plans, infection control, health and safety and medicines management were in place. However we concluded these were not sufficiently robust as they had not been operated effectively to identify all these issues and ensure a consistent high performing service across all three units of the home.

Care assistants had been trained to become Care Home Assistant Practitioners [CHAPs] in some areas of the home. They were trained to administer medicines and apply some basic dressings to wounds. Whilst if managed correctly, this was an acceptable way to take the pressure off nursing staff, we found there was an overreliance on these staff to manage people's total care requirements. For example on Birkshall Mews the nurse on duty spend their whole day on one floor of the home, resulting in a lack of nursing oversight to the other floor. Care staff told us this was a usual arrangement. We saw care plans for people with nursing needs did not have nursing input which meant that risks to their health and safety may not be promptly and accurately identified and managed.

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

Incidents and accidents were recorded and actions put in place to prevent a re-occurrence. We saw incidents were collated and analysed on a monthly basis to help identify possible trends.

A service improvement plan was in place for Birkshall Mews although systems should have been sufficiently robust to prevent standards from slipping on this unit in the first place.

A staffing tool was used which used dependency scores calculated to inform staffing levels. We spoke with the regional manager who said that whilst this was not an exact science, they backed this up with discussions with staff. We concluded this could have been further enhanced by observations of care to deduce whether staffing levels were sufficient, particularly where people displayed behaviours that challenge to keep people safe at all times.

A series of staff meetings were held which included quarterly health and safety audits and clinical governance. Staff confirmed meetings were held regularly. We saw staff meetings were an opportunity to discuss quality issues and ensure improvement of the service.

Systems were in place to seek and act on people's feedback. Feedback on the quality of the service was regularly sought from people who used the service and relatives. A tablet in reception was availabe to provide ongoing feedback. This was analysed on a quarterly basis to look for any trends. A feedback board displayed the 'You said, we did' from the previous quarter (July to September). This stated that 96% of respondents were satisfied and most people felt safe, although only 69% were satisfied with food and activities and a number of people had concerns over malodour. Actions taken as a result were logged which provided assurance that these concerns were being addressed by the service Residents meetings and family forums were also periodically held. We saw a family forum was being held in the afternoon of the day of inspection which we attended. We saw these were an opportunity for people to raise concerns on a range of topics such as food and activities. The outcome of the residents meeting in October 2016 was displayed in the reception area showing what action had been taken to address concerns that people had raised. For example the home had identified through these systems that activities and food required improvement. We saw plans were in place to address these areas of concern.

Relatives and staff praised the unit managers of Brackenbed View and Pellon Manor and said they were approachable and worked hard to run the unit. We saw they worked on the floor and assisted in care, which was confirmed by our conversations with staff. One staff member told us, "[Unit manager] supports me. She's brilliant." Another said, "I get on with my unit manager like a house on fire." Another staff member told us they got good support from the unit manager and added the unit manager was always working as part of the care team and were, "On the floor all the time." Staff told us they could approach the unit manager or senior staff with any concerns and said there was a good team approach. The culture in the service appeared open and inclusive on the day of our inspection and morale appeared good in Pellon Manor and Brackenbed Mews. Staff we spoke with were happy to talk about their work and told us they enjoyed their roles and worked well as a team. One staff member told us, "I love it. I love my job. We all get on well as a team and work to get things done," and another commented, "I like the atmosphere here. We've got a good team." A third told us, "It's a strong team. Everyone tries to help each other out. Team morale is good." We found staff sentiment was not as positive on Birkshall Mews and it lacked a unit manager. This had impacted on the organisation of care, staff morale, support and overall quality of care provided. The home was also without a deputy manager. We saw adverts were out for both these roles. We found that some audits and clinical supervisions had fallen behind within the home due to management vacancies and prioritising areas of high risk.

A registered manager was in post. However staff we spoke with told us that the registered manager was not very visible within the home. A number of people who used the service and relatives also did not know who the registered manager was. One visitor told us, "I have never seen the overall manager."

We found the service had submitted required statutory notifications to the Commission such as allegations of abuse. This helped us monitor events within the service.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care (1) Care was not always appropriate and did not always meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect (1)(2c) Service users were not consistently treated with dignity or respect and the service did not always have due regard for the protective characteristics under the Equality Act 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (1)There were not always sufficient staff deployed with the right competencies and skills

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1)□(2a) (2b) 2(g) Risks to people's health and safety were not consistently assessed, monitored and mitigated. Medicines were not consistently managed in a safe or proper way.

The enforcement action we took:

We issued a warning notice requesting the provider to be compliant with this regulation by 23 December 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance (1) (2a) Systems or processes must be established and operated effectively to ensure compliance with the requirements of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. Systems to assess, monitor and improve the service were not sufficiently robust.

The enforcement action we took:

We issued a warning notice requesting the provider to be compliant with this regulation by 20 January 2017