Community Integrated Care

Pemberton Fold

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 06 April 2016. We returned to the service on 13 April 2016 and this visit was announced. The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC) and a specialist pharmacist advisor.

Pemberton Fold is a purpose built care home operated by Community Integrated Care (CIC). The service is registered with CQC to provide personal care and accommodation to a maximum of 60 people. Accommodation is provided on four separate units over two floors. The home is large and spacious and all bedrooms have en-suite facilities.

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

During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of safe care & treatment and staffing. You can see what action we told the provider to take at the back of the full version of this report.

We looked at night time staffing levels across the four units and found there was one care assistant on each unit. They would be supported by a team leader on each floor who would 'float' between the two units. This meant that during the night, each team leader would be responsible for up to 30 people per floor. Staff told us that night time staffing levels had been reduced as each unit previously had two care assistants on duty at night, in addition to the team leaders. During the day, we found that staffing increased to two care assistants per unit and again, they would be supported by a floating team leader on each floor.

Throughout the inspection we observed that people were left unsupervised in communal areas for prolonged periods of time. This was because staff were busy elsewhere assisting other people and no one was available to supervise in these areas. We found that care staff were responsible for laundry duties which meant they were not always available to respond in a timely way when people needed help.

We found that people who used the service were not consistently protected against the risks associated with medicines. Across each of the four units we found a variety of issues concerning how peoples medicines were managed. We found that people did not always receive their medication as prescribed, that insufficient time was being maintained between doses and that medicines were given after food that were prescribed before food. We also found that one person had not been given their medication for four consecutive days and that medication administration records (MAR) contained errors and omissions.

We saw the service had a corporate medication policy but found a lack of clarity around how the staff interpreted elements of the corporate policy. For example, how and when medication might be given

covertly. Giving medicines 'covertly' means it can be hidden within people's food or drink to ensure the medication is taken. Giving medication in this way can be used to ensure people who lack mental capacity and refuse their medication can still receive the medicines which are important to them.

We looked to see how the service sought to protect people from abuse and found appropriate safeguarding systems and procedures were in place. Staff knew how to recognise and respond to signs of potential abuse.

We looked at people's care files to understand how the service managed risk. We found the service undertook a range of risk assessments to ensure people remained safe. They included personal emergency evacuation plans in the event of an emergency, mental health, nutrition & diet, mobility and moving & handling assessments.

We looked at how accidents and incidents were managed and found accident & incident reports were completed by staff in a timely manner and then entered onto a corporate management system which detailed prevention measures or remedial action taken by the service to mitigate future risks.

Systems and procedures for the recruitment of staff were safe and robust. This was evidenced through our examination of employment application forms, job descriptions, employee's proof of identity, written references and training certificates. Disclosure and Barring Service (DBS) checks had also been completed to ensure the applicant's suitability to work with vulnerable people.

We looked at induction and training & professional development staff received to ensure they were fully supported and qualified to undertake their roles. We looked at eight staff files and saw the staff that had been recently recruited had undertaken a comprehensive induction programme and completed mandatory training. New staff were also given the opportunity to shadow more experienced colleagues and were required to complete a formal probationary period.

Supervision sessions were completed on a regular basis and appropriate records were maintained. We saw discussions had taken place around training, professional development and staff conduct at work. Annual appraisals were also completed and records maintained.

We looked at the mealtime experience on one of the units and found the atmosphere was calm and relaxed. Some people chose to eat in their rooms and we saw staff taking their choice of food and drink to them. In the dining room, staff assisted people to tables and explained the food options to them and awaited their choices. People and staff were engaged in conversation as staff offered a choice of drinks with the meal. We saw staff were patient with people and provided sufficient time whilst they decided what they wanted.

We found Pemberton Fold's approach to end of life care was good. The service was well engaged in the 'Six Steps' End of Life Care Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. This means that for people who are nearing the end of their life, they can remain at the home to be cared for in familiar surroundings by people that they know and trust.

We looked to see how information was shared with people and their relatives and found regular resident and family meetings were taking place. We saw that regular newsletters were produced and distributed which provided details of forthcoming events, special occasions and updates about new members of staff.

At the time of our inspection visit there was a vibrant atmosphere across the service. The activities coordinator was planning a 'food cruise' event and was decorating the communal area to resemble a cruise

ship. Themed food and drink from around the world was planned with catering staff for people during the cruise event. The excitement and anticipation of the food cruise event was clearly evident as we observed people having fun and the sound of laughter carried through the home as people were making decorations and costumes.

We looked at how the service managed complaints and saw a complaints policy and associated procedures were in place. The policy clearly explained the process people could follow if they were unhappy with any aspect of the service at Pemberton Fold. Details of the complaints process was displayed around the home to guide people and their relatives regarding the procedure. We looked at the complaints log and found that accurate and up to date records where maintained.

We saw that staff meetings were held on a regular basis and appropriate records were maintained. Staff told us they were able to contribute to agenda items and that staff meetings were useful and productive.

Audit and quality assurance was completed on a regular basis and covered a variety of topics. We saw that where internal audits had identified issues, action was taken and lessons learnt. However, given the issues we found around the safe management of medicines, quality assurance and oversight in these areas was not effective.

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

Not all aspects of the service were safe.

There were insufficient numbers of staff deployed to consistently keep people safe.

Peoples' medicines were not always administered as prescribed and in line with current legislation and guidance.

Safe recruitment practices were followed.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Improvements were required to ensure the environment was better suited to meet the needs of people living with dementia.

The mealtime experience was positive.

Is the service caring?

Good

The service was caring.

End of life care was good and the service was an exemplar of good practice.

Staff were observed to treat people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People who used the service had the option to participate in both group and one to one activities.

People knew how to make a complaint

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

There was no registered manager in post at the time of our

inspection. Systems for audit, quality assurance and questioning of practice were not always effective.	

Pemberton Fold

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 was planned to check 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.

We carried out an unannounced inspection of this service on 06 April 2016. We returned to the service on 13 April 2016 and this visit was announced. The inspection team consisted of two adult social care inspectors from the Care Quality Commission and a specialist pharmacist advisor.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding and incidents which the provider had informed us about. A notification is information about important events which the service is required to send us by law.

We liaised with external professionals including the local authority and NHS community services.

During this inspection we spoke with 10 people who used the service, three managers, 12 members of staff, four visiting relatives and one visiting healthcare professional.

We looked in detail at eight support plans and associated documentation, six staff files including recruitment & selection records, a variety of training & development records, audit & quality assurance, policies & procedures and safety & maintenance certificates.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt Pemberton Fold was safe and we received a mixed response. Comments from people who used the service and their visiting relatives included: "I can't see anything wrong with the place, very clean, they look after me well." "Staff are very good, brilliant, I am quite happy here." "Staff are very good and help me. If I need anything all I have to do is ask and it is there." "I think they are brilliant with my [relative] not enough staff though. With 15 residents, my [relative] can't walk, needs a hoist and needs two staff for personal care. When staff are seeing to my [relative] people are left unsupervised and at risk." "My concern is all about staffing. Current staffing levels make me feel uncomfortable, when I ring up at night they tell me my [relative] is asleep in the chair when they should be in bed, that's because there isn't enough staff to put my [relative] to bed." "Staff are caring and attentive, but personally, not enough staff, another member of staff would make a difference in terms of socialisation."

We looked at night time staffing levels across the four units and found there was one care assistant on each unit. They would be supported by a team leader on each floor who would 'float' between the two units. This meant that during the night each team leader would be responsible for up to 30 people per floor. Staff told us that night time staffing levels had been reduced as each unit previously had two care assistants on duty at night, in addition to the team leaders. During the day we found that staffing increased to two care assistants per unit and again, they would be supported by a floating team leader on each floor. Daytime care staff were supported by a variety of support staff such as an activities co-ordinator, housekeeping, catering and maintenance.

Comments received from staff we spoke with included: "When I am on my own it can be very difficult supervising everybody. I've had occasions where people have fallen and they have to wait because you're dealing with others who are very demanding." "My view is that just having one member of staff for each unit at nights is not enough, though we do manage. There is always one member of staff in each unit." "If I need help, for example here we need two staff to put people to bed, people have to wait because the team leader is doing medication in the other unit." "The staff are really committed yet get frustrated because they can't do more because there isn't enough staff." "Staffing has been on-going, when I raised issues we are told that is a question of finance and that is our allocation of resources."

Throughout the inspection we observed people were left unsupervised in communal areas for prolonged periods of time. This was because staff were busy elsewhere assisting other people and no one was available to supervise in these areas. We found that care staff were responsible for laundry duties which meant they were not always available to respond in a timely manner when people needed help or support. For example, we observed one person who used the service was in their private room shouting for help. This person had pressed their call bell but no staff were available to respond. We were able to find a member of care staff and we asked them to help this person. We asked the member of staff why they were not on the unit at that time and we were told they were elsewhere in the building sorting out laundry.

We asked the manager how staffing levels were determined and we were told staffing levels were not calculated using any formal method based on people's dependency. We were also told that budgetary

considerations were a key factor in determining staffing levels.

We found the service had failed to ensure sufficient numbers of suitably qualified and experienced staff were deployed to meet the needs of people who used the service; and had failed to demonstrate a systemic approach to determine the number of staff required to keep people safe.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to staffing.

We found that people who used the service were not consistently protected against the risks associated with medicines. Across each of the four units we found a variety of issues concerning how peoples' medicines were managed. We found that people did not always receive their medication as prescribed, that insufficient time was being maintained between doses and that medicines were given after food that were prescribed before food. We also found that one person had not been given their medication for four consecutive days and that medication administration records (MAR) contained errors and omissions.

We looked at people's MAR charts and found examples of where staff had recorded people had 'refused' to take their medication. We asked staff for an explanation about this and were told the 'refusal' was because these people were living with a diagnosis of dementia and did not always 'co-operate' when staff tried to administer their medication. Staff also told us that Pemberton Fold had a policy of not giving medication covertly. However, no further explanation was provided as to the steps the service would take should a person living with dementia continue to refuse their prescribed medication.

We saw the service had a corporate medication policy but found a lack of clarity around how the staff interpreted elements of the corporate policy. For example, how and when medication might be given covertly. Giving medicines 'covertly' means it can be hidden within people's food or drink to ensure the medication is taken. Giving medication in this way can be used to ensure people who lack mental capacity and refuse their medication can still receive the medicines which are important to them.

We spoke with the manager to understand why the service had adopted a local policy around covert medication which deviated from the organisations corporate policy, but no explanation could be provided.

In respect of three people who used the service, we shared our concerns about how their medicines had been managed with the local authority adult safeguarding team.

This was a breach of Regulation 12(2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to safe care and treatment.

We looked at a sample of eight care files to understand how the service managed risk. We found the service undertook a range of risk assessments. They included personal emergency evacuation plans in the event of an emergency, mental health assessments, nutritional and diet, mobility and moving and handling. We found that risk assessments provided guidance to staff as to what action to take to ensure people remained safe.

We looked at how accidents and incidents were managed and found accident and incident reports were completed by staff in a timely manner and then entered on a corporate management system by a member of the management team. Electronic records we viewed demonstrated the preventative measures or remedial action taken by the service to reduce the likelihood of future accidents happening again. We also saw that referrals were made to appropriate external agencies such as NHS falls teams and mental health

services.

We looked to see how the service sought to protect people from abuse and found appropriate systems and procedures were in place. The service had a safeguarding policy and associated local procedure which was up-to-date. We saw safeguarding posters detailing how to raise a concern were displayed around the service. Staff we spoke with confirmed they had attended safeguarding training and demonstrated a good underpinning knowledge around how to recognise and respond to abuse.

We looked at recruitment procedures and found robust and safe recruitment practices were in place. This was evidenced through our examination of employment application forms, job descriptions, employee's proof of identity, written references and training certificates. Disclosure and Barring Service (DBS) checks had also been completed to ensure the applicant's suitability to work with vulnerable people.

The service had a corporate whistleblowing policy which gave clear guidance on how to raise a concern. Staff told us they were confident in raising concerns at a local level but were not always confident their concerns were taken seriously and acted upon. For example, we were told that concerns had previously been raised with members of the management team about staffing levels but staff felt no positive action had been taken about this.

Health & safety and building maintenance records were examined and found to be in order. Up to date certificates and checks had been completed in respect of gas and electrical safety, fire safety, risks associated with waterborne viruses and hot water temperate checks. Records were also maintained to demonstrate that visual safety checks had been completed for portable electrical appliances. Upper floor windows were compliant with safety regulations and suitable window restrictors were place. Equipment used for moving & handling people had been serviced and maintained in line with regulations.

We looked at how well people were protected by the prevention and control of infection. We found the service had been working with the local authority infection prevention and control (IPC) team and following the most recent IPC audit, the service had scored 97%. At the time of our inspection the service was visibly clean and was free from offensive odour.

Requires Improvement

Is the service effective?

Our findings

We looked at induction, training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. We looked at eight staff files and saw that staff recruited recently had undertaken a comprehensive induction programme and completed mandatory training. New staff were also given the opportunity to shadow more experienced colleagues and were required to complete a formal probationary period.

Staff spoke positively about opportunities for training and on-going development. Comments we received included: "I feel we have a lot of training. its good its face to face and not e-learning" "We get offered a lot of training regularly and I can request training, we have mandatory training which is annual." "My induction consisted of shadowing and classroom based training. We have annual mandatory training like moving and handling, safeguarding and infection control. I get a lot of training."

We saw the training matrix which demonstrated all staff had completed, or were scheduled to attend a range of mandatory training and development courses. These included first aid, health and safety, medication, moving & handling, safeguarding, dementia and challenging behaviours. In addition to the corporate training programme we saw that external training opportunities had been sourced from the NHS.

Supervision sessions were completed on a regular basis and appropriate records were maintained. We saw that discussions had taken place around training, professional development and conduct at work. Annual appraisals were completed and records maintained.

Two units at Pemberton Fold provided care and support to people who were living with varying degrees of dementia and behaviours that could challenge. This meant people were at times confused and disorientated. We found the accommodation did not have the design and signage features that would help to orientate people with this type of need. Improvements were required to ensure the environment was better suited to meet the needs of people living with dementia.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager demonstrated systems to manage DoLS and MCA assessments had been completed with people to determine whether they had capacity to make

specific decisions. In instances where people were deemed not to have capacity the manager had completed standard authorisations which had been submitted to the local authority. There was a DoLS policy and associated guidance in place.

During lunchtime service we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Two carers were present during lunchtime service and they were supported by a member of the catering team who assisted to serve people with their lunches. The atmosphere was calm and relaxed. Some people chose to eat in their rooms and we saw staff taking their choice of food and drink to them. Staff assisted people to the tables in the dining area and explained the food options to them. Encouragement was offered to those people who required it and assistance to eat given to others. Where assistance was given, staff members sat on a level with the person so that they were able to interact easily. We looked at menu options and found that each day a choice of two options was offered at mealtimes. The service also provided an 'always available' menu option which meant people could choose other food options at any time if they wished to do so.

We spent time talking with the Chef and saw how they were fully involved in ensuring peoples' nutrition and hydration needs were met. The Chef worked closely with care staff to identify people whose appetite had reduced and they implemented strategies to help maintain peoples' diet and nutritional intake. We saw how the catering staff had developed systems in the kitchen to ensure those people with additional nutritional needs were met, such as fortified food for those with poor appetites, soft diets, thickened foods, diabetic diets and pureed food.

People and their relatives we spoke with were mostly complimentary about the meal time experience. Comments included: "No concern with food, the diet is good. The chef has spoken to my [relative] about their needs." "You get a good choice of food, it's alright." "You have choices of what you can eat; they will ask you what you want to eat." "Food is good and yes we have a choice. If I don't like it they will offer you something else." "Food could be better, they do mention what you can have though." "Food was very good but has gone down recently. We are given a choice."

Good

Is the service caring?

Our findings

We asked people and their relatives whether they thought staff were caring. Comments from people we spoke with included: "Staff are nice and kind and I am very happy here." "I think it's nice, it's OK. Staff are usually pleasant, the majority are." "Staff are lovely and helpful." "Staff are very respectful, they will always knock on doors, all very good, I am quite happy here." "Staff are very good, brilliant, I am quite happy here." "Not often do you see staff sitting with residents and discussing their needs."

We looked at Pemberton Fold's approach to end of life care (EoLC) and found the service was well engaged in the 'Six Steps' End of Life Care Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. This means that for people who were nearing the end of their life, they could remain at the home to be cared for in familiar surroundings by people they know and trust.

We saw how the deputy manager at Pemberton Fold had taken a lead role in EoLC provision at the service and we were shown a comprehensive portfolio of evidence which brought together in one place all the documentation that was required to achieve 'Six Steps' accreditation from the NHS. We saw how the service had developed 'Dove Cottage' which was a dedicated en-suite private room in which relatives of people nearing the end of their life could stay. We also saw that the service provided a portable futon bed which enabled relatives to stay overnight close to their loved ones.

A decorative memorial garden had also been established within the grounds of Pemberton Fold which provided a quiet space and place for reflection. We were told how the deputy manager had liaised with the local authority to source funding for this initiative. A memorial book had been established which was available in the communal area for people and their relatives to read. Relatives and friends of loved ones who had passed used this book to share memories and accounts of their loved ones and this was opened on each anniversary of their passing. An annual memorial service was also held each year at Pemberton Fold to remember and celebrate peoples' lives. We spoke with an NHS end of life care professional who had responsibility for the 'Six Steps' programme and we were told how the work completed by the deputy manager at Pemberton Fold around EoLC was used as an exemplar of good practice for other services.

Throughout the inspection we saw staff supporting people in a sensitive and respectful manner, smiling and encouraging people when undertaking routine tasks such as supporting people to mobilise or when promoting continence.

People who used the service and their visiting relatives told us they believed they were able to influence the care they received. People confirmed they were involved in determining the care they needed and were involved in reviews.

Pemberton Fold had a policy of restricting visiting times to the service. We asked the manager whether people had been consulted about this policy and we were told that visiting hours were restricted to coincide with meal times. We were told that this policy would be discussed at future resident and family meetings in order to ascertain the views of people about this.

Good

Is the service responsive?

Our findings

We asked people who used the service and their visiting relatives if they thought Pemberton Fold was responsive to their needs. Comments from people we spoke with were mixed and included: "Not a lot on during the day, but we have outings and we have singers coming in." "We have singers coming in, and everybody is friendly here. I go to bed and get up when I want." "In the past you seemed to have more to do." "Not much evidence of social activity for my [relative], people seem to be left to sit on their own." "I often see staff sitting spending time with people, not aware of any activities so much." "The staff always encourage my [relative] to participate in activities but often they don't want to and are just as happy sitting and watching others take part. People are not forced to do things they don't want too."

At the time of our inspection visit there was a vibrant atmosphere across the service. The activities coordinator was planning a 'food cruise' event and was decorating the communal area to resemble a cruise ship. Themed food and drink from around the world was planned with catering staff for people during the cruise event. The excitement and anticipation of the food cruise event was clearly evident as we observed people having fun and the sound of laughter carried through the home as people were making decorations and costumes.

We spoke with the activities coordinator and found they had a good knowledge of people's interests and they told us different ways in which they sought to engage with people. For example, the activity coordinator recognised that not everybody was able to participate in group activities and that activities for some people needed to be personalised and provided on a one to one basis. The activities co-ordinator described how they would work with people's key workers to understand their individual likes, dislikes and personal preferences. We saw examples of how this had worked to good effect. For example, one person who used the service was an avid football fan and had been supported by staff from the service to have a private tour of the professional football club which they supported. This person's relative was also able to participate in the event and pictorial and written accounts clearly demonstrated this was a hugely beneficial activity for all concerned.

In another example, we saw how a member of staff had gone the extra mile in supporting a person who used the service who was approaching the end of their life. This person's final wish was to either go abroad or visit the seaside. Due to their deteriorating health the person was not able to go abroad but the member of staff concerned made all the necessary arrangements and supported this person to visit the seaside for the day. The pictorial evidence from this trip clearly demonstrated this was a happy and memorable occasion.

We also saw evidence of how the Chef worked with people who used the service that were living with a diagnosis of dementia. One to one engagement sessions had been established through 'catering workshops'. The aim of these workshops was to raise the interest of people when they were not enjoying their food and were identified at risk of losing weight. We saw evidence of how one person who used the service had enjoyed making biscuits during one of these sessions.

We looked at the care and support plans of eight people who used the service and found they were not

always person centred and were too task led. It focused on what had to be done and didn't account for people's individual needs and promoting people's independence. We discussed this with the manager who told us this was something they had already recognised and that the provider, Community Integrated Care, had plans to introduce new care planning documentation which was person-centred. We were shown a template of this new documentation which appeared to be more comprehensive and captured people's individual abilities, strengths and personal preferences. We sought assurances from the manager that the new care planning documentation would be phased in within a reasonable timeframe and that staff would be suitably trained.

We looked at how information was shared with people who used the service and their relatives and found that a regular programme of resident and family meetings was taking place. This was evidenced through minutes of meetings being recorded. We could see that a variety of topics where discussed during these meetings and that people were able to share their views and experiences. We saw that regular newsletters were produced and distributed which provided details of forthcoming events, special occasions and updates about new members of staff.

We looked at how the service managed complaints and saw a complaints policy and associated procedures were in place. The policy clearly explained the process people could follow if they were unhappy with any aspect of the service at Pemberton Fold. Details of the complaints process was displayed around the home to guide people and their relatives regarding the procedure. We looked at the complaints log and found that accurate and up to date records where maintained. However, we saw that one complaint had not been responded to within the timeframe identified within the policy. We asked the manager about this and we were told that responses to complaints had to be quality assured and 'signed off' by head office which meant delays sometimes occurred in replying to complainants.

Requires Improvement

Is the service well-led?

Our findings

We received a mixed response from people who used the service and their visiting relatives when we asked if they thought the service was well-led. Comments included: "I wouldn't know who senior management are." "I know the previous manager has left but I don't know who the new manager is." "The management are approachable and I can always go to them with any issues about my relatives care." "We visit my [relative] on a regular basis and I don't think the managers are very visible." "I've asked to speak with a manager about my relatives care on a number of occasions and always found them approachable."

Comments from staff we spoke with included: "Good open culture here, no concerns, feel supported and valued." "There is a god culture and management are very approachable and do listen." "No concerns about the way the home is managed, I do feel listened to by management, they are approachable." "I am concerned our manager has too much responsibility covering several homes, and therefore can't focus on the needs of this home."

At the time of our inspection there was no registered manager in post at Pemberton Fold. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Overall operational management was being provided by a manager from within the Community Integrated Care (CIC) group. However, this manager was also the registered manager for another CIC home which meant their time was not wholly dedicated to Pemberton Fold. In the manager's absence, day to day management of Pemberton Fold was led by a deputy manager.

During our inspection we asked for a variety of documents to be made available. We found documentation was kept securely locked away and was well organised enabling the documentation requested to be accessed promptly. We found all the records we looked at were structured and organised which assisted us to find the information required efficiently. This made information easy to find and would assist staff if they were required to find information quickly

We saw that staff meetings were held on a regular basis and appropriate records were maintained. Staff told us they were able to contribute to agenda items and that staff meetings were useful and productive.

Audit and quality assurance was completed on a regular basis and covered a variety of topics. We saw that where internal audits had identified issues, action was taken and lessons learnt. However, given the issues we found around the safe management of medicines, quality assurance and oversight in these areas was not effective.

We had requested a Provider Information Return (PIR) ahead of our inspection visit but this was not returned. A PIR is a form that asks a registered manager to give some key information about the service, what the service does well and improvements they plan to make.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Peoples' medicines were not always given as prescribed and in line with current legislation and guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient numbers of suitably qualified and experienced staff were deployed to meet the needs of people who used the service. A systemic approach to determine the number of staff required to keep people safe was not followed.