Cedarcare (SE) Ltd

Pelham House Residential Care Home with Dementia

Inspection report

London Road
Cuckfield
Haywards Heath
West Sussex
RH17 5EU

Tel: 01444458788

Date of inspection visit:
15 June 2021

Date of publication:
04 August 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Pelham House is a residential 'care home' registered to provide personal care for up to 30 older people in one adapted building. At the time of the inspection there were 28 people living in the care home. Some people were living with dementia or frailty and other associated health conditions.

People's experience of using this service and what we found
There was a failure to assess, monitor and mitigate risks relating to the health, safety and welfare of people. People's care plans and risk assessments lacked important detail to guide staff on how to make people safe.

Governance processes were not effective in identifying some service shortfalls. There was not an adequate process for assessing and monitoring the quality of the services provided or to ensure that records were accurate and complete.

Processes were in place to minimise the risk of infection. This included processes to mitigate the risk of contracting and spreading COVID-19 within the care home. Processes were in place to support safe visiting to the care home.

Systems were in place to protect people from the risk of abuse and improper treatment and staff knew how to identify potential harm and report concerns. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were treated with kindness and compassion and staff were friendly and respectful. People and their relatives told us they were happy with the service they received. Staffing levels were enough to meet people's individual needs.

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 19 September 2019) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating. The inspection was prompted in part to follow

up actions recommended by the coroner in response to a person's death in 2017.

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.

We carried out an unannounced comprehensive inspection of this service on 11 August 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. 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.

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment and good governance.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our well-led findings below

Pelham House Residential Care Home with Dementia

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 undertaken by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We reviewed the Regulation 28 report from the coroner relating to a death of a person in 2017 and the providers action plan response. The provider was 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 took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with ten members of staff including the provider, registered manager, assistant manager, care workers and the chef.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to review information and sought clarification to validate evidence found. We looked at additional information requested and sought feedback from health and social care professionals about the service.

Requires Improvement

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 remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● There was a lack of effective oversight and monitoring of head injuries. We reviewed the way the provider responded to falls resulting in head injuries. This was in direct response to a Regulation 28 report from the coroner regarding the death of a person in 2017. The person had sustained a fatal head injury during a fall. There were continued concerns relating to oversight and monitoring of head injuries at this inspection.

● NHS guidance advises that head injuries are observed closely for a period of 24 hours to monitor whether a person's symptoms change or get worse. We reviewed accident and incidents records for two people who had sustained head injuries. Although professional medical assistance was sought in a timely way there was no evidence that a period of enhanced monitoring had been implemented. This meant people could not be assured staff would recognise the signs of their health deteriorating or know when to seek medical advice. The registered manager told us there had been no further deterioration in people's health following their head injuries and although processes were in place to increase observations these had not been recorded. The registered manager took immediate action to address this.

● Processes were not robust to ensure risks to people were identified and mitigated. For example, . The person's care plan failed to provide staff with guidance to enable them to recognise the signs of the person's seizure activity. Staff told us they had not been provided with epilepsy training by the provider and would call the emergency services if they saw the person was having a seizure. There was a failure to provide staff with epilepsy training and enough information was not provided to ensure staff were able to provide safe and appropriate seizure care and management. We asked the registered manager to take urgent action to address the concerns we had raised.

● Information in people's care records was not enough to ensure safe care. For example, we observed a person having a modified diet. We spoke with the chef who provided documentation from medical professionals to support the person having a fortified diet prepared to the International Dysphagia Diet Standardisation Initiative (IDDSI) level six 'soft and bite' sized consistency. This information was not reflected within the person's nutritional care plan or choking risk assessment. The registered manager was unaware of this assessed need and staff had failed to identify the discrepancy between the persons care plan and the consistency of food they were serving to the person. This meant people could not be assured of receiving the correct support to reduce the risk of significant harm.

The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection there had been an improvement in the way people sought help and how people's

continence needs were managed. Care plans provided clear guidance to regularly monitor people who were unable to use call bells. Daily records evidenced these checks were taking place. People who were at risk of constipation had care plans that detailed the signs and symptoms that might indicate they were constipated. Guidance was provided to ensure staff sought appropriate treatment in a timely way to avoid unnecessary discomfort and prevent any deterioration in people's health.

● Processes were in place to mitigate the risk of people falling and records showed these had been effective in reducing falls. We observed people using equipment to reduce their risk of falling such as sensor mats and walking aids. The environment was light and clear of obstacles and we observed people mobilising freely around the care home. People told us they felt safe with the measures in place to mitigate their risk of falling.

● People received appropriate support to manage their skin integrity. Care plans guided staff on the support people required to maintain good skin integrity and mitigate the risk of pressure ulcers developing. People who were cared for in bed or who had reduced mobility were turned regularly and equipment such as air flow mattresses and pressure reducing cushions were in place to reduce pressure areas forming. Fluids were encouraged and monitored to ensure people remained hydrated and barrier creams were used to support people's skin integrity.

Preventing and controlling infection

● We were somewhat assured that the provider was admitting people safely to the service. The Government has produced guidelines to support safe admissions into the care home from the community and from hospital.

● We received verbal feedback from the registered manager that people had been admitted safely. However, pre- assessment documents and risk management records relating to admission and isolation failed to demonstrate that government guidelines had been considered or how risks had been mitigated to negate the need for isolation or reduce people's isolation period. Although the service has not had an outbreak of COVID-19 a robust process for considering and recording risks associated to new admissions would provide assurances that people were being admitted to the service safely. We have sign posted the provider to government guidelines on new admissions to develop their approach

● 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 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.

Using medicines safely

● Improvements had been made since the last inspection in medicines management. People received their medicines safely and as prescribed. Information was available to guide staff on recognising the potential side effects of medicines. Medicines were stored and administered safely and in line with National Institute of Health and Care Excellence (NICE) guidance.

● Staff completed training to administer medicines and their competency was checked regularly. Medicine Administration Records (MARs) were completed in line with best practice guidance. Regular audits of medicines were carried out by senior staff.

● Protocols were in place for people who required medicines to be administered 'as and when required' (PRN). These included discussions with the person as to why they might need the medicines and if any alternative measures could be taken.
● People told us they received appropriate support with their medicines. We observed staff were competent at recognising the signs and symptoms that could indicate a person was experiencing pain and how to address this appropriately with the person.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes protected people from the risk of abuse. Safeguarding training was completed by new staff during induction and there was a system to ensure staff 's knowledge was updated. Staff were clear about their responsibilities in relation to safeguarding and worked in line with the local authority safeguarding policy and procedures.
● People told us they felt safe and were supported to keep themselves and their belongings safe. One person said, "I feel safe here because there is always someone around". Another person told us they had no reason to feel concerned. People told us staff were kind and relatives said they were assured that their loved ones were safe. One relative said of their loved one "she is definitely safer here".
● Staff knowledge of safeguarding reflected up to date information and guidance. Staff knew how to report any concerns they may have and were confident they would be listened to. Staff knowledge of safeguarding reflected up to date information and guidance.

Staffing and recruitment
● Safe recruitment processes protected people from the recruitment of unsuitable staff. Appropriate recruitment checks were undertaken to ensure staff were safe to work with people. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references.
● People felt staff had enough time to adequately provide their support. Feedback included "staff cannot do enough for you" and "there are plenty of staff around". People told us call bells were responded to promptly and we observed this.
● There were enough staff to meet people's needs. People and their relatives consistently told us there were enough staff and our observations confirmed this. People received support from a core team of staff who knew them well. This ensured people received continuity of care from a familiar team.

Requires Improvement

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection on 11 and 12 August 2019 there was a breach of regulations. There was a failure to operate effective systems and maintain accurate records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- At the previous inspection in August 2019 the provider's quality processes were not effective in identifying shortfalls and driving improvement. At this inspection some improvements had been made to quality systems and processes. However, these had not been effective in identifying concerns found at the inspection and required more time to be embedded across people's care records and monitoring systems.
- Processes for the quality checking of records and quality assurance audits were not robust to identify care plans where information was missing or not up to date. For example, a person's care plan review in March 2021 and risk assessment review in June 2021 both failed to reflect the outcome of need following a medical professional's assessment for swallowing in May 2019. This meant the provider could not be assured there were accurate, complete and contemporaneous records being maintained in respect of each person's care and treatment. This increased the risk of the person receiving inconsistent or inappropriate care to meet their needs.
- The registered manager's process for record keeping and retrieving information were not effective. Feedback received from various sources reflected a degree of management disorganisation described as "a chaotic management style". Throughout the inspection process the registered manager had difficulty finding or recalling information and relied on support from others to provide this. There was not an effective system operated by the registered manager to provided her with assurances that the systems and processes operated were effective and people were receiving appropriate care.
- There were systems and processes to monitor accidents and incidents. Monthly audits of incident and accident reports failed to evidence a robust process for exploring factors that may have contributed to an incident occurring such as underlying health conditions, medicines or environmental factors. There was a failure to evidence the outcome of these audits to demonstrate they had been used to drive improvements and mitigate further risks to people.

Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● During the inspection process we received feedback from people, visitors and staff. Staff acknowledged it had been a difficult year for everyone. Staff felt the registered manager favoured some staff more than others and did not always speak to staff in a way that made them feel supported or valued. Staff told us they had not received an annual appraisal and supervision was not always regular or productive. Staff enjoyed working at the service and described the care team spirt as "the glue that got us through the last year".

● People's views had been sought on the care provided, and people and relatives told us they were listened to. Visitors shared different experiences of communication between the relatives and the provider. Some people found communication poor whilst others described responsive communication that kept them up to date with their loved one's well-being.

● The provided told us they had received a lot of community support over the last year. Staff told us it was heart-warming to know the community valued the work they were doing and understood how difficult it had been. People told us although they had been restricted from participating in community activities due to the global pandemic, they knew they had support from local people, one person said, "neighbours did that clapping and the staff jolly well deserved it".

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

● The registered manager told us they reviewed any feedback so any learning would be taken from this. We found the registered manager had not always learnt from previous incidences and there was a continued failure to safely monitor people following a head injury.

● The registered manager understood their responsibility to be open in the event of anything going wrong. When things had gone wrong the registered manager had notified appropriate authorities and shared the outcomes with people and staff to ensure lessons were learnt. Records showed that all safeguarding concerns had been reported to the local authority and CQC in line with guidance.

●The registered manager worked collaboratively with people, relatives and staff to continuously improve people's care. This ensured issues were addressed promptly, and any changes made communicated to the staff team to implement in a timely way.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture of the service focused on providing person- centred care and support. Care plans provided personalised information about people and their preferences about how they liked to be supported. One person told us about their passion for Brighton and Hove Albion football club. Their bedroom was decorated to reflect this, and they had season ticket to enable them to go to home games supported by staff.

● People received holistic person-centred care. The provider had embedded a values-based culture which was inclusive and reached out to people they supported along with family and friends. The provider told us how they had worked with people to deliver individual dementia care support. For example, the environment can have a big impact on someone with dementia. Symptoms of memory loss, confusion and difficulty learning new things means someone with dementia may forget where they are, where things are and how things work.

● We observed dementia friendly environment and practices that supported people to have a purpose and retain independence. There was clear signage around the service and memory box's outside people's bedrooms to help them orientate themselves. The service was light and bright, and the garden was fully accessible and safe with plenty of shelter and seating areas.
● People told us they were happy and the care they received was good. Staff were described as kind and caring. We observed positive and caring interactions from staff who showed warmth and compassion. People told us they enjoyed the food which was described as plentiful. Some people felt there could be more variety. One person told us the support and care they received was "top class" and described Pelham House as a 'wonderful and happy place'.

Working in partnership with others
● The service worked in partnership with other agencies. These included healthcare services as well as local community resources. Staff were aware of the importance of working with other agencies and sought their input and advice.
● Records showed that staff had contacted a range of health care professionals. This enabled people's health needs to be assessed so they received the appropriate support to meet their continued needs.
● We observed communication between a healthcare professional and senior member of staff. This was professional and informative and demonstrated how people's healthcare needs were reviewed to ensure they received appropriate medical treatment in a timely way.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and contemporaneous records were not always maintained regarding people's care.