Denehurst Care Limited

Passmonds House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 20 and 21 March 2018. The inspection was brought forward as we had received concerns about the risk of infection at the service.

We last inspected Passmonds House in February 2017 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) in that medicines were not always managed safely and recruitment procedures did not ensure suitable candidates were selected to work at the home. At this inspection we found improvements had been made in both these areas, and the service was no longer in breach of these regulations. However, we found concerns in other areas. We found that there were insufficient staff to meet the needs of the service, which was a breach of Regulation 18 of the Health and Social Care Act (2008) Regulations 2014.

We also identified concerns in relation to infection control, poor standards of hygiene and, maintenance of the premises. This meant there was a breach of Regulation 15 of the Health and Social Care Act (2008) Regulated Activities 2014.

A Warning Notice was sent to the registered provider requiring them to comply with Regulation 15(1)(a)(c) (d) (e) and (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014. They appealed publication of the warning notice, however this was not upheld. The registered provide must make sure the poor standards of hygiene are resolved before 17 August 2018.
We made three further recommendations regarding training, capacity and care plan reviews. We found the training provided to staff did not provide them with sufficient information to carry out their duties; staff were not always aware when a person was lawfully being deprived of their liberty; and care plan did not take all recorded information into account.

Passmonds house is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Passmonds House provides accommodation and support for up to 35 people in two double and 31 single rooms. Twenty-two of the rooms have en-suite facilities. At the time of our inspection nobody shared a double room. It is comprised of two units over two floors, with lift access to the upper floor and ramps to all entrances. At the time of our inspection there were 30 people living at Passmonds House.

'A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.' At the time of our inspection the service had a manager who was in the process of registering with CQC.

People who used the service were safeguarded against potential harm, and they told us that they felt safe at

Passmonds House. When we spoke with staff they told us they were confident they would report any issues of malpractice to their manager, and we saw that the service responded to issues of poor practice.

We saw and were told by staff that they were sometimes overstretched, which meant that there was little time during the day for work on an individual basis with people who used the service. However, staff showed a good knowledge of the individuals they supported, their needs and preferences, and respected their religious and cultural beliefs.

We saw records which showed people received supervision, but this needed greater structure and frequency. During our inspection we saw staff and managers communicated well with each other to ensure tasks were completed, and that people took responsibility for their own work. The staff cooperated well with each other to share the workload equally.

Attention was paid to people's diet and nutritional needs, but not everyone enjoyed the food that was offered. However, we were told that if people did not want food that was on the menu they could request an alternative, which was provided.

We saw attention was paid to people's health needs, and a visiting health professional told us staff promptly referred any issues of concern, and followed their advice to ensure people remained healthy. The service had worked with a district nurse to monitor for signs of illness and skin integrity, showing a proactive response to any potential health concerns.

Capacity and consent was generally sought, and there was evidence that where people lacked capacity decisions were made in people's best interest, and appropriate authorisation to support people had been requested. However, when we spoke with staff they were not clear as to who might be subject to any authorisation to deprive them of their liberty, or what this might mean.

Individual preferences were not reflected in the premises or the environment. There was little attention to how bedrooms were decorated and furnished. The layout of communal rooms did not allow for small group work or social interaction, an upstairs room was not used because of the poor light aspect and décor, which meant that there was little room in the downstairs lounges for people to socialise.

When staff were supporting people they were courteous, polite and respectful, and care plans reflected their needs. People told us that the staff knew how they liked to be treated and that they were caring. We saw, and were told that there were some social activities on offer, but there was not always enough stimulation for the people who used the service. When we spoke to staff and the manager they displayed a good understanding of how to support people approaching the end of life.

There were structures in place to review the service, and people had completed questionnaires to check their overall satisfaction with the service. These showed people were generally satisfied but greater analysis would help to improve the quality of service provision, as the questionnaires did not reflect some of the views people fed back to the inspectors.

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.

Appropriate standards of hygiene were not maintained.

There were insufficient staff to meet the needs of the people who used the service.

Medicines were managed safely and people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was insufficient to allow them to carry out their duties competently.

Attention was paid to peoples diets, but not everyone enjoyed the food and drink offered.

People's health needs were well monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Care was often task centred as staff did not always have time to support people individually.

Care was kind and respectful.

People told us that the staff knew them well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans outlined people's needs but some of the profile information was out of date.

Key workers were not always able to complete their

responsibilities, and people were not always consulted about their care plans.

Care notes reflected a good understanding of how people liked their needs to be met.

Complaints were handled appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a manager in place but they had not yet registered with the Care Quality Commission.

People were not consulted appropriately about service delivery.

Previous visits from commissioners and other services identified issues which had not been addressed.

Systems were in place to monitor the quality of the service.

Passmonds House

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.

This inspection took place on 20 and 21 March 2018. The first day was unannounced. The inspection team consisted of one inspector, an assistant 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. We were also accompanied on the first day of the inspection by a member of Rochdale Adult Care Services Infection Prevention and Control Team. Before this inspection, we reviewed the previous inspection report and notifications that we had received from the service. We also contacted the local authority safeguarding and quality assurance team to obtain their views about the service. The inspection was brought forward following concerns raised about poor infection control measures at Passmonds House.

We asked the provider to complete a Provider Information Return (PIR), prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with eleven people who used the service, four visiting relatives, a visiting professional, the manager, five care staff and two nursing staff, the activity coordinator, the cook and the housekeeper. We looked at five people's care records, five staff recruitment files, induction, training and staff supervision records, records relating to medicine administration and records about the management of the home.

We looked around all areas of the home, looked at how staff cared for and supported people, and looked at food provision.

Inadequate

Is the service safe?

Our findings

We brought our inspection forward because we had received concerns about the risk of infection at the service. We asked a representative from the local authority Infection Prevention and Control Team to accompany us on this inspection. They told us that there had been some improvement since they last visited Passmonds House, but we found that there were serious concerns around infection control.

The basement area housed the laundry, kitchen and food storage area and storage of other unused items and files. When we looked in the basement we found plaster was flaking off the walls in some rooms and on corridors, and serious issues with mould and damp which had not been addressed. Severe damp will contaminate clean clothing and other items carried to the main part of the building, and may result in the health of people who used the service being negatively affected over the longer term.

This issue had been identified when the Infection Control Team visited in February 2018, but no remedial action had yet been taken. When we spoke to the manager about this we were told they hoped to have the work done by October. However, given the seriousness of the concerns the risk of infection was too high to leave in the current state for a further six months. The manager told us that they would ask the owner to arrange to begin the work as soon as possible.

We found further issues of concern in the basement area, for example mismanagement of cleaning materials, such as overuse of disposable cloths and cross use of cleaning items in separate parts of the building; mixed rooms for cleaning crockery, ironing clean clothes and storing cleaning materials. Sinks were not clean and the same sinks were used for cleaning dishes and pans and inappropriately for emptying mop bucket waste; there was no separate sink for staff to wash their hands and poor provision of hand hygiene soap, and poor distribution of personal protective equipment. One area underneath a food preparation trolley was very dirty. We were told that the staff were unable to reach underneath to clean it as the trolley was secured to the wall, but we later saw that the maintenance officer had taken the trolley off the wall to allow for the area to be properly cleaned.

We found poor food management, for example, we found uncovered food including crackers spread with pate in the food lift. Food without any covering could increase the risk of bacteria infecting the food and cause food poisoning and other stomach upsets. A fridge in the dining area contained opened packets of sliced meat dated with a date fifteen days prior to our inspection. This was an immediate risk to the staff and the people who used the service. A microwave in the dining room contained a plate of uncovered and congealed fried eggs.

When we toured the building we found that in some bedroom and bathroom water taps ran very hot, causing a risk of scalds. When we asked the maintenance officer about this they informed us that they had fitted cut off valves to some taps but were unable to complete this task without turning off the boiler, which also provided heat to the building, so they were waiting for warmer weather. They assured us that this work would be completed during the summer. We asked the manager to ensure that notices were displayed to warn people of the risk of hot water, and they agreed to do this.

We found one sink on the first floor of the building which was no longer in use. Water left in the pipes could increase the risk of legionella or breeding of other bacteria. We asked the manager and the maintenance officer to run the taps regularly to prevent risk of disease breeding in contaminated water and they agreed to run these taps on a weekly basis.

During our tour of the building we saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service but we found a bottle of shampoo in a communal bathroom. The manager told us that this had probably been left behind by a person who was self-caring, but it could cause risk if used incorrectly.

A boiler room adjacent to the medicines room was used to store archived medicine records and some medical items such as the first aid kit. When we looked in this room we found an overflowing bin filled with crisp packets and empty drink bottles, a urine soaked cushion placed on top of the boxes containing old records. The room had a strong odour of stale urine and was visibly unclean.

We found food trolleys and communal equipment such as wheelchairs were not clean, and the outside decking area, which was used as an area where people smoked, was littered with cigarette, ends, some of which had been trodden into the main communal areas. This presented a health and fire risk.

We asked six people who used the service for their thoughts about the cleanliness of the building. Four thought it was 'fairly clean' whilst the other two believed cleanliness was poor, with one person telling us, "The whole place needs a right good cleaning". Some rooms did not smell fresh, and in one room we found several used utensils and cutlery items in the room. Crockery, used tissues and other objects had been left on the floor which had evidence of various spillages underfoot. When we spoke to the manager and the staff about this room we were told that the person who used the room spent most of their time in their room and objected to anyone entering to clean.

We spoke with the domestic assistant who did not feel they had enough time to complete all the cleaning tasks, telling us, "I can't get round everywhere. I need assistance. It can be hard to do enough".

The above concerns are a breach of regulation 15(1)(a)(c) (d) (e) and (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Premises and equipment must be clean, secure, properly maintained. Appropriate standards of hygiene were not maintained. A Warning Notice was sent to the registered provider requiring them to comply with Regulation 15(1)(a)(c) (d) (e) and (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014. They appealed publication of the warning notice, however this was not upheld. The registered provide must make sure the poor standards of hygiene are resolved before 17 August 2018.

We looked at four staff files. These showed that the recruitment practices adopted by the home were satisfactory. Relevant checks had been conducted before potential staff were appointed including application forms which documented and accounted for any gaps in employment, two references, checks that the person appointed had the right to work in the United Kingdom, and DBS checks (Disclosure and Barring Service). This helped to ensure only suitable staff were recruited, so that people were kept safe. The policies of the home demonstrated that disciplinary procedures were in place for incidents of staff misconduct, and we saw that when issues of misconduct had been raised these were appropriately dealt with by the manager and the provider.

On both days of our inspection we saw there were four care assistants on duty throughout the day. When we looked at the rota we saw this was generally the case. In addition the service employed a part time activity

co-ordinator who would make up their hours working two hours in a care assistant role in the morning to assist people to get out of bed and prepare for the day. The rota showed that there were either two or three waking night staff. We asked people if they thought there were enough staff and in the main they believed there were not. One person who used the service said, "I believe they are short staffed," and another said, "Sometimes I don't think there enough staff for all the residents, especially when there are only two people on at night." We asked the staff if they believed that they were able to meet the needs of the people who used the service. One care assistant told us, "One extra staff member will make all the difference; it would be safer for the residents and the carers. We could spend more time with them and help them in so many more ways". The service employed one full time domestic assistant. However, this did not provide sufficient time or resource to ensure that the building was kept clean.

The above concern is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (staffing) as there were insufficient numbers of staff employed.

People told us they felt safe. One person who used the service said "I feel safe and the care staff seem good. I would leave if I didn't feel safe." Visitors were confident that their relatives were safe, one told us "I know my relative is safe here", and another, "Yes, I think the care my [relative] receives here is safe," but went on to say, "Some belongings have gone missing. These have all been reported. They searched the laundry and looked into the washing machines. Other than that, I am not aware of any concerns."

The service had a policy to protect vulnerable people from harm or abuse and a whistleblowing policy. Whistleblowing provides a commitment by the service to encourage staff to report genuine concerns around poor practice without recrimination. When we spoke with staff they were confident they would report poor practice but were unable to describe what may constitute abuse or when to raise a safeguarding alert. This meant that they might overlook or fail to report any potential harm to vulnerable people. However, people who used the service told us that they had not witnessed any abuse by staff or others whilst they had lived in Passmonds House. One person told us, "I have never seen any abuse or anyone to lose their temper. If I did I would tell [the registered manager] immediately," and when we looked at the safeguarding file we saw that a recent unwitnessed injury caused to a person who used the service had been reported by the manager to the local safeguarding team and investigated appropriately.

We looked at five care records which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, risk of falls, eating and drinking, communication and hygiene. We saw that where risks had been identified a corresponding detailed care plan was put into place to help reduce or eliminate the identified risks and these were reviewed on a regular basis. For example, one risk assessment identified use of footwear may be an issue to a person, and asked staff to be aware that incorrect footwear may increase the risk of falls or stumbles, advising them to be vigilant and ensure walkways were clear.

The manager told us that the people they supported did not present behaviours which were challenging, but on occasion some people could become frustrated and difficult to work with. We asked care staff how they dealt with situations where this arose. They told us that they remained calm, ensured other people who used the service were safe, and did not intervene as they recognised further intervention could exacerbate the situation. They discreetly observed the person and allowed them time to calm down before going back to provide appropriate support. They recognised that they might be a catalyst to the concern, and would seek the support of other staff to ensure that the person would not cause harm. A care worker told us, "We get to know how best to respond. One person can become very verbal. We don't react to inappropriate language and sometimes distract other residents so that they don't react adversely and set off a chain of events".

We saw the service had some systems in place to manage environmental risks. For example, a fire risk assessment identified ways to minimise the risk of fire, including regular servicing of fire equipment, alarms and fire drills, and preventative measures to reduce the fire risk where people smoked. Personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency and take into consideration a person's individual mobility and support needs. However, we saw these contained too much information to be of use in case of emergency. We spoke with the manager about this and they agreed to review and slim down the information needed to assist people to evacuate the building.

At the last inspection of Passmonds House we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not administered correctly, but at this inspection we found systems to administer and manage medicine had improved.

People received their medicines as prescribed and were supported by staff who had completed relevant training and had their skills in administering medicines assessed, to ensure they were competent in following medicines procedures safely.

Medicines were stored safely and securely; the medication trolleys were kept locked in between administering, and securely chained in the medicine room. This room held a locked fridge for storing medicines, creams and drops which needed to be kept at a low temperature, and a locked controlled drugs box secured to the wall. Controlled drugs are medicines named under The Misuse of Drugs legislation. The Misuse of Drugs Regulations 2001 and 2006 restricts how such medicines are stored and recorded. The home used some of these prescribed medicines and we saw they were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We saw evidence of a controlled drugs audit taking place weekly and the manager or the senior care assistant on shift conducted daily checks.

We also saw that the room and fridge temperatures were recorded on a daily basis. If medicines are stored at the wrong temperature they can lose their potency and become ineffective.

However we noticed the first aid kit was kept in a locked side room adjacent to the medication room which also doubled as the boiler room. The kit was found in a box at the back of the room, and a staff member confirmed that this was the active first aid kit that the home used for emergencies. We raised our concerns about how easily accessible this was with the manager who agreed to move it to a more accessible place.

Medicines were clearly labelled and all topical creams which had been opened had an opened and checked date written on the outside. This meant that they could be checked to ensure that they did not lose their efficacy. Medicines were also kept in the container they were dispensed in. We saw evidence that any out of date or unused medicines were returned to the pharmacist for disposal.

We observed a senior care assistant administering medicines. They asked for permission before the medicines were given, passed the medicines to the people they were supporting in a disposable cup, with a glass of juice or water. One person was asked if they would like more juice and the second glass of juice was brought quickly. The member of staff recorded that the medicines had been taken on a medicine administration sheet (MAR). We reviewed 4 MAR sheets and checked that these corresponded with the medication stored. All of these added up to the correct amount and correct dosage. The MAR sheets were legible and there were codes in place for when medication was not given. The folder in which the MAR sheets were stored included protocols for when medicines needed to be given 'as required'.

Application of creams was recorded on the MAR sheets and we saw evidence that these were being applied

at the correct time. Body maps to instruct carers where to apply these creams along with any associated risk assessments were kept in care plans.

Internal and external medication was kept separate and creams were generally kept in the medicines room. However, when we toured the building we found a tube of prescribed medicines in one room. We informed the manager who promptly removed it. None of the people living at the home took supplements or used oxygen, however there was an oxygen hazard notice clearly displayed on the door.

When we spoke with staff they told us that inconsistencies in management meant that issues of concern had not always been addressed in the past, but they were optimistic and felt that things had improved since the appointment of the new manager. They told us that they were encouraged to bring up any issues and that senior staff and managers were more focussed on improving the quality of the service and would listen to any ideas to improve practice. We saw that when things went wrong the service was prepared to look at better working practices, for example, we saw that where issues around a person's mental health had been dealt with incorrectly, the procedures and guidelines in place were amended to reflect the needs of the person, and this helped to improve understanding of how best to meet mental health needs.

Requires Improvement

Is the service effective?

Our findings

Staff training records showed that induction programmes were provided for new staff over three to four days. These covered areas such as moving and handling, fire safety, safeguarding vulnerable adults and children, infection control, food hygiene, hand hygiene and first aid.

A training matrix showed which staff had completed aspects of their training. This also kept track of NVQ levels and mandatory training. All categories included dates of when these courses needed to be renewed or completed. Mandatory training for staff included moving and handling practice, health and safety, life support, safeguarding adults and children, medication, food hygiene, infection control, fire safety and mental capacity. Other training for staff included consent, assessing needs, care planning, challenging behaviour, confidentiality, continence, dementia care, Equality and Diversity, hand hygiene, mental capacity, pressure care, personal care, record keeping, MUST, COSHH, sleeping and hydration. When we looked at the training matrix we found that all staff bar two who were on long term leave had completed refresher training on line and an induction to the service.

We asked the people who used the service if they felt the staff had the skills and knowledge to support them well. They told us that they felt the staff knew them well enough to offer the right support and that they knew how they liked their care delivered. One person told us, "I think the staff are skilled here. I'm not sure about the medications, but I remember having some tablets last night. I don't know about any care plan and I've not spoken to any staff about any particular support. I can get myself bathed or showered independently but they are around to help if necessary. I am sure that the GP would be called, if needed." When we watched staff interacting with people who used the service we saw interventions reflected a sound understanding of people's needs, what they could do for themselves and how they liked their needs to be met.

When we spoke with staff however, they did not always feel they received the correct type of training to do their jobs effectively. Most of the training was done through e-learning and involved logging in to a training module on a computer and completing the relevant coursework. There were no resources in the workplace to complete these courses and staff told us that they were expected to do this at home. One person said, "Training is on-line. We have to sit there on our days off. I think it should be done at work but we don't always get time," and another person told us, "I feel you've got to be a patient person to do online training." We reviewed another staff member's supervision document which stated, "I do not find the Social Care TV training useful; we could do with more training". Records showed people had received training in safeguarding, but when we asked them about protecting people from harm they were unable to tell us what might constitute abuse.

We saw staff had received training around mental capacity and consent including Deprivation of Liberty Safeguarding orders (DoLS) but when we spoke to staff about DoLS they were unable to tell us who was subject to DoLS orders, how this would affect their interactions with people, what a DoLS might mean, or show much understanding of capacity issues.

The Care Certificate is a set of standards that social care and health workers follow in their day to day working, and provides staff with the knowledge to meet the minimum standard of care delivery. At the time of our inspection we were told that the Care Certificate was not yet being offered, but some staff had completed the equivalent National Vocational Qualification (NVQ) in care. We spoke with the manager of the service who told us they were currently in the process of changing training provider and that the Care Certificate would be offered as part of this newly formed training.

We recommend that the service reviews the way it delivers training to all staff members to allow for greater consistency and improve service delivery.

We saw that where training had been delivered face to face staff showed a greater knowledge of how to meet need safely and effectively. For example, they were able to explain the correct moving and handling procedures to support a person who had fallen, and competency checks had been carried out on senior carers administering medicines to show they had administered medicines correctly.

Formal supervision provides an opportunity for monitoring the performance of individual staff members and allowing collective understanding of issues or concerns. Staff told us that they received a formal supervision session but were unclear how often this occurred. One told us, "It's every month or three months, I'm not sure", and another said "I think it is every three months." We asked the registered manager about the regularity of supervisions, they told us, "They are every 3 months moving forward but we only started this in October when the previous manager left. The next ones are due in April". We saw records to indicate that staff had received supervision in October 2017, and some in January 2018, but there was no evidence of spot checks which might indicate how a person was performing. Staff were not yet being offered yearly appraisals, which would give an opportunity for the manager and staff member to reflect on their performance over the previous year and set goals and objectives, but the manager told us that they planned on starting these over the next few weeks.

Where supervision had taken place staff told us that they found the session useful. One person said "I can ask questions and check my work. If I need something I can ask and use supervision to think about what might help, for example I asked for dementia training and [the manager] arranged for an on line course". The supervision documents in use were detailed and included categories 3 month progression, diverse needs of residents, own initiative, workloads, management actions, training/qualifications, role at Passmonds, training and mentors comments.

Attention was paid to people's diet and nutritional needs. Weights and food intake was monitored and when issues were identified appropriate referrals were made to medical services for support and advice was followed. Where people required specific diets, the kitchen staff were notified and notices placed in the kitchen to say how people's meals needed to be prepared. For example, pureed, to assist with swallowing, or fortified to help people maintain or increase weight. People's personal preferences or cultural requirements were taken into account. For example where people did not eat meat an alternative was always offered. There was a choice of two main meals at lunch and teatime, and we were told that if people did not want either of the choices, an alternative would be prepared for them. One person told us, "I can choose meal options and, as far as I'm concerned, it's all good".

When we asked people about the food there was a mixed response. On the first morning of our inspection, one person told us, "The meals are OK, for example, I've just had tomatoes, egg, bacon and lots of toast here in my room," but another commented, "The less said about the meals the better. They are not good. It's not what I would call good food and it's not well cooked. I tend to buy a lot of my own food and drinks. I have a small fridge in my room". A member of staff told us, "it's not so easy to please everyone, but we don't get

many complaining about the food. We offer variety if someone prefers something not on the menu we will try to provide it. We take some people to the supermarket every week, so they can choose their own food".

Some people chose to have their meals in their room, but others ate in the dining room. This room only accommodated fifteen people, so there were two sittings.

The first sitting for lunch was taken in the dining room at around 12.15 pm. The room was well lit and bright, but it was bare - there were no knick-knacks or ornaments to add a homely feel, and tables were not set prior to the meal being served. A whiteboard showed the day's main courses, but there were no visual prompts or information about dessert. There were no cloth or paper napkins, or salt and pepper sets on the tables, but these were provided on request. The dining area was open with space to eat and there was room for wheelchair access. On one day of the inspection, people were offered either sausage and mash with peas, or chicken and vegetable pie with mash, followed by a chocolate cake with cream. We were told that the chocolate cake was suitable for diabetics. The food was well presented and contrasted fairly well on the white crockery. Tea and coffee were served with the meal.

All staff attended a changeover meeting at the start and finish of each shift. This helped to ensure that staff were given an update on a person's condition and behaviour and ensured that any change in their condition had been properly communicated and understood. Staff shared information about individual people who used the service and tasks were delegated appropriately and shared fairly. Staff told us, and we saw that they worked as a team and supported each other through the day.

We saw that staff monitored people's physical and mental health needs, and ensured they had good access to healthcare staff. For example, we saw care records had been updated to reflect one person's weight loss, including a referral to the speech and language therapist and notes to show what action was required to fortify the person's meals.

We saw in care plans that people had regular access to other health care professionals such as dentists, opticians and chiropodists or specialist nurses, such as Asthma or diabetic nurses. Any visits to or by health professionals were recorded.

We spoke to a visiting health professional. They told us that they felt the staff at Passmonds House monitored people's health well. They told us that they promptly referred any issues of concern, and responded well to instruction, "Pressure care, and health care in general, is good, and monitored well. There is good communication all round. If I ask for anything they will provide it". We saw staff were conducting their own testing for UTI's using 'dip sticks' and colour coding charts. Staff told us that a district nurse had provided instruction, and results were reported to the person's general practitioner (GP).

Whilst we were inspecting the service we saw one person had a condition which may have required medical attention. We enquired about this and were told by the manager that they had informed the person's optician, who had come out to visit, and we saw notes to show the suspected condition had been referred to the GP, who had arranged to conduct a home visit.

Individual preferences were not reflected in the premises or the environment. On the ground floor there were two communal lounge areas, one being smaller and quieter. There was a television in both lounges, but armchairs all around the sides of the room did not lend to small group work or social interaction. In the linking corridors there was barely sufficient space for wheelchair users and the corridor walls offered poor contrast with the flooring and handrails throughout the home.

Most of the bedrooms were characterless and did not reflect the tastes or personality of the person who inhabited them. There were very few personal items or photographs. Some had call bells which had come away from the bracket on the wall but placed on tables. In one bedroom we saw exposed telephone wires from a disconnected phone. There was little attention to how rooms were decorated and furnished For example, a man's bedroom was decorated in pale pastel shades with a pink flowery duvet, whilst a woman's adjacent room was decorated in stronger colours. The bedrooms on both the ground floor and first floor did not feature people's names or photographs on the doors, which could help to both make them more individual and support people's memory and recognition. There was a lift for residents and 2 stairwells with keypads at the top and bottom. Three rooms were currently vacant.

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.

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 procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether Passmonds House was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us, and we saw information to show that applications to deprive people of their liberty had been authorised by the supervisory body (local authority), or were awaiting authorisation. We had been informed where authorisations had been granted. Capacity assessments had been completed as part of the process to determine whether people needed a DoLS authorisation.

Paper copies of all requests and authorisations were kept in the person's care record file, and a matrix displayed who was subject to a DoLS order, when this came into effect and when it was due for renewal. When we reviewed this matrix, however, we found it misleading. For example, one reference related to a renewed DoLS order, but this actually referred to the request for an extension to the order, so it was unclear if the DoLS order had lapsed or not, without looking at the paperwork.

However, care records reflected people's abilities to make their own decisions and changes in capacity. One file we reviewed included a signed consent form with specific issues of consent, including recording and sharing information, being photographed, contact with health and other professionals, family access to care plans, expenses, and night checks. Another noted, 'now has DoLS in place and must be accompanied when going out'.

When we spoke with staff they were not clear as to who might be subject to any authorisation to deprive them of their liberty, or what this might mean. This meant that any restrictions on people's liberty could be overlooked, and increased the risk of people being deprived of their liberty unlawfully.

We recommend that the service reviews procedures around mental capacity and ensures all staff are aware of people's legal status.

People who did not have family or representatives and were unable to speak for themselves had access to advocates who gave independent advice and acted in the person's best interest. Where this was the case, we saw information in care records that showed when an independent advocate had been consulted.

Requires Improvement

Is the service caring?

Our findings

It was clear from our discussions with the staff and the manager of Passmonds House that they knew the people who used the service well, and understood how they would like their needs to be met. Interventions were kind and friendly. Where possible, the staff tried to encourage people to remain as independent as possible, and we saw people were treated with dignity. One visiting relative told us, 'The staff members seem to be kind and caring. They listen to us and try to support my [relative] to be as independent as possible. For example, she can choose what clothes she wants to wear each day.'

However, care was often task centred and based on meeting generic rather than specific need due to the low staffing levels. For example, at lunchtime there were two members of staff serving food either in the dining room or taking food to people in their rooms. There was no time for conversations with people sitting at the tables. Activities were organised to meet the general needs rather than focussing on how to support people to maintain their hobbies and interests but when people's needs changed, opportunities to support people to maintain their lifestyle were sometimes acknowledged. For example, one person who used to enjoy going out to the local shops was no longer able to weigh up the risks involved, although staffing levels did not allow for regular escorted trips they told us the service tried to take them to the local supermarket each week. This provided the person with stimulation and maintained their community presence.

We saw some complimentary notes and cards from relatives. For example, one read, 'Staff have been absolutely amazing since the day [my relative] arrived, and supported [them] thorough difficult times. I am aware that [my relative] did not settle easily; staff had a lot to cope with but didn't give up. [My relative] is now at ease at Passmonds. I am very grateful for the caring love staff have given."

People told us the staff were respectful, and responsive to their needs. For example, one person told us, "[the staff] are caring and they respect my views and listen to me. They always knock on my door and respect my privacy. They would never come in when I was showering. They also react well, for example, I asked for a glass of water last night and a carer brought it for me. They let me manage my own routine as I can get around independently. I feel that they have my best interests at heart." Another told us that the staff had supported their relationship with another person who used the service, respecting their need for privacy, "The staff are kind and caring and they knock on the door before coming in. I am treated with dignity and respect and I have my privacy. For example, they don't interfere with [another person] and me".

When we asked, people who used the service and their relatives told us that the staff were generally kind, and courteous, but they felt that they did not have enough time to spend with them. This meant that they did not always have the time to listen to them or consider ways that they could support them in a more person centred way, or fully meet their needs. One person told us, 'The carers are kind, but often they are too busy, so I don't always get any support. I'm not sure that they listen to what I have to say. I sometimes feel overlooked." Another said, "It's generally OK, but sometimes there can be inconsistencies. Not all the care workers are the same. For example, I should have had a shower yesterday (Monday) but they were too busy. I can wash and shave myself, but I have some problems getting dressed. I usually ask the night staff because they have more time to put my socks on."

When we spoke with staff they displayed a sound knowledge of the people they supported. They spoke in friendly terms about the people who lived at Passmonds House, their backgrounds and their history. One told us how they enjoyed spending time helping a person to retire for the night: "We can share a laugh and a joke. [The person] is here for us to help them, and we care about [them]." Another told us about working late in the evenings and how "A couple of the [people who use the service] like a glass of wine and will stay up 'til later. We'll have a nice conversation before they go to bed". We saw interventions were friendly and considerate, overhearing for example, a care assistant who had been supporting a person to sit in a lounge saying, "I'll get you some Easter cards, if they didn't have any left here. Don't get any from the local shop as they will be too expensive. I'll get you some from town. They have packs of six for £1."

Case notes recorded people's night time preferences and these were respected, for example, it was recorded that one person preferred the lights in her room off and the door closed. There was a signed consent form to say that the person did not want to be checked at night.

We were told the cultural and religious backgrounds of people were respected. However there was nobody living at the home who required any special cultural consideration. We spoke to one visiting lay member of the local church who had visited the service to give communion to "the people who wanted it". We also saw in records that some people would attend the Catholic Church for Sunday mass. In discussion with staff they were able to tell us how they would support people from different backgrounds to their own, respecting culture and belief. One member of staff told us about an incident where they witnessed racist behaviour, but was not afraid to challenge the person in a sensitive but forthright manner. They demonstrated good people skills and an understanding of how to correct intolerance, reinforcing positive attitude and merits of multi-culturalism.

Staff understood the need for confidentiality and the service had a confidentiality policy. Any notes or records relating to individuals were locked away when not in use to prevent unauthorised access.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff responded to their needs and provided them with support when they required it. One person said "staff are on hand to support me. I can manage a lot for myself but I think I am in good hands".

Information contained in care plans gave a good outline of the individual's needs and preferences, and the actions staff should take to support the person to maintain their independence, meet their personal preferences, and reduce any potential risks. Care files included an easily accessible 'care plan overview' of the person and how they would like to be supported, which could help any new member of staff who was unfamiliar with the person, but when we looked at one overview we noticed that the information it contained had not been updated as it stated, 'memory is deteriorating and is due an assessment in January 2017'. However, when we looked at the details of this person's plan we saw that they contained up to date information about the person's memory and mental capacity.
We recommend that reviews of care plans take into account all recorded information about individuals.

We looked at five care records. For each person a care file contained useful information about the person including a pre-admission assessment, personal details and contacts, and a consent form which had been signed to say that the person consented to their care at Passmonds House. Separate sections provided detail and instruction about how care would be delivered, considering mobility; physical health; mental health; skin care; food hydration and diet; personal care including continence and oral hygiene; religious and cultural requirements and social activities.

They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted action to reduce or eliminate any identified risk was recorded, or if this was not possible, staff were instructed to be mindful to risk. For example one care plan noted a person felt more comfortable in footwear too big for their feet; this was identified as a trip hazard and staff to be vigilant to this whilst the person mobilised.

Records were reviewed regularly to ensure the information was fully reflective of the person's current support needs, but when we asked, people told us that they had not been consulted about their care plans. One person told us, "I'm sorry, but I don't know what a care plan is." Another said, "I don't know about any care plan and I've not spoken to any staff about any particular support."

Charts were kept to monitor and check people's health and well-being. We saw that specific specialist information and guidance from the relevant professionals involved in their care was contained within the care records, with notes of visits and consultations.

Each person had their own key worker and we saw that some keyworkers would complete a checklist to ensure all needs are met and record any follow up actions necessary. For example, one key worker noted that a person had a distended stomach, alerted the GP and recorded the outcome of the consultation. However, not all key workers were able to fulfil their role; for instance, where care staff had been moved to

night work they remained key workers but could not carry out some of the duties which would require work during the day. One person told us, "[Having a keyworker} it doesn't mean anything. That named key worker doesn't fulfil key worker duties, because they work on nights now. It's all meaningless."

Care notes provided good background to the individual and reflected the information care staff were able to tell us about the people they supported. One care record we looked at gave a good social history including issues the person had overcome and reflected the way the person was cared for. They also reflected peoples religious and cultural needs; in one care plan we saw 'encourage to practice faith if [person] wishes, and respect wishes'.

When we asked people about the activities at Passmonds House, one person told us, "I like some of the activities, such as bingo, skittles, colouring and celebrating birthdays". They told us that they also made decorations to celebrate events such as St Patrick's Day and Easter, and sometimes had a visiting entertainer. A visiting relative said, "There is generally enough to do, I take my relative out quite a lot and they don't tell me they are bored." Other people were spoke with did not want to get involved in the activities provided, one said, "I like to smoke, have a beer and watch television rather than get involved in other activities." We saw this person's wishes were respected.

The service employed a part time activity co-ordinator, but this person was not working on the first day of our inspection and there was little to stimulate the people who used the service. One member of staff organised a short lived sing-along, but we did not see any other group activities on the first day. When the activity coordinator was present on the second day, we observed a greater level of stimulation. For example, in the morning we saw them reading the newspapers to a group of people who used the service. The activity coordinator told us that the people they supported were interested in specific news stories, for instance they enjoyed hearing about current international affairs. The activity coordinator told us they arranged to escort some of the people who used the service on trips, such as into the town centre for shopping, or for a pub lunch but different interests made meeting social need difficult. They told us that some activities they had tried such as quizzes were 'not ideal' but others had proved popular, and all the people who used the service enjoyed reminiscence sessions.

We saw the service had a complaints policy and a copy was on display near the entrance, and on the back of bedroom doors. The manager kept a log of any formal complaints received and we saw that all had been responded to appropriately. The manager told us that they did not receive many complaints, but because they kept an open door policy and were visible within the service people were able to raise any issues before they developed into formal concerns. When we asked, people told us that they knew how to complain, but did not need to. One said, "I haven't had any need to complain, but I would be able to speak to any of the staff here. I get on generally with the staff. I would speak to [the manager] if things were wrong".

Care plans showed that people's views about how they would like to be supported at the end of their lives had been considered. We saw records included a 'what if' template, which help care staff to discuss end of life arrangements with people who used the service. We were told that not everyone wanted to complete these forms. The template was left in care records, but only completed if people wished to discuss how they wanted their care during their final days. At the time of our inspection the manager was completing a course at the nearby hospice in end of life care. They told us this training had assisted them to consider life stories, supporting beliefs and encouraging personal choices at the end of life.

Requires Improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service is registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission (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. At the time of this inspection, a manager been appointed by the service provider, and had begun the process of registering with the commission. They had been working at Passmonds House for a number of years, and had been promoted following the departure of two previous managers in quick succession in 2017. The manager was present throughout our inspection.

People told us the manager was approachable, knowledgeable and would generally listen to them. A member of staff told us that the manager was, "Down to earth and OK. If we need something she will help, and she is hands on and will always assist us if necessary. We all get on fine". Another care assistant said, "I can speak to [the manager], and she is very supportive. I can approach her about anything to do with the residents or my work in general. People who used the service said, "The manager is friendly", and, "The manager is approachable and everybody knows me well. I think the home has a fairly good standard and is well managed." A visiting relative told us, "The manager here is good. She is approachable and listens to us. I can raise any concern with her and I know she will try to get it sorted out."

People felt that the staff were generally attentive, but that there were not enough staff to ensure that their needs were met in a timely way. For example, one person told us, "I enjoy having a banter with some of the night staff, but the atmosphere in this place is not as good as it used to be. There a lot of short-staffing issues and there doesn't ever seem to be time to care." Another person told us that they did not feel the staff knew them very well, as they did not seem to have the time to spend sitting and talking with them, as they were "always too busy dealing with other residents or doing the jobs around the home, like sorting out drinks and meals". From our observations during our inspection we saw staff on duty seemed willing to help but a general shortage of staff affected opportunities for one to one support, activities, wider engagement and quality time. Opportunities for residents to maintain daily living skills were observed not to be well supported. People who had opportunities to get out and about with friends and family visitors had wider experiences. There were some people, however, who had little or no family support to keep them engaged, motivated and forward-thinking.

The manager had developed systems to monitor the service, and showed us a list of audits undertaken either weekly, monthly or six monthly. This list was up to date and evidence showed regular checks. For example of the environment, medicines and care plans. We looked at three recent audits; of rooms, complaints and medicines. We saw that where issues were identified action was taken to remedy the issue. For example the medicine audit identified a build-up of unused stock which was returned to the pharmacy for destruction.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance

testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The manager kept a schedule which showed when servicing was required for the call system, lift, fire extinguishers and alarms and boiler and gas cooker. The maintenance officer had scheduled work to reduce the high temperature of the water in some taps and had begun checks to minimise the risk of legionella breeding in unused water pipes.

We reviewed the home's policies and procedures which were stored in a file in the office where they were accessible for all staff. All of the policies we reviewed were dated between 2012 and 2015. However, in each policy we saw evidence of a review being completed by the manager in 2016, 2017 and 2018 which stated that no changes were required.

Some of the people who used the service told us that they had not completed any surveys about the quality of the home or the care they received, but we saw that the service had conducted questionnaires with all the people they supported in October, November and December 2017. This asked people to tick their satisfaction level regarding the appearance of the home, standard of care, social activities, food and refreshments, specific events, health care, and attentiveness and response of staff. Nearly all the returned questionnaires indicated a high satisfaction level, but where issues were reported there was evidence that this was followed up. For example, where one person had raised a concern about oral care this was followed up with appropriate action taken. However, the questionnaires did not reflect some of the views of people who used the service as fed back to us during our inspection.

We did not see any minutes of resident or relative meetings. When we asked the manager about this we were told that they had tried to arrange meetings in the past, but 'nobody turned up', and consequently they did not have any meetings. They did not produce a newsletter, so there was no way of providing general information or any changes affecting the service to people's relatives, other than when they visited.

When we contacted the local authority and health service they told us that the service generally worked well with them. The adult care commissioners had recently conducted a quality assurance visit, which identified issues around staffing and training, and the Infection Prevention and Control Team identified issues around poor hygiene. These issues reflect the concerns we identified during this inspection, but insufficient action had been taken following these earlier visits and we found breaches of the regulations in both these areas.

Before this inspection we checked our records and saw that the service had told us of incidents which affected service delivery, such as police incidents, deaths and other serious incidents as required under the Care Quality Commission (registration) Regulations 2009.

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 18 HSCA RA Regulations 2014 Staffing there were insufficient numbers of staff employed

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment standards of hygiene were not maintained to a standard appropriate for use, and poor infection control measures were in place.

The enforcement action we took:

warning notice