Mr Barry Potton

Pennine Lodge Care Home

Inspection report

Pennine Lodge Care Home
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5 and 12 October 2016 and was unannounced.

At the last inspection on 18 and 21 August 2014 we found three regulatory breaches which related to medicines, person-centred care and quality assurance.

Pennine Lodge provides personal care for up to 40 older people living with dementia. Accommodation is provided over two floors with passenger lift access. There are 36 single bedrooms and two shared bedrooms. The home is split into three separate units each with their own communal areas. Harrison unit has 14 places, Ryland and Williams units each have 13 places. There are secure garden areas at the front and rear of the home. There were 40 people using the service when we visited.

The home has a registered manager who has been in post for four years. 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 marked differences in the three units we visited which impacted on the outcomes people experienced. For example, Harrison unit has a spacious layout and large communal areas, the other two units are more confined and have small communal areas at opposite ends of a corridor. The registered manager told us people could be admitted to any of the units as there was no specific admission criteria for each unit.

Although the registered manager had looked at people's dependencies and used a staffing tool which showed the home was over-staffed, we found there were insufficient staff deployed to meet people's needs. For example, we observed two people did not get up until late morning, not through choice but because there were not enough staff to assist them. We saw delays in people receiving help they needed from staff at mealtimes and occasions when there was only one care staff member available to support 13 people.

We found inconsistencies in how individual and environmental risks were managed. We saw some areas of good practice, yet others where risks had not been assessed or mitigated. For example, two people had detailed risk assessments and care plans in place to manage challenging behaviour and we saw staff put this into practice. However, there was a lack of assessment and guidance for staff in relation to another person who displayed similar behaviours. Similarly, most upstairs windows had openings restricted in line with Health and Safety Executive (HSE) guidance to keep people safe, yet we found two windows opened to three times the limit recommended by the HSE.

Medicines management was not safe and we found some issues we identified at our last inspection in August 2014 had not been addressed.

Staff were aware of the different types of abuse and knew the reporting systems. Records showed that incidents reported to the registered manager were dealt with appropriately and referred to the local safeguarding team. However, we found the reporting systems were not always effective as we found two safeguarding incidents had occurred which the registered manager was unaware of as these had not been reported to them and they had not been dealt with.

We found overall standards of cleanliness were maintained, however there were isolated areas which were not clean, we also found continence pads had not been bagged before being placed in the clinical waste bins and there were odours. Although the Statement of Purpose stated the home provides specialist dementia care we found a lack of aids, adaptations and use of colour in the environment meant it was not easy for people living with dementia to find their way around the home.

Robust recruitment procedures were in place which ensured staff were suitable to work in the care service. Staff received the induction, training and support they required to fulfil their roles and meet people's needs.

People told us they liked the food but we found people's nutritional needs were not always being met. We found there were not effective systems in place to ensure that people who were nutritionally at risk were receiving sufficient to eat and drink. We found people's mealtime experiences differed depending on which area of the home they lived in and people did not always receive the assistance they required with eating and drinking in a timely way.

The registered manager had a good understanding of their responsibilities under the Mental Capacity Act 2005. However, we found conditions stated in one person's deprivation of liberty safeguards (DoLS) authorisation had not been met.

Relatives were satisfied with the care provided. We observed some kind, caring and sensitive interactions between staff and people who used the service. However, we found examples which showed a lack of respect for people and compromised their dignity. Activities were provided which we saw people enjoyed, yet there was little to occupy and interest people in some areas of the home.

There was a complaints procedure displayed. The registered manager told us they had received no complaints.

We found there was a lack of effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved and any improvements made were not sustained.

We found shortfalls in the care and service provided to people. We identified seven breaches in regulations – regulation 18 (staffing), regulation 14 (nutrition), regulation 12 (safe care and treatment), regulation 10 (dignity and respect), regulation 13 (safeguarding), regulation 15 (premises) and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Not all aspects of medicines management were safe and effective and some issues found at the last inspection had not been fully addressed.

Risks were inconsistently managed which placed people at risk of harm. There were insufficient staff deployed to meet people's needs.

Robust recruitment processes ensured staff were suitable to work with people who used the service.

Many safeguarding incidents had been recognised, dealt with and reported appropriately, however we found two safeguarding incidents had not been reported, dealt with or referred to the Local Authority safeguarding team.

Generally the premises were clean, secure and well maintained, although there were isolated parts of the home which were not clean and odours were noted.

Is the service effective?

Inadequate

The service was not effective.

Staff received the training and support they required to fulfil their roles and meet people's needs

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not met.

Generally people's healthcare needs were assessed and people had access to a range of health professionals.

The environment was not suitably adapted, decorated or designed to meet the needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

Relatives told us they were happy with the care provided and we saw staff were kind and caring in their interactions with people. However, we found differences in how care was experienced by people on the different units in the home.

Staff maintained people's privacy; however we observed some practices which compromised people's dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person-centred care which met their needs and preferences.

A variety of individual and group activities and outings were provided, although we saw there was a lack of social interaction and stimulation for some people.

A system was in place to record, investigate and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to assess, monitor and improve the safety and quality of the service were not always effective and issues identified at the previous inspection had not been resolved.

Pennine Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 12 October 2016 and was unannounced. On the first day the inspection was carried out by one inspector, a specialist professional advisor in mental health and an Expert by Experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An observer from the Department of Health also attended on the first day. On the second day two inspectors and the same specialist professional advisor in mental health attended.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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. The registered provider returned the PIR and we took this into account when we made judgements in this report.

We observed how care and support was provided to people. We spoke with 20 people who were using the service, eight relatives, seven senior care staff, three care staff, the activities co-ordinator, a domestic staff member, laundry person, two cooks, the registered manager and the deputy chief executive. We also spoke with a visiting healthcare professional.

We looked at five people's care records in detail and five others for specific information, four staff files, medicine records and the training matrix as well as records relating to the management of the service. We

looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspection in September 2014 we found medicines were not always managed safely. At this inspection, although some improvements had been made, concerns remained.

Medicines were administered to people by trained care staff. We observed the morning medicine round and looked at the provider's medicines policy. The policy demonstrated most elements of medicine administration had been addressed but fell short of current guidance. For example, the medicine administration records (MAR) showed some people were not being administered their evening medicines because they were asleep. We also saw the policy required staff to compile 'as necessary' (PRN) protocols for all medicines prescribed in this manner. We found these were not always in place. For example, we looked at the MARs for six people who were prescribed PRN medicines and found on five occasions no PRN protocol existed. We raised these issues with the registered manager who assured us they would be addressed. They said they would review the policy and make changes to comply with current guidance as found in the National Institute for Health and Care Excellence (NICE) document "Managing medicines in care homes guideline (March 2014). However, people missing their medicines in the evening and the lack of PRN protocols had been raised as issues at the previous inspection.

We carried out an audit of medicines supplied in boxes. Whilst we were able to reconcile stock levels we saw staff had made errors in counting which appeared to indicate medicines had not been administered as recorded on the MARs. For example, we saw incorrect stock balances had been transposed from previous MARs onto the current MARs. However, we found people had received these medicines as prescribed despite these recording errors.

Care records showed one person's pain reliving medicine had been changed by the GP on 5 September 2016 to a liquid as the person was refusing to take it as a tablet. The liquid medicine was not received by the home until staff contacted the chemist on 19 September 2016. This meant there had been a delay of 14 days between the medicine being prescribed and being received in the home. This was discussed with a senior care assistant who acknowledged the matter should have been identified sooner through the internal audit systems in place. The MAR showed staff had offered the medicines in tablet form throughout this period and the majority of times the person had refused to take it. The MAR also showed when the medicine was changed to liquid form the person continued to refuse to take it on a regular basis.

Staff told us one person was prescribed a thickening agent and showed us this was kept in the cupboard in the kitchenette which was accessible to people who used the service. We checked this person's MAR and the thickening agent was not prescribed on the chart. When we looked at the tin in the cupboard the prescription label showed this thickening agent was prescribed for another person. Thickening agents are prescribed medicines for individual use only and need to be kept securely. An NHS England patient safety alert in January 2015 identified the risks of asphyxiation if the powder was accidentally swallowed.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs (CD). We audited all the CDs and found the service was not complying

with current guidance. For example, one person was prescribed a pain relief patch. The CD register recorded three patches remained when we found there were only two. When we checked the MAR we found the last administration of the CD had not been recorded in the CD register and saw previous entries in the CD register had only been signed by one staff member. We found incorrect checking procedures had occurred with the other CDs we checked. For example, one person was prescribed a pain reliving medicine and on 12 June and 27 July 2016 a second staff member had not signed the register and witnessed the administration. The same for another person who was prescribed a pain relief patch yet on the 14 and 21 September 2016 a second staff member had not signed the register and witnessed the application. We concluded while some improvements had been made since the last inspection which reduced the risk of people not receiving their medicines as prescribed the provider remained in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines, including controlled drugs, were stored safely and securely. Medicines requiring cold storage were kept in a medicine fridge where the temperature was monitored daily and recorded. The application of creams was delegated to care staff who were delivering direct care. We saw creams were safely stored in people's bedrooms and topical medicine administration records kept in people's rooms were completed correctly.

We looked at how the service managed behaviours which challenged. We found they used a behaviour management approach and only used PRN medicines as a last resort.

People we spoke with were not always able to tell us if they felt safe. When we asked one person they said, "Yes (I feel safe), but not always." Relatives we spoke with were confident their relatives were safe. One relative said, "I've not seen anything to give me any concern, the laundry could be better and [relative's] not wearing their own shoes but nothing that worries me."

The registered manager told us the usual staffing levels between 8am and 8pm were seven care staff which included at least three senior staff. They said two staff were allocated to each unit and the additional care staff member was based on one unit but helped out on the other units when needed. At night there were four care staff; one based on each unit and the fourth staff member moved between the three units. The registered manager worked Monday to Friday and her hours were supernumerary. The duty rotas showed these staffing levels were maintained. The registered manager showed us the dependency assessments they had completed for people which they had used to calculate the number of care staff hours required per day. Their calculations showed the home was over staffed by 38 hours a day.

However, our observations and discussions with staff showed there were not enough staff deployed to meet people's needs. Staff we spoke with gave mixed feedback about the staffing levels. Although some staff said they thought there were enough staff they said this depended on which staff were working. Others said there were not enough staff and told us the floating staff member spent most of their time on one unit unless they specifically asked for assistance.

We saw the layout of Ryland and Williams units with communal areas at opposite ends of a long corridor made it difficult for two staff to supervise people in both of these areas. We saw staff were constantly busy and people in the communal areas were frequently left unattended. On the morning of the first day we went into the lounge on Ryland unit. The door to the lounge was closed and when we went in we found a person bent over in their chair coughing. We stayed with the person who recovered quickly. However, there were no staff present and although there was a call bell on the wall this was not accessible to the three people who were in the room and staff told us they would not be able to use it. We saw on Ryland and Williams units when care staff went for their breaks this left only one care staff member on each of these units. When both

staff were attending to people in their rooms there were no staff left on the unit to assist or support other people. Staff told us ten of the thirteen people accommodated on Ryland unit needed two staff to assist them with personal care. On the second day on Williams Unit at 11:30am two people were still in bed. Staff told us these people had not requested to stay in bed but they had not had time to assist them with their personal care needs. Both people required two staff members to assist them. Staff confirmed neither of these people had been offered a drink or anything to eat and one person had not had their morning medicines. We looked at the night report and found no indication either person had been offered a drink during the night. This meant we could not be sure they had been offered anything to eat and drink since 8pm the previous day when a light supper had been served. One person was assisted to get up and dressed at 11:45am and the second person at 12:15pm just in time for lunch. We asked staff if our observations were typical of a normal working day and they told us every day varied but it had been a typical morning.

We saw at lunchtime on all the units there were delays in people receiving the support and assistance they needed with their meals. For example, we saw people sat with food in front of them for up to 25 minutes while waiting for assistance from staff. We saw staff had to break off from assisting one person to help another and other staff trying to assist two people at the same time. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us all staff had received safeguarding training which was updated annually and this was confirmed in our discussions with staff. Staff were able to describe the common types of abuse and the signs which may indicate abuse was occurring. They knew the reporting procedures and were confident any concerns raised would be dealt with appropriately. The registered manager told us the Local Authority safeguarding team required all falls to be referred to them under the safeguarding procedures. We saw falls were recorded on accident reports. The registered manager told us staff reported any accidents or incidents to her verbally and she made referrals to the Local Authority safeguarding team. Records we saw confirmed referrals had been made and appropriate action had been taken. However, we found this system was not always effective as we identified safeguarding incidents had occurred which the registered manager was unaware of. For example, we saw entries in one person's care records which showed in July 2016 they had hit and sworn at another person and in August 2016 they had pushed another person to the floor. When we discussed these with the registered manager they told us they had not been informed of these incidents. The registered manager showed us a form they planned to introduce for staff to record all safeguarding incidents which they felt would address this issue. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found systems were in place to address the potential risks of cross infection. For example, anti-bacterial gel dispensers were located throughout the home and we saw staff washed their hands and wore personal protective equipment such as gloves and aprons when supporting people with their personal care needs. Staff had completed training in infection prevention and control. We spoke with domestic staff who had a good understanding of infection control and had the equipment such as colour-coded cloths to ensure safe cleaning practices were implemented. We saw evidence of a post-infection outbreak review conducted by public health professionals, which concluded the outbreak had been effectively managed with staff actions having a positive effect in controlling the infection.

However, whilst overall the home was clean, we found areas where good cleaning standards had not been maintained. For example, we saw the shelves in cupboards in a kitchenette were unclean and a dead plant was stored inside. We noted a smell of urine in two of the lounges on both days of our visit. We saw soiled incontinence pads and wipes had not been bagged before being disposed of in two clinical waste bins which had resulted in a malodour and soiling on the bin lid and clinical waste bags. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the home and inspected people's bedrooms, bathrooms, laundry facilities and various communal living spaces. We found the home was generally well maintained and saw fire safety equipment was in place and radiators were covered to protect people from harm. Floor coverings were good quality and where repair or replacement was necessary we saw this was listed in the maintenance records. We reviewed fire safety records and maintenance certificates for the premises and found them to be compliant.

However, although detailed environmental risk assessments had been completed we observed areas of risk that had not been addressed. For example, we saw some fire doors were propped open with items of furniture or equipment, which had been identified as a risk at the previous inspection. We found cleaning solutions stored in a kitchen cupboard were accessible to people on Ryland unit as the door to this room was left unlocked when staff were not present. Whilst the majority of windows upstairs had restrictors fitted to limited the opening to 100mm, as recommended in the Health and Safety Executive (HSE) guidance for care homes, we found two windows which opened to a gap of 300mm. This was of particular concern as one person in close proximity to the area had an altered mental state which led to them trying to climb out of windows. We brought our findings to the attention of the management team.

We saw risk assessments were in place for areas such as falls, nutrition, skin integrity and risks due to declining mental health. Yet we found inconsistencies in how these risks were assessed and managed. We saw some evidence of good practice. For example, the community mental health team had been involved in planning the care for one person with a history of increasing verbal and physical aggression. We saw antecedent-behaviour-consequence (ABC) charts were well completed and used effectively which had resulted in a significant decline in this person's untoward behaviours in the past four months. Another person had a history of hitting people and staff. We saw a risk assessed care plan was in place which identified staff interventions designed to protect others from harm and we observed staff followed this in practice. Staff told us the person was declining medication which increased the risks identified and they had arranged a medicine review. On the second day of our inspection we saw changes to medication had occurred with a resulting marked improvement in the person's quality of life.

However, we also found evidence which showed risks to people and staff were not always managed safely or appropriately. For example, one person's care records showed they had physically assaulted staff and other people who used the service. An ABC chart was in place, yet the risk assessment provided minimal information about how these risks should be managed and had not been updated since March 2016 despite further incidents occurring. We saw a risk assessment for the same person used to assess the risk of developing pressure ulcers had not been completed correctly therefore giving an inaccurate level of risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the files of two recently recruited staff. The files showed all the required checks had been completed before new staff started work. This included two written references and a criminal records check with the Disclosure and Barring Service (DBS). Application forms detailed employment histories and interview records demonstrated how suitability for the job role had been assessed. This helped to make sure people were protected from the risk of being cared for and supported by staff unsuitable to work in the care service.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw 36 standard authorisations had been submitted to supervisory bodies and 35 of these had been granted with one awaited. We saw conditions attached to authorisations had been translated into support plans and enacted. For example, one condition required the managing authority to gain evidence of family members having lasting powers of attorney (LPA). We saw the registered manager had secured evidence from the Office of the Public Guardian detailing named attorneys for the specific person. We saw where issues around lasting powers of attorney required consideration in care planning this was clearly annotated in the care file. We saw evidence of people being supported in their decision making by the Relevant Person's Representative and appointed Independent Mental Capacity Advocates. We spoke with two staff about the use of restraint. They were able to describe de-escalation techniques to minimise restrictions to people's liberty. They said, "We never use physical restraint here".

We spoke with the registered manager specifically about one individual who was subject to an authorised DoLS but who was subject to significant restrictions to their liberty. The person was prone to wandering and a high desire to leave the home. We saw the person was restless, continuously pacing up and down trying all the door handles, peering out of the windows and saying, "Can't do it, want to get out." During the two days of our inspection we saw the person was largely restricted to one locked upstairs area. We asked staff if this person went outside and we were told no because when they had taken the person out once they had tried to run away so they felt it was not safe for them to go outside. A staff member told us, "[Name of person]is constantly trying to get out, I've seen them climbing on the windowsills trying to get out." Another staff member said, "[Name of person] is not able to go out as it takes four or five of us to get [person] back in." Whilst we understood the need to protect the person from harm we were not given a satisfactory explanation as to the level of restriction nor were we assured an assessment had been made to balance safety with a degree of autonomy. We did not see any record of a plan to distract the person from their intention to leave the building nor did we see any therapeutic items such as a reminiscence box to focus the person's attention. When we discussed this with the registered manager they told us they were going to seek advice and enter into discussion with the family with the aim of allowing some supervised access outdoors. Following the inspection we asked the registered manager for a copy of this person's DoLS so we could determine if there were any conditions applied to the DoLS. This was provided and we saw the DoLS had been issued in July 2016 with two conditions, one of which was to support the person to go out walking in the community. Our evidence showed this condition had not been met.This was a breach of Regulation13

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food. One person said, "It's very good I like it." Another person told us, "I don't like the chicken so they give me something else."

However, we found people's nutritional and hydration needs were not always being met. For example, one person's care records showed they had lost a stone in weight (over 6kgs) between 14 July and 14 September 2016. The care records stated the person was on a soft diet as they were 'storing solid foods', was weighed weekly and had a food chart to record daily intake. We saw this person at lunchtime and they were given a pureed meal first and then twenty minutes later were given a normal meal. When we asked staff about this they said, "We give (person) the pureed meal first as they pouch food and then give a full meal after to make sure they get something down." We asked if this person's food intake was recorded and staff said no. There was nothing in the person's care records to show the weight loss had been raised with any healthcare professionals. We raised our concerns with the registered manager and when we went back on the second day the person had been re-weighed and their weight had increased and their food and fluid intake was being recorded.

Another person's care records showed they were at high risk of malnutrition due to low body weight and body mass index (BMI). The care records stated they were taking nutritional supplements, were on a fortified diet, had high calorie snacks between meals and were on a food and fluid chart. We looked at this person's food and fluid charts which provided limited information as they were not fully completed and quantities of meals were not stated. For example, entries stated 'toast x 1' or 'kippers – ¾' and it could not be determined if this meant one slice of toast or half a slice or one kipper or more. There was no daily target fluid intake and no evidence to show anyone had reviewed the charts to ensure the person was receiving enough to eat and drink. The care plan stated the person was to be given small portions as large portions over-faced them, yet at lunchtime on the first day of the inspection we saw they were given a large plate of food and ate only a quarter of it. The food was taken away by staff without any attempt being made to support them eating or them being offered any alternative. We checked this person's food and fluid chart at 12.20pm and no entries had been made for that day. The chef told us high calorie snacks were available between meals such as freshly juiced fruit smoothies made with cream and we saw from the care records the person had enjoyed having these and other high calorie snacks last year. However, there was no evidence to show the person had been offered or had received regular high calorie snacks recently. We looked at other people's food and fluid charts and found these had not always been completed correctly by staff and it was difficult to establish if people were having sufficient to eat and drink. This was discussed with the registered manager who confirmed they would address this matter.

Another person's weight records showed they had lost 10lbs between August and September 2016. The person had not been weighed again since that date. We discussed this with one of the senior care staff who could give no satisfactory explanation for the weight loss but said there had been problems with the weighing scales and they had been re-calibrated. There was no mention of the weight loss within the care documentation we looked at and the person was not on a food and fluid intake chart.

Our discussions with the chefs and review of the menus showed there was a good variety of foods available with a choice at each meal. The chef said if people did not like what was on the menu they would make them something different. They said they baked every day making fresh biscuits and cakes. They showed us lists of fortified dishes and nourishing drinks which were available to people who needed extra calories. The chef provided us with a list of people who were on special diets which included those who required a fortified and enriched diet. This provided detailed information however, none of the people detailed above were included on this list. This was a breach of Regulation 14 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The care records showed people had input from different healthcare professionals such as GPs, district nurses, chiropodists, dentists and opticians. We spoke with a visiting health care professional who said they believed the care to be good. They told us their team visited regularly and there had never been any concerns expressed. They told us the advice they gave was understood and carried out to a good standard. We were told people's needs requiring their support were brought to their attention without delay. However, we saw one person had been complaining of toothache and six days later their tooth had fallen out. Although the records showed the person had received dental treatment earlier in the year there was no evidence to show a dentist had been contacted on this occasion. We asked staff about this and they were unsure if the dentist had been contacted, although they later told us this was being arranged. However, when we went back on the second day and asked the registered manager if this person had seen a dentist they said they did not know and were not aware the person's tooth had fallen out. The registered manager said they would address this.

The statement of purpose stated the home provides specialist dementia care. We identified environmental shortfalls in being able to deliver this type of care. We found the size of windows provided good natural light and window sills were low enough for people to have good views of the surrounding area. Whilst artificial lighting provided an even spread of light the light switches were not of a contrasting colour and therefore may be hard for people living with dementia to find. We saw there was wheelchair access to secure, flat outdoor spaces. The dining room provided good quality furniture, tables with smooth edges and of a height which would accommodate wheelchairs. However, there was a complete lack of contrast in colours; the tables, curtains, chairs, table clothes and floor coverings were all in shades of brown or dark red which can lead to confusion for people living with dementia. We also saw the carpets on the ground floor were of good quality but highly patterned. Likewise bedroom floorcoverings of carpet or vinyl were commonly brown with brown wood furnishings providing no contrast. Furthermore we saw no evidence of bedroom furniture labelled to identify the contents. Whilst some communal areas had clocks they were not large and were not of a colour or type which were easy for people living with dementia to see and interpret. We saw no evidence of features such as calendars or day clocks to help people know the day of the week. We saw many doors in communal areas and all bedroom doors were signed with pictures and words to meet the needs of people living with dementia. We saw some attempt to introduce colour into toilets but this was not universally so. We saw no evidence of memory boxes in or around bedrooms and there was a lack of pictures which may help people to reminisce. The home provided adequate communal space in the lounges to enable staff ease of access between chairs to meet people's personal needs. This was a breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these matters with the registered manager and the deputy chief executive on the second day of our inspection. They told us they had completed an environmental audit and had a refurbishment plan in place to make the environment more accessible for people living with dementia. They provided us with a copy of this plan which showed canvas prints, dementia clocks, orientation boards and coloured hand rails were to be provided but gave no timescales for the works to be completed. We also found some decisions already taken with regard to replacement of furniture showed a lack of understanding regarding choices of colour and design. For example, we discussed dementia friendly bedroom furniture with clear drawer and door fronts that allowed people to see the clothes kept in drawers and wardrobes. The deputy chief executive expressed an interest but said replacement furniture had already been ordered.

The registered manager told us staff accessed training through a training school owned by the provider and also through distance learning modules provided by a different training organisation. We saw training certificates in the staff files we reviewed which demonstrated staff had received up to date training in areas

such as safeguarding, moving and handling, health and safety, medicines, basic life support, infection control and fire safety. The registered manager told us all staff had received dementia awareness training and they were arranging a more in-depth dementia course for all staff. We saw staff competencies had been assessed in areas such as bathing and showering people, assisting with meals, moving and handling and medicines.

We saw evidence which showed new staff completed a detailed induction process which included a period where they worked supernumerary shadowing more experienced staff. One staff member, who told us they had no previous experience of care before starting work in the home, described their induction as 'very good' and said working alongside senior staff helped them get to know people well.

Staff we spoke with told us the training they received was good and was kept up to date. They told us they received regular supervision and had appraisals and this was reflected in the staff files we reviewed.

Requires Improvement

Is the service caring?

Our findings

Relatives we spoke with expressed satisfaction with the care provided. One relative said, "I'm very content with the way [my relative] is looked after." Another relative told us, "I come all times of day or night, I've never found [my relative] distressed." A further relative said, "They always keep [my relative] clean and tidy". Another relative said, "[My relative] wanders about [the home], they [the staff] don't mind and just let them".

One relative said, "They [people who use the service] are treated with dignity and respect if they spill anything or soil themselves, the staff will take them to their rooms to clean them up." Another relative said, "[Name of person] is always clean and tidy".

We observed people having breakfast and lunch and found a marked difference in people's experiences in different areas of the home. On Harrison unit the dining room was spacious and tables were laid with tablecloths, place mats and napkins. On the other two units the dining rooms were cramped and the tables were bare. People were asked what they would like to eat and on Harrison unit we saw when people did not understand the choices on offer staff showed them two plates of food to aid choice and we heard staff asking people the size of portion they wanted. This did not happen in the other two areas.

We observed some people had difficult eating with the utensils provided. For example, one person whose lunch was provided on a plate was given a spoon to eat with. We saw the person struggled as the meat was not cut up into small pieces. There was no plate guard and as the person ate the food was pulled over the plate and onto the person's clothes. We saw another person eating porridge at the dining table which they spilt over the table and onto their clothes. The person did not have a clothes protector on and there were no napkins available. The person was trying to pick up the porridge from the table with their spoon and licking their fingers to clean them. When the staff member came into the room they noticed, spoke kindly with the person and brought a cloth to wipe the table and the person's trousers and gave them a clean spoon. We saw other people were given food and drinks which they had to balance on their knees. We saw another person was given their tea to drink out of a plastic drinking glass and when we asked staff why they said the person could not lift the heavy china mugs. We asked if there were any plastic mugs or cups with handles and the staff member told us they had a few but thought they probably needed more.

We saw some people's rooms were personalised and contained treasured items, family photographs and a personal television. However, in comparison other people's rooms were sparsely furnished with no personal items on display. For example, several staff told us one person was a fan of a particular singer and said their bedroom reflected this with photos and posters of the singer. We looked in this person's bedroom and found there was nothing displayed just a poster of the singer folded up on top of the wardrobe. We looked in two other bedrooms and found these were equally stark. We saw a pile of framed family photographs and other pictures in one of the offices and asked staff about these. They told us these had been removed from rooms and walls as in the past people had thrown or damaged them.

Staff spoke and interacted with people in a calm and friendly manner. We saw people appeared relaxed and confident in the presence of staff and the staff were able to communicate well with people. For example,

where people had limited levels of verbal communication it was evident the staff understood their needs and responded accordingly.

Staff we spoke with were clear in their understanding of protecting people's rights to privacy and informed us they always knocked and sought permission before entering a person's room. They also informed us they ensured doors were closed when providing personal care. We saw this happened in practice. People were treated with respect. We saw examples where people's privacy, dignity and human rights were commonly respected. For example, staff asked people's permission and provided clear explanations before and when assisting people with medicines and personal care. We saw people refusing care and whilst staff gave encouragement, people's refusals were respected. This showed people were treated with respect and were provided with the opportunity to refuse or consent to their care and or treatment. Yet we also observed differences in how staff responded to people. For example, we were in the lounge and heard one person twice ask staff, "Have you got some of those for me?" when staff had brought in biscuits for another person. The staff member did not respond to what the person had said and instead asked the person if they wanted a shave and took them to their room. In contrast when we visited on the second day the same person heard staff asking another person if they wanted a bacon sandwich and when they said they would like one too staff brought this for them.

We also witnessed some less dignified areas of care. We saw men who had not had a shave for a number of days yet their care plans did not indicate this was their choice. We spoke to one person and asked if they wanted a shave and they said, "It's about time I had one." We saw two people's fingernails were dirty and one person wearing a jumper which was stained with food.

We saw some people had no shoes or slippers on. When we asked one person they told us their shoes hurt because they had blisters and when we asked if they had any others they could wear they said, "They tried to get some, but I don't have any." When we asked a staff member about this they confirmed the person had blisters on their toes and said that was why they did not wear shoes or slippers. There was no information about this in the person's care records and when we asked a senior staff member about this they were not aware of the blisters but said they would look into this matter. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

The registered manager told us they completed pre-admission assessments with people and their families before people moved into the home so they could make sure the home could meet their needs. We saw evidence of these assessments in people's care records. Staff we spoke with told us the assessment process included information about people's background and lifestyle before they moved into the home and personal preferences. We engaged in a conversation with a person and a senior care worker. The conversation focussed on the person's family, social and employment history. The conversation clearly demonstrated the member of staff had a good knowledge of the person which fitted with our understanding gained from the care record.

Care records we reviewed varied in the amount of detail recorded, however generally we found they were not person-centred and did not always reflect people's current needs. We found the care plans consisted of a series of reviews and updates from staff rather than an actual plan of care. This meant staff had to read all the reviews to gain a full picture of the care and support the person required. For example, the last review for one person showed they were on a fortified diet due to unplanned weight loss and their diet was being recorded. However, staff told us the person was also on thickened fluids and had a soft diet yet this was not evident from the review.

Another person's care records showed they were prescribed laxatives as they were prone to constipation and said staff were to 'monitor'. We asked staff how this was monitored and they told us staff recorded bowel movements in the daily records. We looked at this person's daily records for a nine day period and there was no information recorded about this. The person's medicine administration record (MAR) showed they were prescribed a laxative to be given twice a day and this had been administered only once a day since 23 September 2016 with entries stating the medicine had either not been required or refused. We discussed the care records with the registered manager who agreed the care plans required more information to reflect people's needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw one person's care records mentioned many times that the person liked dolls and had two in particular which were special to them. We saw the person in the lounge during the morning and they did not have a doll with them. When we asked care staff about this they brought a doll and the person was delighted and cuddled the doll talking to it contentedly. It was obvious the doll provided the person with an important focus and comfort yet this was not provided by staff until we prompted them even though the care plan showed this was important to the person's well being. When we visited again on the second day this person did not have their dolls with them.

We spoke with the activities co-ordinator who had joined the staff team in June 2016. They were very enthusiastic and obviously got a great deal of job satisfaction from their role. We saw they had organised a range of leisure and social activities both within the home and in the local community. The activities co-ordinator confirmed if people were reluctant to join in group activities they engaged with them on a one to one basis to make sure they did not become isolated.

They told us they had made plans to hold a twice monthly coffee morning at a local public house for people and their families. They said some people attended meetings organised by "Dementia Friendly Todmorden" a group set up to promote dementia awareness within the local community. Mini bus trips to places of interest were also arranged on a regular basis.

We were told people were able to use the hydrotherapy pool and social facilities located in a neighbouring service operated by the same provider, within walking distant of Pennine Lodge. A physical therapist also visited the home three times a week and offered people a range of a physical activities tailored to their needs and ability. We saw people participating in this session on the first day of our inspection.

A list of activities was displayed on the notice board and the activities co-ordinator kept a daily record of the activities people had participated in. We saw people taking part in activities on both days of our inspection.

However, although the activities co-ordinator provided people with a range of activities we found in their absence there were insufficient care staff on duty to engage people in meaningful activities. We found on Ryland unit there was little to stimulate, interest or engage people other than the television and a fish tank. There were no books, magazines, reminiscence or therapy items such as rummage boxes or puzzles to occupy people. We saw some people sat for long periods of time in communal areas with nothing to do, while others walked continuously up and down the corridor between the lounge and dining room.

The complaints procedure was displayed in the home. The registered manager told us they had received no complaints. They said if people raised minor concerns then these were dealt with straight away but acknowledged this was not recorded. The registered manager told us they recognised these needed to be recorded and would put systems in place to ensure this happened. No complaints were raised in our discussions with people and relatives, although two relatives said they felt the laundry service could be better. One relative told us, "They don't iron clothes properly, [name of person's] clothes are creased sometimes."

Inadequate

Is the service well-led?

Our findings

We found there was a lack of consistency in how the care service was provided in different areas of the home which impacted on the outcomes for people using the service. For example, we observed the higher staffing levels and more spacious environment on Harrison unit provided a calm atmosphere where there were more activities taking place and staff had time to engage with people. This contrasted markedly with our observations of daily life on the other two units were there were fewer staff, communal space was limited and there was less social interaction or engagement. Quality assurance systems were in place however we found these were limited in their effectiveness to ensure continuous improvement of the service. This was evidenced by the breaches we found at this inspection which demonstrated shortfalls in the quality of care people received and led us to conclude the service was not well-led.

We saw evidence of audits of the environment, staff adherence to uniform policy and medicines. We compared the outcome of the staff uniform policy to our own observations. The audit had found on a number of occasions staff wore jewellery, had painted nails and untidy hair. Our observations showed the staff to be smartly dressed, hair in place and no sign of nail varnish. This showed the actions taken as a result of this audit were effective. However, we found other audits had not been as effective as issues we found during the inspection had not been identified or resolved by the provider. For example, our previous inspection in September 2014 had identified people missing their medicines in the evening and a lack of PRN protocols and these same issues were found at this inspection. Similarly we had previously identified risks around fire doors being propped open and found this was still occurring at this inspection. We found people's beds were not made by the care staff until after lunch although the rooms had been cleaned by the housekeeping staff. This meant if people had wanted to return to their room to rest they would not have been able to do so. This had also been identified at the previous inspection.

We saw an infection control audit had been carried out in May 2016 by the Local Authority infection control team. Some improvements had been identified and the home had addressed these through an action plan. However, we observed safe infection control procedures were not always being followed and saw clinical waste was not disposed of correctly, some areas were unclean and there were discernible odours.

We saw detailed monthly visit reports had been completed by the provider and identified where improvements were needed. However, they had not identified the issues we found at this inspection.

The registered manager told us accidents and incidents, including safeguarding, were audited monthly and this was reflected in the records we saw. The audits showed the actions that had been taken in response to each individual incident or accident however the analysis was limited as overall themes and trends had not been identified or addressed to prevent further recurrences and reduce risks to people. For example, the accident audit for July 2016 showed that five out of the six accidents that had occurred had happened on one unit, yet there was nothing to show that this had been explored further. We discussed this with the registered manager who agreed that further analysis would be useful.

The registered manager told us there were no care plan audits. They said they wrote and updated a lot of

the care records and checked others but said these checks were not recorded. We found the care plans consisted of a series of reviews and updates from staff which did not fully reflect the care the person required. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager who had been in post for four years. Staff we spoke with told us the registered manager and senior care staff were supportive and approachable. Staff told us they enjoyed working at the home and felt staff worked well together as a team. Staff told us they had regular staff meetings and this was evidenced in the minutes we saw from recent meetings. We also saw the minutes from residents and relatives meetings which had been held this year.

The registered manager told us as part of the quality assurance monitoring process they sent out survey questionnaires to people who lived at the home, their relatives, other healthcare professionals and staff on a six monthly basis. We looked at the results of the most recent service user/relative survey carried out in June 2016 and found all fifteen questionnaires returned by people who used the service or their relative rated the service overall as either good or excellent.
Two questionnaires returned by healthcare professionals both rated the service as excellent.

We looked at the most recent staff survey carried out in July 2016. The registered manager confirmed the survey was carried out to seek their views and opinions of the service and to establish the level of engagement they had with the organisation. We saw fifteen survey questionnaires had been returned by staff and the majority of staff had made positive comments about the support they received from senior management. However, we noted two staff members indicated that they did not feel valued as member of the staff team. The registered manager told us although survey questionnaires were routinely sent out they did not collate the information or inform people of the results of the survey.