Tamaris Healthcare (England) Limited

Pennine Lodge

Inspection report

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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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of this service on the 23rd and 24th of October 2014.

Pennine Lodge is a recently built 70 bedded care home. It operates across two floors and provides nursing and personal care. The ground floor is occupied by older people who are physically frail and the first floor accommodates people who live with dementia. There are several large and small communal areas and a hairdressing area. The home is set in its own grounds which includes a parking area and gardens.

The home is managed by a registered manager. 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 (HSCA 2008) and associated Regulations about how the service is run.

We inspected the home under five domains, safe, effective, caring, responsive and well led.

Summary of findings

We found that the home was not safe as it lacked sufficient numbers of staff to safeguard the health, safety and welfare of people who used the service. We had previously found the provider in breach of regulation 22 of the HSCA 2008 which applies to staffing.

We found that the home did not provide effective care. The home was in breach of regulation 23 of the HSCA 2008 which states that all staff should receive appropriate training. We found that there was no training available to help the staff support people with behaviour that challenged.

We found evidence that the home was in breach of Regulation 24 of the HSCA 2008 as it did not, so far as reasonably practicable, work in cooperation with other providers of health and social care. We saw that the way people were supported nutritionally required some improvement particularly around the planning and recording of nutritional support.

We found that the service required improvement in the way it cared for people. We saw that though staff were caring they lacked the resources to provide a structured meaningful day to people who used the service.

The service was not responsive to the needs of the people who it cared for. During our previous inspection we found that the provider was in breach of regulation 9 of the HSCA 2008 in that they had failed to plan care around people's individual needs. The home continued to fail to meet the criteria of this regulation. The service could not provide sufficient evidence that they were acting on people's and/or their relative's feedback. In fact some relatives were reluctant to speak with the home manager.

The service was not well led and this required improvement. The manager had systems in place to gather and analyse information about the service they provided. However they had failed to correctly identify that staffing was inadequate, care planning was inadequate and that cleanliness and hygiene required improvement.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe because it did not have sufficient staff to meet people's needs in a timely manner. This was particularly evident in the unit that cared for people who lived with dementia.

Improvements were required to how the home was kept clean and odour free. We found that chairs in the communal areas of the dementia unit were malodourous and needed to be replaced.

Is the service effective?

Inadequate 

The service was not effective because people were supported by staff who had not received adequate training appropriate to their role. Improvements were required to the way people were supported with their nutrition.

We asked if anyone in the home was subject to deprivation of their liberty under the Mental Capacity Act 2005. We were told that no-one was being cared for under this legislation but found evidence that the service had previously done so without issue.

Is the service caring?

Requires Improvement 

The service was not caring and required improvement. We found that though the staff themselves were caring there was no evidence of the implementation of a clear dementia strategy.

People were left on their own without interaction for prolonged periods of time and were not enabled to participate in a meaningful and structured day.

Is the service responsive?

Inadequate 

The service was not responsive. People's needs had not been correctly identified or assessed. Therefore care plans were inadequate. People were not supported to take part in activities and there was very little stimulation in the home. Some relatives were unwilling to make complaints and comments as they did not wish to upset the staff or the manager.

Is the service well-led?

Inadequate 

The service was not well led and required improvement. There was little evidence of a culture that encouraged people who used the service or their relatives to participate with or talk openly about their care.

The manager had failed to identify many of the areas that we assessed to be unsatisfactory. We found that improvements we had asked the manager to make during our previous inspection had not been made.

Pennine Lodge

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 checked 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 23-24 of October 2014 and was unannounced.

The home was inspected by two CQC adult social care inspectors and an expert by experience in older persons care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held on this home including statutory notifications and information provided by the local authority.

During the inspection we gathered further information by speaking with 10 people who used the service, 10 of their relatives and 18 staff. We read 16 people's records of care and looked at other records that related to the service. We observed staff whilst they worked and looked at the interior and exterior of the building. We used a Short Observational Framework for Inspection (SOFI) which is a tool we used to capture the experiences of people who were unable to express this themselves.

Inadequate

Is the service safe?

Our findings

We judged that the provider breached regulation 22 of the Health and Social Care Act 2008. This was because there was insufficient staff to support people in the dementia unit and which had a major impact on people's safety.

During this inspection we asked relatives of people who were cared for in the dementia unit if they considered there were sufficient staff to support people in a timely manner. One relative said, "Sometimes we have found him saturated in urine. He nearly always has a bed bath, as they are short staffed, and he doesn't have enough showers." Another relative told us that people were often left unattended in communal lounges while carers supported others with their personal care needs and commented, "No criticism of the care staff but there's not enough of them." We were concerned as we had brought this to the attention of the provider in our previous report. People who were supported on the ground floor told us, "Staff work very hard and are very caring."

We spoke with staff who told us that there was not always sufficient staff on duty, though one member of staff commented, "We have enough staff to work the unit." Another said, "Not enough staff! Not enough time!" Staff also told us that on occasions cleaning staff would assist with supporting people. The domestic cleaning staff we spoke with confirmed this.

On the day of our inspection there were 63 people resident at the home. 31 people were being cared for in the dementia unit on the first floor and 32 people were being cared for on the ground floor. We were told that people cared for on the ground floor were frail and elderly. There were 15 care staff on duty including two senior carers and two registered nurses. These were split evenly across the two floors though the unit that cared for people with dementia was short of one carer due to a short notice absence. Therefore the ground floor had six care staff on duty accompanied by one senior carer and a registered nurse. The dementia unit had five care staff on duty accompanied by one senior carer and a registered nurse. In addition to this the manager and her deputy were also present as well as an activity co-ordinator who worked between both floors.

We observed staff working hard throughout our inspection. We noted that two extra care staff were told to work in the dementia unit on the first day of our inspection. This was above the amount of care staff we had been told were working when we arrived that morning. We asked why these staff were now working and were told that they had been training in a building next door. When we looked at the rota we saw someone had pencilled the words 'in' against both of their names, there was no specific shift times. During the afternoon both the deputy manager and the activities co-ordinator carried out care tasks on the dementia unit, including helping to seat people and supporting them with meals.

The two additional care staff were present over the lunch time meal service. We noted that meals were served at the same time in all areas of the home. During lunch we carried out short observational framework inspections in two areas of the dementia unit and observed meals being served on the ground floor. We identified that people were kept waiting for their meals, particularly those who chose to eat in their rooms. We observed that some people required additional support with eating. This support ranged from helping people to eat to prompting them to eat. We observed one person who was supposed to be regularly reminded to eat be spoken to twice in 45 minutes. The person was not prompted to eat.

All of the people we spoke with who were able to verbally communicate told us they felt safe at Pennine Lodge. People whose relatives had dementia said they were unsure as to whether people were safe or not.

We looked at records we held on the service. We saw that there had been some serious incidents at the home recently in which people were subject to assault from other residents. We asked the home manager if people in the dementia unit exhibited behaviour that challenged, she told us that they did not. A senior carer on the unit reiterated this. We looked at people's records of care and saw that there had been incidents of assaults on staff by people who used the service as well as assaults on people by other residents. This meant that people who used the service were not adequately protected from bullying, harassment, avoidable harm and abuse. This was because staff, including the manager, did not acknowledge, or were not aware, that behaviour that challenged was an issue. This in turn meant that strategies to minimise risks were not being devised or employed.

We noticed a strong odour of urine on the dementia unit. We traced this smell to all of the chairs being used in the

Inadequate

Is the service safe?

communal lounges, with the exception of one chair. We informed staff who acted immediately to clean the chairs. New chairs were ordered by the regional manager before we completed our inspection. A relative told us, "Sometimes when we got home we would change our clothes because of the awful furniture we had sat on."

In order to ensure that the service was managing other types of risks to individuals we looked at 16 people's records. We saw that people had risk assessments in place. For example some people had been identified as being at risk of falling. We saw that plans were in place to mitigate or reduce these risks by the use of specialist equipment such as walking aids.

We looked at the management of medication at the home. We found that medication was stored safely in locked rooms in the home and that controlled drugs were appropriately managed. People who had been assessed as requiring nursing care were given their medication by a qualified nurse. People who had been assessed as requiring residential care were given their medication by appropriately trained staff. We noted that all medication was signed for correctly on the medication administration record (MAR). There were plans in place for people who occasionally required extra medication and we saw evidence that medication reviews had taken place. Unused or unneeded medication was disposed of appropriately.

Inadequate

Is the service effective?

Our findings

We judged that the provider breached regulation 23 of the Health and Social Care Act 2008 (HSCA 2008) because staff were not adequately supported to carry out their roles. This could put people at risk of not receiving adequate care. The provider also breached regulation 24 as they did not always follow the advice of other providers to ensure appropriate care was taking place.

We requested that the training records were sent to us following our inspection. The manager sent us 27 out of a potential 92 records. The records she sent included domestic staff, kitchen staff, care staff and nurses. We looked at all the records and saw that only two types of training were delivered face to face which were moving and handling and fire safety. The rest of the training courses were done via electronic learning (e-learning).

We focused in depth on the seven staff on duty in the unit that cared for people living with dementia on the morning of our inspection. All of the staff had completed their safeguarding training, two types of moving and handling training and infection control training. Six of the seven staff had completed dementia e-learning, the seventh member of staff training in dementia had expired in 2013. We saw that two members of staff had completed Mental Capacity Act training but this had not been repeated since 2012 for one person and 2013 for the other. Only one person had completed specific person centred care training which was provided in 2012. Staff had completed electronic conflict resolution training to help them deal with behaviour that challenged. However the provided accepted that this training was insufficient. We found that all the staff were not fully trained in how to treat people in a person centred way and none of the staff had been taught how to deal with behaviour that challenged to a satisfactory level. This meant that people were at risk of not being supported properly when exhibiting behaviours that challenged.

During our inspection we addressed the lack of adequate training in behaviours that challenged with a senior carer and the regional manager of the home. They immediately sourced external training to equip the staff with the knowledge to help them support the people they cared for.

We observed lunch being served during our inspection. We saw that people were offered a choice of nutritious meals. Where people did not like the choices available they were offered an alternative meal. We spoke with a relative in the unit on the ground floor who said that care staff put a, "Great deal of effort" supporting people to eat. Our observations confirmed that staff on the ground floor worked closely with people who required their support at meal times. On the dementia unit we saw staff working equally as hard, however people did not always receive the support they required in a timely manner. For example we saw that some people who required assistance had to wait until staff were available to support them.

We looked at people's records of care and saw that a nutritional screening tool was in use. Where people were thought to be at risk of malnourishment the frequency of monitoring their weight was increased from monthly to weekly. We noted though people's weight did at times fluctuate there was no significant weight losses or gains recorded.

We looked at records that the home kept about the nutritional intake of people they had identified as being at risk of malnutrition. We saw that weights and amounts of food were not recorded properly. For example the home accurately recorded how much fluid was being consumed but did not do the same with food. Food was recorded by the amount served, there was no accurate description of how much food was consumed. This meant that it was difficult to assess if people were taking adequate nourishment across the course of a day.

We found that one person regularly refused food other than their breakfast. This was not acknowledged in their care plan. Therefore no strategies to support this person to eat more were being developed. This may have increased the person's risk of malnourishment.

We saw that the home referred to other professionals for additional advice around people's nutritional needs. One person had had assessments from both speech and language therapists and the dietician. Both professionals had recommended a soft diet as they had identified that the person was at risk of choking on their food. This advice had not been acted upon as we observed this person being served a full English breakfast on two occasions. We looked at the records for this person and saw that a decision had been made not to follow the advice that had been given. We could not find any evidence as to why this decision had been made, how it had involved the person who used the

Inadequate

Is the service effective?

service or any evidence that stated it was in the person's best interests. We spoke with the regional manager about this. Following the inspection they provided evidence that this situation had been rectified.

We saw that the home had also appropriately referred to other health and social care providers to ensure that people's needs were met. For example the local community mental health team (CMHT). We contacted health and social care providers who regularly liaised with the home. Some told us that their advice was often 'ignored'. This meant that people may have been at risk of unsafe or inappropriate care.

We asked if anyone in the home was subject to a Deprivation of Liberty (DoL) safeguard under the Mental Capacity Act 2005. We were told that no-one was being cared for under this legislation. We checked what training care staff received about DoLs and the Mental Capacity Act. We saw that this was only provided to senior carers and managers. The provider may wish to consider extending this training to more care staff to assure that satisfactory support is provided to people who require care under this legislation.

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Requires Improvement

Is the service caring?

Our findings

We judged that the provider was in breach of regulation 9 of the HSCA 2008 in that they were not meeting service users individual needs.

Through our observations we saw that staff had developed positive caring relationships with many of the people who used the service. This was particularly evident on the ground floor of the home. One person told us, “Staff are very caring, all of them work very hard.” Another commented, “Cannot ask for anything better.” On the dementia unit staff had developed positive relationships with people but were unable to spend time maintaining and improving these relationships. This was due to the inadequate staffing in the home and not the care staff’s lack of effort. One member of staff told us, “There isn’t enough time.”

We looked at the day to day experience of people living in the home. We noted that there was an activity co-ordinator present throughout our inspection. We observed that they were often involved in care duties such as assisting at mealtimes and helping people to be seated. We saw one activity of someone having their nails painted during our inspection. We saw records that activities had taken place such as a trip to Blackpool. However there was very little stimulation available for people in the home.

We looked at one person’s daily diary which stated that they had been taken to the living room ten times in 7 months. A relative told us, “They just sit in their room all day, it was ages ago we last saw them in the lounge, they slump in their chair in silence with the door shut, but if you get their attention they will wake up and have a chat.” A different relative commented, “They’ve been out the home twice in fourteen months.” Another relative told us, “There is no quality of life.”

We observed that there were five people seated in chairs in the lounge throughout our inspection. They received no stimulation other than being served their meals. They were often seated in what appeared to be uncomfortable positions. They slept at times but did not engage with each other. Three people were constantly on the move exploring their environment. We saw that staff, including the activity coordinator, were often occupied ensuring that these people did not trip, fall or upset other people who used the service. This demonstrated that the home did not have a strategy for supporting people with dementia as their lack of daily stimulation may have contributed to them exhibiting behaviours that challenged.

We saw that care staff constantly encouraged people to express their views when making day to day choices. For example when and where to eat their meals or where they would like to sit. People’s capacity to make decisions had been documented as had their preferences.

We observed staff working hard to try and ensure that people’s privacy and dignity was respected at all times. Staff always knocked on doors before entering people’s rooms and spoke with people in a warm and friendly manner.

Inadequate

Is the service responsive?

Our findings

We judged that the manager and staff of the home failed to act on information provided by concerned relatives. Furthermore some relatives appeared frightened or unwilling to share information with the staff. This constituted a breach of Regulation 19 of the HSCA 2008 in that the manager was not taking people, or their representatives, views into account. This had a moderate impact on people who used the service.

We looked at 16 peoples written records of care. During our previous inspection we had noted that care plans were not based on people's assessment of need. We saw that there had been an improvement with some care plans being completely re-written to reflect the assessments the home had undertaken.

We examined all the care plans in depth. One person suffered from continence issues. We saw that they also exhibited behaviour that challenged at times. We had commented that there were no strategies in place to support this person with their continence during our previous inspection. We found that the care plan still did not identify strategies had been discussed and put in place for this person. For example despite identifying that the person had sight difficulties no appropriate signage had been acquired to indicate where the toilet was.

We observed that one person was sitting slumped in a chair. They were unable to support themselves to remain upright. We looked at their record of care which stated they needed to sit on a pressure relieving cushion. We saw that this was in place. However there was no seating assessment to indicate what kind of chair would be suitable to support the person to sit comfortably. We spoke to relatives who told us that the person initially had a reclining chair provided by the home though it had been 'Very grubby.' They went on to say the chair had 'Disappeared' and were not sure where it now was.

We looked at how the service routinely listened to and learned from people's experiences, concerns and complaints. We spoke with relatives of people who were supported in the unit that cared for people with dementia. One person told us they had asked for their relative to be assisted with eating after seeing that her clothes were often covered in spilled food. They felt that the response from care staff had been curt and had been told if their relative wanted more help they needed to be reassessed. They raised this with the manager and she said she would look into it. They told us that there had been some improvement but about half of their relatives clothing remained covered in spilled food.

We looked at another person's written record of care. We saw that there had been a review meeting in which a relative had raised concerns over the lack of care staff available to support people in the home. A staff member documented that they told the relative, "We have enough staff and if they went anywhere else they would not have the same amount of staff."

We spoke with another relative who told us, "We don't like to complain as nothing happens and we don't want to fall out with the manager and staff. It's best to keep on the right side of them."

Inadequate

Is the service well-led?

Our findings

We judged that the provider had breached regulation 10 of the HSCA 2008 in that they had not correctly identified, assessed and managed risks relating to the health safety and welfare of the people who used the service.

We looked at how the service promoted a positive culture that was person centred, open, inclusive and empowering. We could find little evidence to say that the service promoted any of these things. There was a clear divide in the quality of the service provided to people on the ground floor as compared to people on the unit that supported people with dementia. We observed that the staff were attempting to ensure people's needs were met. However they did not receive support from their manager to be able to do this as they had not correctly assessed staffing levels against people's needs. We spoke with one senior carer and a nurse who clearly had good knowledge of people with dementia and knew the type of environment they wished to create. However they were focused on trying to ensure all necessary care tasks were completed each shift and were unable to develop many of their ideas. This meant that care staff were disempowered which had an impact on the quality of care they were able to provide.

During our inspection the manager of the home was unavailable for personal reasons. On previous inspections we noted that she knew the people who used the service and walked the floor of the home. We spoke with the regional manager who told us that they visited the home once per month and spoke with the home manager on a daily basis. The home manager was expected to provide the regional manager with regular reports including dining quality audits, care plan audits and a report about the performance of the home on a monthly basis. The regional manager would check this information during their regular visits.

The home sent out customer satisfaction questionnaire's to people who used the service and their relatives. The information gathered in these questionnaire's was collated and analysed.

We saw that the outcomes of these audits, reports and questionnaire's was used to formulate action plans to improve the home. The action plans were displayed prominently in the home and were entitled 'You said, we did, we plan to.' We looked at the most recent findings and saw that people had expressed their worries about staffing levels in the home and the lack of meaningful activities. The 'We did' section of the action plan stated that staffing levels had been reviewed based on people's dependency needs and plans were in place to 'overstaff' the home to allow activities to take place. We did not find evidence that people's dependency needs had been correctly assessed and there were no activities taking place. This meant that the people who had raised concerns may have been misled by the action plan which did not accurately reflect what was happening in Pennine Lodge.

We found that though quality checks were in place the manager had failed to detect that care plans, cleanliness and hygiene and the dining experience in the home were not satisfactory. Relatives were clearly unhappy with the service received particularly within the dementia unit. Some struggled to communicate with the manager, others expressed themselves through written surveys. It is of concern was the manager refused to acknowledge that people within the dementia unit, at times, displayed difficult and distressing behaviour. Care staff had also told us that there was no behaviour that challenged within the unit. This meant that the manager did not demonstrate good leadership and management skills as she failed to identify risks within the unit and therefore did not adopt strategies to minimise these risks.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person must have suitable arrangements in place in order to ensure that people employed for the purpose of carrying out the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 23 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers **The registered person must make suitable arrangements to protect the health, welfare and safety of service users in circumstances where the responsibility for the care and treatment of service users is shared with, or transferred, to others.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (i) meet the service users individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	19 (2) (b) The registered person must provide service users and those acting on their behalf with support to bring a complaint or make a comment where such assistance is necessary.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers 10 (1) (b) the registered person must identify, assess and manage risk relating to the health, welfare and safety of service users and others who may be at risk.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.

The enforcement action we took:
We served a warning notice that required immediate improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (a) The carrying out of an assessment of the needs of the service user; and (b) The planning and delivery of care and, where appropriate, treatment in such a way as to – (i) Meet the service users individual needs.

The enforcement action we took:
We served a warning notice that required immediate improvements.