Seacole's Limited

Pelham House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Pelham House in a residential care home providing care and support to up to 22 older people, some of whom were living with dementia. At the time of the inspection there were 19 people living at the service.

People's experience of using this service and what we found
People were not supported to have their medicines safely. Medicines were not always ordered on time and medicines were not always stored correctly.

Risks to people had not been consistently assessed, monitored and reviewed. When people had had several falls, they had not been referred to the relevant health care professionals for advice.

Some areas of Pelham House were not clean. Staff were not wearing face masks in line with Government guidance and there was no risk assessment to show any rationale for this or how risks to people would be mitigated.

People were not supported by staff who had been recruited safely. Staff did not always complete an induction before working with people. There had been a turnover of staff and the service was regularly using agency staff. People commented about frequently seeing new faces and having to tell staff how they should be supported. Staff training was not up to date and some staff had not met with their manager for one to one supervision to discuss their performance.

There was a lack of oversight of the service. Accidents and incidents were not regularly reviewed to ensure patterns were identified. Checks on the quality and safety of the service were not robust. For example, some checks completed by the nominated individual around medicines management did not identify the shortfalls found during the inspection.

The provider failed to maintain and sustain improvements. This was the fifth consecutive inspection which identified breaches which resulted in breaches of Regulation.

People were able to have visitors when they wished and there were no restrictions.

Staff worked with visiting health care professionals and followed advice given.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 18 March 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations. The service has been rated requires improvement or inadequate for the last four inspections, where a rating has been given.

Why we inspected
The inspection was prompted in part due to concerns received about medicines, recruitment and the management of the service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines management, recruitment, risk management and governance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Pelham House

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Pelham House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Pelham House is a care home without nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with CQC to manage the service.

At the time of our inspection there was not a registered manager in post. The service has not had a registered manager since September 2021. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We reviewed information received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with four people living at the service and two relatives about their experience of the care and support provided. We spoke with one health care professional. We spoke with the manager, three staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We spoke with a further three care staff. We continued to seek clarification from the provider to validate evidence found. We reviewed further accident and incident forms, staff rota and quality assurance records. Following the inspection, the nominated individual informed CQC of immediate action taken to keep a person safe.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection, we identified gaps in the records to monitor the temperature of the medicines room, as an area for improvement. During that inspection the manger, at the time, implemented a revised protocol. Whilst improvements had been made since the previous inspection, these needed to be embedded and to be maintained.

Using medicines safely

- People did not always receive their medicines safely and as prescribed.
- There was a lack of systems in place to manage ordering of medicines and medicines stock. One person's medicine had run out of stock the day before the inspection. The medicine had failed to arrive when expected and staff had not identified this. The deputy manager resolved this on the day of the inspection so that the person had their medicine.
- Some people were prescribed medicines on an 'as and when' basis (PRN), such as pain relief. There were no PRN protocols in place for at least three people's medicines. PRN protocols include information, such as why the medicine is required, the dosage over a 24-hour period and whether the medicine was effective.
- Staff told us nobody was prescribed medicines which required two staff to administer and record them. During the inspection we checked one locked medicines cupboard and found two bottles of medicine which required this level of administration. There was a medicines administration record (MAR) which noted the medicine was to be taken every four hours if needed, however there was no record of whether the medicine had been offered, administered or declined. There was no PRN protocol in place. Two staff told us they did not know this person had this medicine prescribed. There was no evidence this medicine had been offered. The person was not able to communicate if they were in pain and there was no guidance for staff about what signs the person may exhibit should they be in pain.
- Medicines were not always stored safely. Staff told us they checked the temperatures of rooms where medicines were stored in the morning. Consideration had not been given to fluctuating temperatures throughout the day. It is important for medicines to be stored in line with manufacturer's instructions. This is usually under 25 degrees. The deputy manager checked the temperature in one person's room where medicines were stored, and this was 26 degrees. There was a risk the temperature may affect the efficacy of the medicines. The deputy manager moved medicines from people's rooms to a cooler medicines room.
- People's MAR were not always completed accurately and there were gaps where staff had not signed the MAR to note the medicine had been administered. It could not be assured therefore that people were receiving their medicines as prescribed. This included when people had been prescribed anti-biotics. The nominated individual had identified a shortfall around gaps in signatures, however had not identified the further shortfalls.
- Medicines competency assessments had been completed. These were basic and did not include who had completed the assessment. Therefore, the provider could not be assured the person completing the

assessment was qualified to do so.

The provider failed to ensure care and treatment were provided in a safe way to ensure proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risks to people's health, safety and welfare had not been consistently assessed, monitored and reviewed. A relative told us, "I don't think [our loved one] is safe here."
● Some people were at risk of falling and had fallen. For example, one person had fallen once in January 2022 and twice in March 2022. Staff had not considered seeking medical advice to establish any underlying cause for the falls or considered moving the person to a downstairs room. Following the inspection, the nominated individual confirmed this person had been moved to a ground floor room and had been referred to an occupational therapist.
● Another person had had several falls and was in hospital, following a fall, at the time of the inspection. A member of staff told us, "I said that [person] needs a sensor mat because they had falls, but management said she doesn't need it."
● People living with dementia were not always protected from environmental risks. For example, the laundry was not locked and there were cleaning products which had not been locked away.
● The hot water in the laundry, kitchen and sluice room were not temperature controlled. This meant people may be at risk of scalding themselves if they used these hot water taps. One member of the management team told us the laundry and kitchen were kept locked. Throughout the inspection, when we checked, these rooms were not locked. The manager confirmed these rooms were not kept locked.

The provider failed to ensure care and treatment were provided in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were not assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were not assured that the provider's infection prevention and control policy was up to date.
● We were not assured that the provider was responding effectively to risks and signs of infection.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● Staff, including the nominated individual and manager, were not wearing face masks in line with Government guidance. The manager told us masks had not been worn in the five weeks they had been working at the service. No risk assessment had been completed to evidence how risks were mitigated. Some staff wore a face mask when providing people with personal care and others did not. Staff said, "We have been told we don't need to wear them. [The nominated individual] never wears a facemask. We have not worn them for weeks and weeks" and, "I wear a face mask when I am doing personal care but not the rest of the time." Staff testing for COVID-19 was being completed daily.
● Staff did not dispose of personal protective equipment in clinical waste bags. We discussed this with the manager who arranged for the clinical bag to be put in situ. Later during the inspection, this had been removed and a black sack had been put in place again instead.

● The service was not clean. For example, walls were scuffed and there were stains on surfaces and carpets. Inspectors did not observe touch point cleaning taking place during the inspection, which would be in line with best practice, such as NHS – The National specifications for cleanliness. There were no records to demonstrate regular touch-point cleaning had been completed. The most recent record was completed on 20 July 2022. A member of staff said, "Some cleaners are doing caring. Some things are just not getting done."
● The service had a problem with one of the three boilers which had not been working since 22 July 2022. This had resulted in a lack of hot water in part of the service. One staff said, "I try and make people comfy when I am doing pad changes. It is horrid not having hot water. I can't just up and move [a person] to a bathroom the other side of the home. When they need to be pad changed that is it. That means we have to use cold water. It is undignified."
● During the inspection one ground floor communal toilet, with a hand basin outside this room, had no hot water. A second ground floor toilet had no hot water, no soap and no hand towels.

The provider failed to assess the risk of, and preventing, detecting and controlling the spread of, infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.

Visitors were able to see loved ones when they chose to.

Staffing and recruitment
● People were not supported by staff who had been recruited safely. References had not always been obtained prior to the new staff working at the service in three staff files reviewed. Two application forms had gaps in employment histories which were not explained. In one case, the member of staff had begun working at the service prior to any good character checks or risk assessment in their absence.

The provider failed to operate effective recruitment processes and ensure information specified in Schedule 3 of the Health and Social Care Act was available for each member of staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Disclosure and Barring Service (DBS) checks were completed before new staff began working at the service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

● People's needs were assessed, and a dependency tool was used to make sure there were enough staff on duty. However, staff had begun working without an induction and training and had only shadowed experienced colleagues. Following the inspection, the manager told us they had commenced the induction process.
● Staff were not all aware how to use the electronic care system. We asked staff when they read people's care plans and risk assessments. One member of staff told us, "I don't know how to use [the electronic system]. I only use it for writing daily notes or if I needed to do an accident form. No-one has shown me how to use [the electronic system]." Another member of staff commented, "No-one has been trained on using [the electronic system]. I have learnt as I have gone along."
● There had been a turnover of staff and the service was reliant on the use of agency staff along with staff from a neighbouring domiciliary care agency also owned by the nominated individual. The manager, deputy

manager and five care staff had resigned during July 2022. People told us, "Waiting here is an experience. Especially at night. You can wait a while for help. There are a lot of new faces. They don't know what I need, and I have to tell them what support I need. I have not seen my care plan", "I don't like being alone" and, "[Staff] come when I need them to."

● Staff told us, "I feel that working with agency staff all the time, I am either doing everything myself or constantly checking what they are doing or have done" and, "There are a lot of new staff and they are learning. The residents are tired of always having different staff."

● Generally, there were three care staff and a team leader on each day shift. Support was also available from the manager and deputy manager. There were four staff at night to ensure people could be supported safely in the event of an emergency.

● Staff did not consistently have regular one to one supervision meetings. Staff told us, "I had one a little while ago with the previous manager", "I don't think I have had one" and, "I don't remember ever having one."

● The nominated individual had identified staff training was not up to date. We reviewed several training schedules. Staff had not completed basic training such as, mental capacity awareness, general data protection regulations, equality and diversity. Additional training, such as catheter care and dementia, had not been completed by several staff to ensure they were up to date with current guidance and best practice.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Accidents and incidents were poorly recorded and managed. There was no overview of accidents or incident to help identify any themes to ensure people were referred to the relevant health care professionals as needed. The nominated individual had identified, on 30 July 2022, the analysis of accidents and incidents had not been completed by the previous management team since 2021.

● Some accidents and incidents were recorded on the electronic system and others on a paper form. The nominated individual had taken paper forms for July and August away from the service as they had identified there was no analysis of these being completed. This is an area for improvement.

● We asked to review the accident forms from January to June 2022. The nominated individual was unable to locate these. We were only able to review those which had been input on the electronic system.

● Staff understood the potential signs of abuse and told us about the reporting process. Staff were aware they could escalate safeguarding concerns to other bodies, such as the local authority safeguarding team.

● Not all staff had up to date safeguarding training completed. Neither the manager nor the nominated individual had up to date safeguarding training.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection on 25 January 2022 the provider failed to assess, monitor and mitigate risks to the health, safety and welfare of service users and others who may be at risk which arise from carrying out the regulated activity. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had addressed the concerns regarding the heating system following the last inspection. At this inspection further concerns were identified. The provider remained in breach of Regulation 17. This is the fifth consecutive breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There were widespread shortfalls in the day to day running of the service leading to multiple breaches. There was a lack of oversight of the service. The nominated individual failed to maintain and sustain improvements, following their action plans submitted after previous inspection reports, requirements or enforcement actions.
- Checks and audits had been completed up until the end of June 2022. There was a file of daily walk around checks – the last form completed was 04/07/2022. The manager stated they walked around the service each day but did not record this. There was no evidence of audits completed by the manager since they began at Pelham House.
- The nominated individual had identified several shortfalls in the quality and safety of the service, including gaps in MARs, training not being up to date, high use of agency staff, lack of staff supervisions. Basic risk assessments had been completed, however action to address the shortfalls was not efficient and effective. A risk assessment noted 'Medicines have not been audited since 27th June 2022 and current organisation of medicines administration is poor.' The checks completed by the nominated individual were not sufficiently robust. For example, medicines audits had not identified the shortfalls we found during the inspection.
- The nominated individual told us he had instructed staff they did not need to follow Government guidance regarding the wearing of face masks and that this had been decided at a board meeting. The nominated individual was unable to provide the minutes of this discussion. No risk assessment had been completed. Current guidance notes: 'Face masks should be worn by all care workers and encouraged for visitors in care settings and when providing care in people's own homes, irrespective of whether the person being cared for is known or suspected to have COVID-19 or not.'
- The service had not had a registered manager since September 2021. A registered manager from a service owned by the nominated individual began working at the service in July 2022 and was in the process of

registering until a new registered manager had been recruited. A manager and deputy manager had been overseeing the service on a day to day basis until May / June 2022.

The provider failed to assess, monitor and mitigate risks to the health, safety and welfare of service users and others who may be at risk which arise from carrying out the regulated activity. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was no evidence people were involved in the day to day running of the service. Minutes from a board meeting on 26 May 2022 noted there had been a 'family and friends' meeting. We requested a copy of the minutes; however, the nominated individual was not able to provide these.

● A relative commented, "I don't feel well informed about what goes on here."

● Systems and processes to obtain feedback from people, relatives and staff had not been followed. Support for staff was inconsistent and staff did not always have regular one to one supervision meetings to discuss their performance. Staff meetings had not been regularly held to ensure staff were able to feedback about the day to day running of the service. There was a handwritten note on the white board in the manager's office which noted, 'Can we have a staff meeting please'. Staff told us, "I have never been to one", "The last one was when the previous managers were here" and, "We had one when the old managers were here. [The nominated individual] did one but it was all about changing the name on paperwork and payslips. Staff have brought up about communication and I think it is better now [manager] and [deputy manager] are here." The manager told us they were scheduling a staff meeting.

● Staff were positive about the manager and felt they could raise any concerns and that they would be listened to.

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

● The nominated individual was aware of their legal responsibility to be open and honest when things go wrong.

Working in partnership with others

● Staff worked with visiting health care professionals, such as community nurses and GPs.

● One visiting professional told us the staff followed any guidance given.