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

Summary of findings

Overall summary

About the service
Pelham House is a residential care home providing personal care to 21 people at the time of the inspection. Some people were living with dementia. The service can support up to 22 people.

People's experience of using this service and what we found
People were not supported to have their medicines safely and on time. There had been medicines errors and action had not been taken to address these. Temperature checks, to make sure medicines worked effectively, were not consistently completed.

People were not protected from the risks of avoidable harm. Risks were not well managed. Staff did not have clear guidance to follow to help reduce the risks to people's health, safety and welfare.

There were not enough staff to meet people's assessed needs. Action had not been taken to increase staffing levels when people's needs had increased. Staff were not always recruited safely.

There was a lack of leadership, oversight and scrutiny. Checks and audits to monitor the quality of the service were not robust and effective. Action was not taken when shortfalls were identified. The culture within the staff team was poor and morale was low. Staff did not feel listened to.

We were assured the provider was protecting people from the risks of infection. Staff wore personal protective equipment, such as facemasks. The service was clean.

People were supported by staff who knew them well. People and their relatives had developed strong relationships with staff. People were treated with dignity and respect by staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support 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 January 2021).
The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We received concerns about people's safety and welfare, and medicines management. As a result, we undertook a focused inspection to review the key questions Safe, Caring and Well-Led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has deteriorated to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pelham House on our website at www.cqc.org.uk.

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.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to unsafe medicines management, poor assessing and mitigating of risk, staffing levels, recruitment and a lack of leadership and oversight.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring 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 Care Act 2014.

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 or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. They are also the provider and are legally responsible for how the service is run and for the quality and safety of the care provided. An appointed general manager supported the day to day running of the home.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We used all of this information to plan our inspection.

During the inspection-
We spoke with seven people living at Pelham House and one person's relative. We spoke with the registered manager, the manager, deputy manager, care co-ordinator and four staff.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records and safety checks. We spoke with two relatives. We reviewed a range of medication records. We asked the manager to send a range of documents by email to support the inspection.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At the last inspection in November 2020 the provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 20018 (Regulated Activities) 2014.

At this inspection improvements had not been made and the provider remained in breach of Regulation 12.

- Medicines were not managed safely. Staff had recently started to use an electronic system for the recording and administration of medicines. Staff told us that they had not received training on how to use the new system. There had been no audit of medicines during July 2021. We found mistakes had been made. Medicines prescribed by peoples GP's had been missed or not signed for by staff.
- Some people were prescribed medicines, 'as and when' needed. There were policies and procedures in place for these medicines but there was no individual guidance to tell staff how to give these medicines safely and consistently or about the signs they would see if the person needed the medicine. One person was prescribed a medicine for when they became upset and distressed. It was agreed with the GP, and other relevant health care professionals, that the medicine was administered covertly. Staff we spoke with did not know when they would administer this medicine and said because they were unsure, they had never administered the medicine to the person. There was no information on how and when to administered medicine covertly.
- People received as and when medicines for pain. There was no individual guidance in place to inform staff when these medicines should be given.
- For most medicines to be effective they have to be stored at a temperature of under 25 degrees Celsius and temperatures should be checked daily. The temperature in the clinic room were medicines were stored was checked inconsistently. No action had been taken to address the inconsistency. When temperatures were recorded, they were within the recommended limits. Medicines people took daily were kept in locked cabinets in their bedrooms. Temperature checks in people's medicines cupboards were taken inconsistently the cupboards we checked were within normal limits but there was risk that temperatures may exceed the recommended limits. There was a risk that people were receiving medicines that may not be effective.
- Some people's medicines had 'run out' and had not been administered. A staff member told us that the medicines had not arrived from the pharmacy. When we looked at the person's electronic medicine record, medicines had been signed by staff as given even though they were not available. Another person's important medicine which they needed to help them with their illness had not been signed for as given for three days. The medicine record did not record why this had happened. Other records recorded peoples eye drops had not been given as staff could not find them. We found that they were in a cupboard in people's

bedrooms.
● We received a report from the manager that a person had been given too much medicine. Action had been taken to seek medical advice and the person was not harmed. At the time of the inspection this was being investigated but had not been concluded.

Assessing risk, safety monitoring and management
● Risks to people's health, safety and welfare were not well managed. Staff did not always have clear guidance on the actions they should take to protect people from avoidable harm. Risk assessments did not always have the correct information recorded to make sure people received the care and support they needed in the safest way.
● One person was at risk of choking. There was a risk assessment in place, but it was irrelevant to the identified risk of choking. The risk assessment guidance given to staff for was for someone who was receiving their nutrition directly through a tube via their nose or mouth to their stomach. No-one living at Pelham House received their nutrition in this way. There was no guidance in place about what to do to prevent the person from choking and what to do if they did choke.
● One person had a catheter in place to drain urine from their bladder. There was no care plan or associated risk assessment in place to tell staff how to support the person with their catheter care. There was no information to inform staff about what action to take if the catheter was not working properly or the signs to look for if there was the risk of infection developing.
● Some people were at risk of developing pressure sores and were on special mattress to reduce the risk of their skin breaking down. We looked at three mattresses and two of them were set at the incorrect settings. Some of the mattresses were not recorded as checked and others were recorded as checked and correct yet when we reviewed the settings, they were incorrect.
● Some people displayed behaviours which could put themselves or others at risk. There were behaviour support plans and risk assessments in place. However, these lacked step by step guidance on the action staff needed to take to make sure people were supported consistently and safely. The behaviour plans contained information irrelevant to the risk and contained information on pressure sores and infection which were also documented and repeated in other parts of the care plans and risk assessments. Risk assessments failed to mention that some people had sensory impairment and they was no explanation or guidance on how they should be supported and cared for in a way that suited them best. Staff were not sure how to manage people's behaviour and had not received any training about behavioural management.

Systems and processes to safeguard people from the risk of abuse
● People could not be assured they were protected from the risks of abuse. The provider did not recognise their failure to ensure correct administration of medicines and mitigate risk represented potential neglect, a form of abuse.
● Staff had been trained about safeguarding adults and were able to tell us how to identify and respond to allegations of abuse, they also failed to recognise their actions in relation to poor administration of medicines constituted neglect.
● People told us that they felt safe. One person said, "I feel much safer here than I did at home. There is always someone around to talk to if I am worried." A relative commented, "I think [my loved one] is very safe at Pelham House. I haven't ever been worried about his safety."
● Staff said that the manager would take action if they reported any concerns of abuse. They knew where they could go outside of the organisation to raise their concerns if necessary, such as to the local authority safeguarding team.

Learning lessons when things go wrong
● Lessons were not consistently learned. Medicines errors continued to be made. There was no analysis of

medicines errors to identify any theme. The lack of staff training and competency had not been identified or addressed by the management team to drive improvements and improve the safety of the service.
● Accidents and incidents were recorded. However, they were not consistently detailed, and this lack of detail had not been addressed by the management team. The manager reviewed accidents with the senior staff team and discussed any emerging theme in order to contact the relevant health care professionals as needed.
● Staff did not take responsibility for shortfalls identified throughout the inspection and there was a culture of blame.

Care and treatment was not provided in a safe way. Medicines were not effectively managed leaving people at risk of harm. The provider had failed to assess risks and did not do all that is reasonably practicable to mitigate any such risks. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff to meet people's assessed needs. Senior staff assessed people's needs and completed a dependency tool to help assess the number of staff required to provide people's care and support. This information was shared with the registered manager and manager. Action had not been taken by the management team to increase staffing. For example, assessed needs in July 2021 indicated there should be four staff on duty to meet people's needs. Only three staff continued to be on duty.
● When medicines were being administered (four times a day) this reduced the staff number further. The medicines took about an hour to complete, leaving only two staff to support 21 people, many of whom required the support of two staff for either their mobility, eating and drinking or personal care.
● At night there were only two staff on duty. The provider's dependency tool in July 2021 noted ten people needed the support of two staff. We raised concerns with the manager that, in the case of an emergency such as a fire, staff would not be able to support people to safety.
● Staff said, "They [the management] expect too much from us. We work with the minimum amount of staff. There are only three staff working on the floor. We can't get everything done. We have lots of people who need two staff to help them." Another staff member said that they did not have 'quality' time with people as they were too busy to sit and talk to them.
● Some people were cared for in bed to poor health. Staff briefly looked into their rooms or carried out essential checks but did not have quality time to spend with them, such as to encourage them to have a drink. People said, "Sometimes we have to wait a little while, but we always know [the staff] will come as soon as they can" "I do get lonely here but I know the girls are busy".

The provider failed to deploy sufficient numbers of suitably qualified, skilled and experienced staff. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● People were not protected by safe recruitment. We reviewed three staff recruitment files. Staff had not been recruited in line with Schedule 3 of the Health and Social Care Act. Two staff recruitment files did not have a full employment history and there was no satisfactory explanation of gaps in employment. In one staff recruitment file the dates of employment in one role, on the application, differed from the dates given in the corresponding reference. This had not been identified and subsequently not addressed.
● A checklist had been signed by the manager at the front of each recruitment file. The manager told us they only checked the documents were in place and had not reviewed them. The registered manager and manager informed us on the day of the inspection they had recruited a new human resources member of staff who was due to start the following week. The manager told us they would prioritise a recruitment audit of all files to identify and address shortfalls.

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.

● Two references were obtained; health checks were done and criminal record checks with the Disclosure and Barring Service had been completed to ensure new staff were suitable to work with people.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the inspection in March 2018 (published April 2018) this key question was rated as good. This key question was not inspected in January 2021. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Although staff were compassionate, a lack of awareness did not always enable staff to recognise poor care or respond meaningfully. For example, staff giving medicines will have seen gaps in records of administration. However, none had questioned whether medicines had been administered or recognised potential consequences of non-administration. Staff did not take ownership of concerns they should have identified. This did not make sure people were well treated and supported or demonstrate the behaviours of a caring service. This is an area we have identified as requiring improvement.
- People were supported by staff who knew them well. Staff had built up trusting relationships with people. When staff spoke with people, they were respectful. Staff knew people's choices and preferences.
- People said, "Its good here, they look after me well" and "Nothing is too much trouble all the staff are very helpful." A relatives commented, "The staff are really caring and very kind. They are very friendly to me and to [my loved one]." . People were supported to maintain relationships that were important to them and visitors were welcomed. Relatives told us they visited their loved ones and said they carried out a Covid-19 test before seeing their loved ones.

Supporting people to express their views and be involved in making decisions about their care

- People, their relatives and health care professionals were involved in the planning of their care and support. People were involved in making decisions about their care and support. Records showed the involvement of people and their relatives at the point of their initial assessment before they moved into the service. We observed staff giving people choices. People were encouraged to express their views on how they preferred to receive their care and support.
- Staff knew people's backgrounds and life histories. They were able to chat and talk with them about topics and people that were important to them.
- Relatives said, "The staff always contact me, if there are any concerns or if there are any changes to [my loved one's] care. When I call the staff are always able to tell me and know what's going on. They know [my loved one] very well" and "I feel involved as much as I want to be in her care. I ask staff questions sometimes and have always been happy with their responses."

Respecting and promoting people's privacy, dignity and independence

- Staff knocked on people's doors and waited to be asked in. Staff spoke with people discreetly and assisted them back to their rooms when supporting them with personal care. People were encouraged and supported to be independent.

● Staff said, "Before we do anything, we ask if it is alright and explain what we are going to do." We observed this throughout the inspection.
● A relative told us, "The personal care is always good. I visit regularly and [my loved one] is always well looked after. They make sure their fingernails are cut and cleaned. They make sure their mouth is cleaned after they have helped [my loved one] to eat."
● People decided how they wanted to be supported. People's ability to do things for themselves was assessed.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

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

At our last inspection in November 2020 the provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection, we found improvements had not been made and there was a continued breach of Regulation 17.

● There was a lack of leadership, oversight and scrutiny at the service which placed people at risk of harm. There were many checks and audits in place. Different senior staff had responsibility for several checks. They were defensive and did not take ownership of the shortfalls we identified throughout the inspection. There was no co-ordination of the audits and there was a lack of oversight and scrutiny of the checks by the registered manager and manager.
● When senior staff had identified concerns, and escalated them to the registered manager and manager, action had not been taken to address the concerns. For example, senior staff had raised concerns about the staffing levels. No action had been taken to remedy this.
● Staff had suggested improvements to follow best practice. However, they told us they were not listened to. One member of staff commented, "It is extremely frustrating, all the time. There is so much I want to do but I am prevented from doing it. When you go above [to the registered manager] you are told no you can't have or can't do. I feel like piggy in the middle. It is all about money". Staff had suggested to the registered manager setting up a homely remedies policy to ensure people were not waiting for medicines such as paracetamol. The registered manager had not agreed to implement this.
● There was no evidence of reflective practice to support driving improvements. For example, there continued to be medicines errors and action had not been taken to ensure staff were trained and competent to use the electronic medicines system.
● The management team understood their regulatory responsibilities, including in relation to duty of candour. This is a set of legal requirements that services must follow when things go wrong with care and treatment. They understood when to inform the Care Quality Commission (CQC) and local authority of important events. However, we found one occasion when there had been an incident reported to the local

authority but CQC had not been informed.

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; Working in partnership with others

● The culture at Pelham House was not open and inclusive. The registered manager was out of touch with what was happening at the service. Staff morale was low, and staff were stressed and felt overloaded with work. Staff did not feel valued or supported. Senior staff were territorial about their own audits and there was a blame culture.

● Staff told us that they felt frustrated with the management of the service. They said they got no support from the management and were not listened to. Staff meetings were held, however, one staff member said, "We tell them our concerns, but they take no action". Relatives told us they only saw the registered manager when there were functions at the service. Staff said that the registered manager was not at the service very often.

The provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us the communication was good and they felt they and their loved ones were involved, as far as possible in their care and support.

● The manager and staff liaised with people's health care professionals, such as clinical commissioning groups and GPs to seek advice and guidance and to support people to stay healthy.

● Surveys had been completed by people and staff in December 2020. The manager had reviewed the responses and analysed the results. The numbers of responses were low, and they reviewed the process to encourage a higher response in future. A further survey was completed with people in April 2021 and a higher response rate was achieved. Results were mainly positive. Some people felt there were not enough activities. Action had been taken to increase activities for people and this included spending time with people who were unable to leave their rooms due to their health.

● Staff worked closely with people, their relatives and health care professionals.