Pendlebury Care Homes Limited

Lyme Green Hall

Inspection report

Lyme Green Settlement
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Macclesfield
Cheshire
SK11 0LD

Tel: 01260253555

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19 April 2018

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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

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.

Lyme Green Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. This home is not registered to provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 60 people across three separate units, each of which have separate adapted facilities named the Villa Suite, Lymes Suite and Manor Suite. Staff and the people who live at the home refer to each unit as the Villa, Lymes and the Manor and we have done the same throughout this report. At the time of our inspection there were 24 people living at the home.

This focused inspection of Lyme Green Hall was undertaken following our receipt of a number of concerns raised by the local authority. We visited the home unannounced on the 19 April 2018 and requested further information in writing from the registered provider on the 25 April and 26 April 2018.

This location requires a registered manager to be in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was no registered manager in post at the time of our inspection.

At the last inspection which we carried out between 31 October and 19 December 2017, we found the provider was not providing safe, effective, caring, responsive and well led services and was rated inadequate overall. The provider was not meeting the requirements of multiple regulations including regulations 9, 11, 12, 13, 14, 15, 16, 17, 18, and 19 of the Health and Social Care Act Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The service was put in special measures and we took enforcement action adding a condition to the provider's registration restricting new admissions to the home until such time as the service was deemed safe, effective, caring, responsive and well led. This additional condition remained in force at the time of this inspection.

This inspection focused on two key questions only safe and well led. Whilst we could see that the provider had made some improvements we again found that the service was not safe or well led and people were at risk of receiving unsafe and ineffective care. We identified breaches of the regulations in respect of Person Centred Care, Safe Care and Treatment, Safeguarding service users from abuse and improper treatment, Good Governance, Staffing and Requirement as to display of performance assessments.

We found that people did not always receive care that was centred on their needs. The registered provider

had failed to carry out an assessment of each person's needs with the involvement of the relevant person and failed to develop plans of care designed to meet their needs and personal preferences.

Care was not being provided in a safe way. The registered person was not assessing the hazards presented to people or developing plans and effective arrangements for care to mitigate risk of harm.

Managers and staff failed to protect people from the risk of abuse. Poor communication in the home meant that managers were not always aware of incidents of abuse and on some occasions when they were made aware they failed to operate effective adult safeguarding procedures.

Whilst there were sufficient numbers of staff on duty the registered provider failed to ensure that staff had received appropriate training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The registered person was unable to demonstrate that a sufficient number of staff had received adequate training on first aid to ensure staff would know what to do in the event of an emergency.

We found that there was confusion and poor communication between managers and staff. The registered person told us that one person had been designated as manager but another manager told us that the person designated as manager had refused to take on that responsibility.

The provider had instigated systems to monitor the quality of care provided but these did not identify the concerns we identified during our inspection.

The provider had failed to display the ratings awarded to them at our last inspection on the home's website.

The home was clean and odour free throughout. We could see that the registered provider had made a number of improvements including redecoration of some parts of the home.

The fire services told us that they were pleased with improvements made to the home's fire integrity and emergency fire procedures so people were safe in the event of a fire.

All the residents presented as relaxed and at ease in the home's environment. They all spoke well of the care provided and we could see they had good relationships with the staff. They told us that they were offered plenty of drinks and the food was good. Records showed that staff were monitoring people's weights and took appropriate action if there was any unintended weight loss or weight gain.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough

improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

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.

People were at risk of receiving poor and ineffective care and their needs not being met because risks were not always identified and mitigated and care planning was ineffective.

The provider failed to operate effective adult safeguarding procedures so vulnerable people remained at risk of harm and abuse.

Is the service well-led?

Inadequate

The service was not well led.

People were at risk of receiving unsafe and ineffective care because the management team failed to identify, assess and mitigate the risk of harm.

The management team failed to notify the Commission of serious incidents including allegations of abuse.

There was no registered manager and managers designated in charge of the home were not always communicating effectively with each other and lacked knowledge of the provider's requirements and responsibilities under the regulations and local adult safeguarding procedures.

Lyme Green Hall

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.'

The inspection took place on 19 April 2018 between the hours of 2:43pm and 8:15pm and was unannounced. The inspection team consisted of one adult social care inspector.

Before our inspection we reviewed the information we held about the service. This included notifications we had received from the registered provider about incidents that affected the health, safety and welfare of people who lived at the home, previous inspection reports and information provided by other agencies including the local safeguarding authority.

The inspection was prompted in part by notification of an incident during which a person using the service sustained a serious injury. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk associated with the management of challenging behaviour. Simultaneously we also received information from the local authority which indicated that there had been a failure to respond effectively to the incidences of abuse and failure to assess risks and plan care. This inspection examined those risks.

CQC was aware of past incidences where people had been put at risk of harm and in some instances sustained injuries at the home. Subsequent investigation of these incidences had identified that people had been put at risk of harm because of failings in assessment, risk assessment, care planning and managerial oversight and governance.

The methods used during this inspection included talking to people using the service, their relatives and friends or other visitors including visiting health and social care professionals. We interviewed staff, undertook pathway tracking, observed care practice, read records including personal care records for 2 of the people who used the service. We also looked at a range of other records associated with the

management of the home.

We met 15 of the 24 people who were living at the home and had conversations about the quality of care provided with six of them. We spoke with eight members of staff including the Operations Director, a supporting manager, two senior care staff, two care staff, and the provider's representative. We wrote to the provider on the 25 and 26 April 2018 and requested and received further information from them in connection with this inspection.

Inadequate

Is the service safe?

Our findings

When we carried out our last inspection of this home between 31 October and 19 December 2017 we found that the home was not providing safe and effective care and an overall rating of inadequate was awarded and the home was put in special measures. We took enforcement action and added a condition to the home's registration to prevent the provider from admitting any new people until such time as the provider could demonstrate that they provided safe, effective, caring responsive and well led care.

We had found that people were at risk of receiving poor and ineffective care and their needs not being met because care planning was ineffective and the manager and senior staff lacked required skills and oversight. People were exposed to uncontrolled health and safety hazards that put people at risk of harm. Medicines were not always managed, recorded or stored safely. Vulnerable people remained at risk of abuse because staff failed to take action as soon as they were alerted to alleged or actual abuse, or the risk of abuse.

This inspection was prompted in part by notification we received of an incident during which a person using the service sustained a serious injury. Because this incident was subject to an ongoing investigation by the local safeguarding authority at the time of our visit we did not look at the circumstances leading up to the incident. However, we did look at action taken by the provider to manage challenging behaviour and mitigate any future risk of harm presented to other vulnerable people at the home since the incident. We found that the provider had failed to take effective action to protect other vulnerable people from abuse and harm.

We looked at the care records of a person who had presented with physical aggression that had resulted in another vulnerable person suffering a serious and potentially life threatening injury. This person's care records showed that there had been a long history of them presenting with verbally and physically aggressive behaviour but there were no risk assessments, care plans or risk management strategies to respond to and mitigate the risks presented to other vulnerable people.

Staff recorded 16 incidents of aggressive behaviour dating back to August 2017 but there was no evidence that any of these incidences had been analysed or risk assessed. We asked a senior care worker how they would manage this person's behaviour. They told us that they would ask them to go to their bedroom. We could see that this strategy had proved to be ineffective in the past and could be seen to exacerbate the presenting behaviour. Some of the incidences described by staff indicated that this person subjected other vulnerable people to degrading treatment in that they would try to put food into their mouths, against the person's protests and left them in a state of agitation with food around their mouths. The senior care worker told us that they had never seen any care plans, risk assessments or risk management strategies regarding this person's aggressive behaviour.

Records showed that since the incident where a vulnerable person had been injured, only the weekend before our visit, there had been two subsequent incidents of physical assault of two other vulnerable people, but again no action had been taken to protect vulnerable people from abuse.

One person had been discharged from hospital almost two weeks prior to our visit and a senior care worker told us this person had specific care needs and a condition that required them to be barrier nursed. We looked at this person's care records and found that most of their care plans and risk assessments had not been updated, reviewed or revised since October 2017. We could see from their care file that there was no evidence of any assessment being undertaken by any of the home's staff prior to this person's readmission to the home after a long stay in hospital. There were no relevant risk assessments, care plans or risk management strategies regarding this person's pressure area care or requirement to be barrier nursed on discharge from hospital. The senior care worker on duty told us that they had never seen any assessment since this person was discharged from hospital and had never seen any risk assessments or care plans regarding their skin integrity or need for barrier nursing.

We could see from the records that the district nurse had raised concerns about the person's pressure area/skin integrity care on the 13 April and a social worker had visited on the 16 April and reported that there were no care plans or risk assessments in place to ensure the person's needs were met. Staff told us that one of the managers was aware that these care plans and risk assessments had not been completed but the manager who was in charge of the home at the time of our visit was not aware this person had skin integrity issues.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment. Care was not being provided in a safe way. The registered persons were not assessing the hazards presented to people or developing plans and effective arrangements for care to mitigate risk of harm.

Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. They are required to carry out, collaboratively with the relevant person, an assessment of their needs and preferences for their care and treatment.

We found care staff did not have access to relevant assessments, risk assessments and care plans to guide their practice for one person despite the fact that a district nurse had raised concerns about their care on the 13 April and a social worker had identified the lack of assessments and care plans on the 16 April. We found that this person's assessments, care plans and risk assessments had not been reviewed or revised since 17 October 2017 despite the fact their needs had changed.

We also found that care staff did not have access to appropriate assessments, risk assessments and care plans for a person who presented with a long history of aggressive behaviour. After the inspection the provider told us that risk assessments and care plans had been written up and shared with this person's community based professional health care advisor. We found that these risk assessments and care plans were inadequate. They were not reflective of good practice, offered little protection to other vulnerable people; there was no indication that they had been developed collaboratively with the relevant person or their representatives. When we spoke with this person's community based health care advisor they told us that they had not seen these risk assessments and care plans and conversely had been told by a senior care worker that the home was able to meet this person's needs and manage their behaviour safely.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 person centred care. The registered provider failed to do everything reasonably practicable to make sure that people who used the service received person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences.

Information provided by the local authority indicated that managers and staff were not always following local safeguarding procedures to ensure that people were safeguarded from abuse. A representative of the local authority raised concerns that the local authority had not been notified in a timely way of two incidences of abuse. In respect of one of these incidences that occurred on the 4 April that the local authority had not been made aware until the 17 April. The second incident occurred on the Saturday 14 April but staff made no attempt to report the matter to the emergency duty team as in accordance with locally agreed policies and procedures. Furthermore the manager in charge of the home on the following Monday made no attempt to report the matter to the local authority and did not send a referral until the 17 April 2018. We asked the managers for an explanation and were told that they were unaware of locally agreed adult safeguarding procedures.

Whilst looking at the records of a person who had physically assaulted another vulnerable adult on the 14 April 2018 we found documentary evidence that the same person had subjected two other vulnerable people to physical abuse on the 16 and 19 April respectively. Neither of these incidences had been reported to the local authority and when we asked managers they told us that they were unaware of these incidences and therefore they had not reported them. This identified poor communication between managers and staff and showed us that staff were not acting in accordance with the home's or the local authority's safeguarding procedures so vulnerable people had remained at risk of harm.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13. The registered person failed to establish and operate effectively systems and processes to prevent abuse of service users. Vulnerable people remained at risk of abuse because staff failed to take action as soon as they were alerted to alleged or actual abuse, or the risk of abuse.

There was an adequate number of staff on duty. However, when we made further enquiries on the 27 April the registered provider and designated managers were unable to demonstrate that they could ensure that at least one staff member on every shift had appropriate training and skills in emergency first aid. This meant people were at risk of not receiving effective first aid in the event of an emergency.

The above comprised a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing. The registered provider failed to ensure staff had received such appropriate training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Inadequate

Is the service well-led?

Our findings

When we carried out our last inspection of this home between 31 October and 19 December 2017 we found that the home was not providing safe and effective care and an overall rating of inadequate was awarded and the home was put in special measures. We took enforcement action and added a condition to the home's registration to prevent the provider from admitting any new people until such time as the provider could demonstrate that they provided safe, effective, caring responsive and well led care.

Since our last inspection staff turnover has been significant with numerous staff leaving their posts or being dismissed on grounds of unsatisfactory performance or misconduct. The importance of good communication between managers and staff is always imperative but where there is a high turnover of staff it is even more important.

There was no registered manager in post at the time of our inspection. The previous registered manager resigned on the 7 November 2017 and the registered provider had appointed the Operations Director to manage the home but they also resigned on the 4 December 2017. Another manager was appointed to manage the home supported by two other senior staff, but they also resigned in February 2018 and by April 2018 the two senior staff had also moved on. The provider appointed another manager in February 2018 and on the 2 March entered into a management agreement with another registered provider to carry out management functions at the home, reporting to the provider's representative, known as the nominated Individual.

On this inspection we found evidence of poor management, miscommunication between various managers and poor communication between staff and managers that left vulnerable people at risk of harm. For example one of the managers involved was aware that a person who lived at the home presented with needs that had not been risk assessed or planned for but the manager who was in charge of the home at the time of our visit did not know this vital information. Another manager had assumed that another manager had notified the Commission of a serious incident in the home but in fact they had not done so. We found evidence in care files that vulnerable people had been subjected to abuse but managers were unaware of the incidences and had not taken action in respect of them.

On the 2 March 2018 the provider gave us the name of a manager who was already registered with the Commission and told us that they had been designated as manager. However, on the 19 April 2018 another manager told us that the person the provider had designated as manager was not prepared to act as overall manager. This level of confusion had consequences for the people who lived at the home whose needs were not being met and on occasion had been left exposed to the risk of abuse.

Failure to appoint and register a suitably qualified and experienced manager is a breach of the home's conditions of registration.

On the 17 April 2018 we received a notification from the person the provider had designated as manager about the abuse of five people which occurred on the 4 April 2018. This was an extremely serious allegation

which was supported by photographic evidence. On the 19 April we asked the manager who was in charge of the home at the time why there had been a delay in notifying the Commission. They told us that they were unable to give an explanation and did not know that we had not been notified until the 17th April 2018. When we gave our feedback about what we had found during this inspection another manager offered an explanation that they were of the view that the registered person was required to investigate allegations of abuse before they were required to notify the commission or the local authority. This showed a marked lack of knowledge of the locally agreed adult safeguarding procedures and the requirements of the regulations.

We received another notification on the 17 April from the person the registered person had designated as manager. This time of a serious injury to person who used the service which, according to the notification occurred the day before on the 16 April 2018. However, information provided by the local authority and confirmed by another manager at the home showed that the incident occurred on the 14 April 2018. We asked a manager as to whether there was an explanation as to why this notification was inaccurate and delayed. They told us that they were unable to offer an explanation as to why the notification was inaccurate and late only that another manager was on duty on the 16 April 2018 and assumed that they would have done it. This was another extremely serious incident where a vulnerable person had been injured as a result of abuse.

Records showed that on the 13 April 2018 a visiting professional had raised a safeguarding alert regarding suspected neglect of a vulnerable person. The Commission had not been notified of this allegation of abuse.

One of the managers told us that the district nurse had said they were only minded to make a safeguarding referral and on that basis did not think the matter was notifiable. This showed a marked lack of understanding of the requirements of the regulations. Another of the managers told us that they were aware of this incident and that another manager had referred the matter to the local authority. The manager in charge of the home at the time of the inspection told us that they did not know why the Commission had not been notified.

The above comprises an offence under the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents. In that the registered person failed to notify the Commission of any abuse or allegation of abuse in relation to a service user, without delay. We are dealing with this matter separately to this report.

The provider had systems in place to monitor the quality of care provided but these proved ineffective in identifying the concerns identified on our inspection. The provider told us that they were aware of a serious allegation of abuse but did not take any action to make sure the Commission had been notified of the incident in accordance with the requirements of the regulations. The provider also told us that a community based healthcare professional had seen a person's risk assessments and care plan but when we asked the professional they told us that this was not correct. We also found that the provider had not maintained an accurate contemporaneous record of the care provided for each person who lived at the home. It was clear that the home's quality assurance and governance procedures were not being operated effectively.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(1) Good Governance. The registered person failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and failed to maintain an accurate and contemporaneous record of care provided each person.

At our last inspection of this home between 31 October and 19 December 2017 the service was awarded the

rating of "Inadequate". Providers must display their ratings both on their premises and on their websites. CQC has provided digital products to enable providers to do this. Using these will ensure that they display all the information required under this regulation. The most recent inspection report was displayed on the home's notice board. On the 25 April we searched the web and found the provider's website www.lymegreenhall.co.uk and found that the latest report posted was dated 13 November 2013 and there was no mention of the inspection carried out between October and December 2017 with the subsequent rating of "Inadequate".

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20A: Requirement as to display of performance assessments. The registered person failed to display ratings on any website maintained by them.

The home was clean and odour free throughout. We could see that the registered provider had made a number of improvements including redecoration of some parts of the home. The fire services told us that they were pleased with improvements made to the home's fire integrity and emergency fire procedures so people were safe in the event of a fire.

All the residents presented as relaxed and at ease in the home's environment. They all spoke well of the care provided and we could see they had good relationships with the staff. They told us that they were offered plenty of drinks and the food was good. Records showed that staff were monitoring people's weights and took appropriate action if there was any unintended weight loss or weight gain.

The environmental health officer told us that they had visited the home in September 2017 and awarded a four star rating regarding the cleanliness of the home kitchens and food preparation producers. A Five start rating is the highest rating the environmental health officer can award a food catering service.