Care Quality Commission

Four Seasons Homes No.4 Limited

Pellon Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 and 18 May 2017. The first day was unannounced; the second day the provider knew we were returning.

Pellon Care Centre is divided up into three units and has a total of 100 places. Pellon Manor has 35 places and provides residential care for people living with dementia. Birkshall Mews has 30 places and provides nursing care for people living with dementia. Brackenbed View also has 35 places and provides nursing and intermediate care. At the time of the inspection there were 77 people using the service.

A new manager had been appointed to the service in December 2016. At the time of the inspection they had not completed the process to achieve registered manager status. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was present on both days of this inspection.

At our last inspection in November 2016 we identified five breaches of regulation and issued warning notices to the provider in respect of two of these breaches. These breaches were in relation to person centred care, dignity and respect, staffing, safe care and treatment and good governance.

We found variations in the quality of care within the home with an overall higher quality of care experienced on the Brackenbed View and Pellon Manor units.

Staffing levels were not appropriate to meet the needs and maintain the safety of people on the Brackenbed View and Pellon Manor units.

Safe recruitment procedures were in place which helped ensure staff were suitable to work in the care service.

Staff had not received the received the training they needed to carry out their roles and meet people's needs.

Medicines management systems were not always safe.

Not all staff were clear about what constituted abuse. Where safeguarding concerns had been raised these had been reported appropriately.

Individual risks to people were not clearly assessed and there was out of date and inaccurate information in care records.

In some areas improvements were needed to make sure the environment was clean. Checks on the safety of the environment were in place and up to date.

People were not provided with appetising and nutritious meals appropriate to their needs and some people experienced a poor dining experience. There was a lack of overview of records relating to people's diet and fluid intake.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Appropriate Deprivation of Liberty Safeguards (DoLS) had been made by the service; however conditions applied to DoLS had not been met. Best interest processes where decisions needed to be made for people who lacked capacity, had not been followed in line with the Mental Capacity Act (MCA).

Staff appeared caring, and people told us staff were kind and attentive. However we found people's privacy and dignity needs were not always met.

People and relatives told us they felt able to raise any issues or concerns and were confident these would be dealt with appropriately. Records showed complaints received had been investigated although we were made aware of one complaint that had not been recorded.

We found care was not planned with a person centred approach and we found care records to be inaccurate and out of date.

People did not have access to appropriate and meaningful activities.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had failed to achieve compliance with breaches of regulation identified at the last inspection or identify the issues we found during this inspection.

People had confidence in the new manager and felt they were approachable and responsive. However we concluded the provider had failed to provide the manager with the support they needed in their new role.

We found the service had failed to take sufficient action to achieve compliance with the warning notices and requirements issued at our last inspection.

This meant we found continued breaches in relation to person centred care, dignity and respect, staffing, safe care and treatment and good governance. We identified further breaches in relation to need for consent and meeting nutritional and hydration needs.

The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

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.

Systems for managing medicines were not always safe

Staffing levels on Birkshall Mews and Pellon Manor were not sufficient to meet people's needs and maintain their safety.

Individual risks to people were not clearly assessed and there was out of date and inaccurate information in care records. Safeguarding procedures were followed but not all staff were clear about what constituted abuse.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the received the training they needed to carry out their roles and meet people's needs.

Conditions applied to Deprivation of Liberty (DoLS) authorisations had not been met. Best interest processes had not been followed in line with the Mental Capacity Act (MCA).

People did not receive appetising or nutritious food suitable for their requirements.

Is the service caring?

Inadequate

The service was not consistently caring

Staff appeared caring and people told us staff were kind and attentive.

People's privacy and dignity needs were not always met.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not planned with a person centred approach and care records on Pellon Manor and Birkshall Mews were inaccurate and

out of date.

People did not have access to meaningful activities.

Complaints were not consistently managed appropriately

Is the service well-led?

Inadequate

The service was not well led.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had failed to achieve compliance with breaches of regulation identified at the last inspection or identify the issues we found during this inspection.

People had confidence in the new manager but we did not see evidence of higher level managerial support.

Care Quality Commission

Pellon Care Centre

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 16 and 18 May 2017. On the first day of the inspection, which was unannounced, there were three adult social care inspectors, a pharmacy inspector and an expert by experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, which was announced, two inspectors attended.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

On this occasion we had not asked the provider to complete a Provider Information Return (PIR). 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.

We observed how care and support was provided to people. We spoke with 20 people who were living in the home although not all of these people were able to respond to verbally, seven relatives, two nurses, four senior care workers, ten care workers, a domestic, the chef, the activity organiser, the manager, the regional manager, the regional support manager and the resident experience regional manager.

We looked at a total of 15 people's care records, four staff files, medicine records, training records and records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2016 we found there were not enough staff available to maintain people's safety. We found medicines were not consistently managed in a safe or proper way and risks to people's health and safety were not consistently assessed and mitigated. We issued a warning notice to the provider in respect of these findings.

On this inspection we checked to see if the provider had taken action to meet the requirements of the warning notice and therefore maintain people's safety.

People we spoke with did not raise concerns about staffing levels. One person told us, "There is a satisfactory level (of staff), but very busy." Another person told us they felt the staff responded well to their alarm bell. They said, "They come immediately, day and night."

On Birkshall Mews and Pellon Manor we found there were not enough staff to meet people's needs and keep them safe. Staff told us they needed to maintain a presence in the lounges to intervene with any altercations between people and to be able to support people who were at risk of falls when mobilising. However, we saw there were several times when staff were not present in the lounges. On one occasion when staff members were busy assisting other people, we saw a person in the lounge on Birkshall Mews exposed themselves and the three other people present were of the opposite gender, one of whose care records identified risks they presented to others due to their sexualised behaviour. Although staff dealt with the situation promptly and sensitively the situation could have been avoided had staff been present in the lounge.
We saw a lounge area on Pellon Manor was unattended by staff for 35 minutes, during which time one person became agitated and shouted out, but no staff came to assist.

We found the lack of staff availability meant risks were not always well managed. For example, some people had been prescribed a thickening agent to minimise the risks of choking on fluids. We saw thickening agents were kept on drinks trolleys which were often left unattended in the lounges leaving them accessible to people who used the service. Thickening agents are prescribed medicines for individual use only and need to be kept securely. An NHS England patient safety alert in January 2015 identified the risks of asphyxiation if the powder was accidentally swallowed.

In the afternoon we found one person in a lounge on Birkshall Mews had taken a sachet of Complan from the drinks trolley which they were trying to open, no staff were present. A visitor was trying to persuade the person to give them the sachet so they could return it to the trolley. We spoke with the person and they gave us the sachet.

Our observations of meal times on Birkshall Mews further indicated a lack of staff. We saw a number of people needing support to eat their meals but staff were not available to assist. One person had spilled their food down their clothing and in trying to clean this up themselves had got food in their hair. Other people were not eating at all and, by the time staff came to assist, their meal had gone cold.

This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

We looked at the systems in place for managing medicines. We found appropriate arrangements were in place for recording the administration of oral medicines, but some improvements were needed. When people had not taken their medicines, for example if they refused or did not require them, then a clear reason was recorded. However, for medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose.

All of the medicines administration records (MAR) we reviewed contained a photograph of the person concerned and included their allergy status. This reduces the risk of medicines being given to the wrong person, or to someone with an allergy. Although staff carried out regular checks of medicines records to make sure they were completed properly, we identified a number of errors.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. We saw, however, the topical MARs were not fully completed and it was not always possible to confirm that they had been offered to people, or applied regularly. For example, one person should have had a cream applied three times daily to their legs. Their topical MARs indicated that in the previous week, this had been applied once daily on five days, not at all on one day and four times on another day. For another person with a cream prescribed to be applied twice daily to the lower legs no record of any applications could be found.

Medicines were stored safely and the home had appropriate arrangements in place for the management of controlled drugs (medicines that require special checks and storage arrangements because of their potential for misuse) and medicines requiring refrigeration, however whilst the actual temperature recorded was in range the maximum temperature recorded was above that recommended on Pellon Manor. This meant medicines may not have remained safe to use.

Some people were prescribed medicines to be given 'when required'. We found protocols were not always in place to guide staff on when and how to safely administer these medicines. For example, there was no protocol in place for one person who was prescribed a medicine used for agitation. For another person anxiety medication had a different dose on the 'when required' guidance to that on the MAR. In addition, we found staff did not record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way.

Some people had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw the GP had authorised covert administration for people who did not have capacity and were refusing essential medicines. However, the information on how this would be done was not clear and there was no information to confirm that guidance had been sought from the pharmacist to make sure that these medicines were safe to administer in this way. This information would help to ensure people were given their medicines safely when they were unable to give consent.

We looked at the current MAR for one person prescribed a medicine that required regular blood tests. Arrangements were not in place for the safe administration of this medicine. Staff could find no confirmation of the current dose or next test date.

For a medicine that staff administered as a patch, a system was in place for recording the site of application; however this was not fully completed for two people whose records we looked at. This is necessary because the application site needs to be rotated to prevent side effects.

We saw medication audits had been completed for Brackenbed View and for Pellon Manor which had not highlighted any issues. We noted the question 'Has the home had any requirements from the regulators in the last six months, if so have these been addressed?' had been answered 'No' or 'NA' (not applicable). This was of concern as a warning notice had been issued following the inspection in November 2016.

This was a continued breach of Regulation 12 Safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found some aspects of the environment presented risks to people. On Birkshall Mews we saw the trolleys used to deliver meals were situated on the corridor outside the dining room. Staff told us the trolleys were very hot to touch. We saw one person reach out to touch the food trolley to steady themselves; we intervened to make sure the person did not make contact with the very hot surface. Staff were not present when this happened.

We found call bells in bathrooms, toilets and people's en-suites on Birkshall mews and Pellon Manor had been tied up, in some cases above head height. This meant people would not be able access the call bells from a sitting position or if they had fallen. Despite us raising this as an issue on the first day of our inspection, the situation remained unchanged when we returned two days later.

Most staff we spoke with were able to identify the signs of possible abuse and they knew the procedure to follow to ensure people were safeguarded. We saw staff intervened when one person began to express some angry words and they distracted them from engaging with another person, to prevent the situation from escalating. However, one member of staff told us they would not report people shouting and swearing at each other as this was "only verbal" and staff would "be doing nothing else" if they reported every verbal incident. We saw the majority of safeguarding incidents had been identified and referred to the local authority safeguarding team; however we found one had not.

Staff were said they would use the whistleblowing procedures if they witnessed poor practice, to ensure people were safe.

Staff told us they felt able to support people in the event of an emergency and there had been an emergency evacuation at the weekend due a problem with a boiler. However, when we looked at the Personal emergency evacuation plans (PEEP's) for all of the people living in Birkshall Mews, we found they included details of usual mobility needs but no details of how the person would be evacuated in an emergency. On Pellon Manor we saw PEEP's on file for the same person contained conflicting information.

Staff we spoke with said they understood people's individual risks and how to support them. However when we spoke with the unit manager on Pellon Manor they said there was no detailed overview of risks in the unit, such as who was at high risk of falls, choking, pressure ulcers, weight loss. They said this was because staff knew people well and the information was 'in staff's head'. We asked to see risk assessments for two people who the manager had highlighted to us through notification when an incident had occurred between them. The manager said in the notification that the two people 'clash' and said the relationship between these people could 'flare up'. The unit manager told us there had not been other incidents between the two people but found, on checking the notes, that there had been. There were no relevant risk assessments in place for these two people.

Individual risks to people were not clearly assessed and there was out of date and inaccurate information in care records. For example one person required a diabetic diet, yet there was no care plan in place to show how their care and nutrition should be managed safely. Where it was stated on one person's care plan they were at high risk of falls, there was no assessment of how staff should manage and monitor the risk and there was no reassessment of the risk when the person's mobility changed.

We saw staff supported people appropriately with moving and handling, although risk assessments in people's care records did not always show how staff should support a person safely and there was conflicting and out of date information. For example, the equipment and the number of people required to move a person was recorded, but not the method staff should use. One person's care record stated they walked with the support of one staff, yet in another section it said they were to be transferred at all times and were unable to mobilise independently. The person's record stated they preferred a bath, yet there was no mention of any equipment needed to this or any risk assessment for this aspect of their care.

Staff were not always clear about which people were at risk of choking. For example, staff identified some people but not others. One person's care record said they were at 'medium risk of choking' yet when asked, staff did not know this. We observed one person whose records said they needed a 'mashable diet' putting a half a slice of bread in their mouth.

Waterlow assessments were in place to assess people's risks of developing pressure ulcers. However actions were not taken consistently to mitigate identified risks. For example, we saw from one person's care record they needed to be repositioned every two hours as they were at very high risk of pressure ulcers. We saw the person was laid on their back at 12.45 and saw the last entry was at 8.14 at which the person had been positioned on their back. We checked the record again at 14.00 and found there had been three further entries made since 12.45, at 10.00, 11.45 and 12.10. We spoke with the deputy manager and the unit manager to question whether these were accurate entries and ask why staff were not recording interventions as they occurred. The deputy manager told us they were confident the staff had completed the repositioning, just not the records, as there had been a district nurse visit at 12.10. We saw a record on the person's notes which confirmed the district nurse's visit. We later saw an entry at 15.10 which stated 'redness to inner foot'.

This was a continued breach of Regulation 12 of the Health and Social Care Act 200 (Regulated Activities 2014) Regulations.

We found inconsistent standards of hygiene within the home with standards on Brackenbed View and Pellon Manor generally good. However on the first day of our inspection we identified a very dirty toilet and drain in the shower room in Birkshall Mews. When we returned two days later, the toilet had not been cleaned at all and the drain not been cleaned to an acceptable standard. We found dried on food on the underside of dining chair arms and dining tables. We saw cups and mugs in use were stained and in some cases dirty. We also saw plates ready for use to be dirty with dried on food.

Staff used gloves and aprons appropriately and we saw there were accessible supplies of these.
Safety checks on the premises were undertaken by the maintenance worker. These included water temperatures and systems relating to fire safety. Passenger lifts; lifting equipment, water storage systems, gas, fire and electrical equipment were checked and serviced in line with requirements by external contractors.

Staff recruitment processes were thorough and ensured staff were safe and suitable to work at the home. We reviewed four staff recruitment files and found all the necessary checks had been completed before the

staff member commenced employment. This included a criminal record check through the disclosure and barring service (DBS)

Inadequate

Is the service effective?

Our findings

At our last inspection in November 2016 we found the service was not working within the principles of the Mental Capacity Act. We said improvements must be made.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We reviewed issues regarding the MCA and DoLS on Pellon Manor and Birkshall Mews.

People we spoke with felt that the staff were good at explaining what they were going to do and asking consent. One person said "Yes, they explain and ask consent".

We saw one person had a DoLS authorisation which had three conditions, and saw none of these had been met. Although the circumstances had changed in relation to one of these conditions there was no evidence to show that a review of the DoLS had been requested.

We looked at the care records for two people who received their medicines covertly (hidden in food or drink). We saw one person had a DoLS in place with a condition which related to the covert medicines. The condition had not been met. Records showed a mental capacity assessment and best interest decision had been completed in April 2016, however the only people involved in these processes were the person who lacked capacity, and staff from the home. There was no evidence of a pharmacist or GP advice. Similarly the other person had a mental capacity assessment and best interest decision which had been completed in May 2016, yet the only person involved was the staff member who completed the forms.

One person's care file included two mental capacity assessments one of which said the person had capacity and the other saying they did not have capacity and a DoLS authorisation was in place. We found there was not a DoLS authorisation in place for this person. We saw from this person's file that their relative was informed about their medical appointments but could not see any records to show that the person had given consent for this. We asked if there was a lasting power of attorney (LPA) for health and welfare in place which gave the relative rights to be informed of the person's medical and care situation. Staff were unable to confirm to us if an LPA was in place.

Our discussions with staff showed variable understanding of the MCA and DoLS. One staff member on Birkshall Mews told us DoLS was "about who we communicate with" whilst another told us it meant staff could not wash a person after they had died, and was about supporting people with food and care.

Staff we spoke with on Pellon Manor were clear about who had a DoLS in place. They showed us a list of who had an authorised DoLS and said this was kept up to date for reference as well as information in the care records.

We saw there were patio doors in the lounge on Birkshall Mews which led out into a secure garden area. Although the curtains were open at all the windows, they remained closed across the patio doors. When we asked staff why they said it was because one person tried to go outside without their walking frame and so the curtains were kept drawn so people would not be able to see that they could go out into the garden. This meant people were restricted in accessing the outdoor area.

We found dining rooms on Birkshall Mews were locked when meals were not being served. This meant people's choice of where to spend time and movements around the unit were restricted.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We saw some staff were more skilled than others when speaking with people living with dementia; some staff told us they had done training in their own time to understand dementia and how it affected people's lives. We saw at times staff did not seem sure how to interact with people. For example one member of staff walked away when a person shouted at them and became angry and another member of staff did not respond when a person became confused with what they were trying to say.

Training records showed us that many staff did not have up to date training in a number of important areas. For example, of the 101 care staff named on the training record only six had received safeguarding training, only 13 had received training in dementia care, only ten had received training in dignity and less than half of the staff had received training in MCA and DoLS.
We also noted some staff were not up to date with moving and handling and fire training.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

One member of staff who had been in post four months said they had been new to care and had done a thorough induction which included shadowing experienced staff. Staff told us they had regular supervision, usually every two months with their line manager. The supervision matrix confirmed this. Staff also told us they could request supervision or discuss information with their manager at any time in between and felt supported to do their work. We saw a supervision matrix was in place.

Staff told us communication between staff on the Pellon Manor unit was good and they worked closely as a team to make sure people's needs were met. As a result, they said morale was good and they trusted each other to care for people well.

On Brackenbed View the unit manager told us about how communication was working well between the home's own staff and the intermediate care team from the clinical commissioning group (CCG). They told us about how both teams of staff got together for handover and the daily 'safety huddle'. Staff from the service were also taking part in the multi-disciplinary meetings and had been invited to training events.

The manager told us the catering provision was contracted out to an external provider. They told us they had been raising concerns about the quality of the food for several months. Our discussions with people, relatives and staff and our observations identified a number of concerns in relation to the food.

The dining experience differed between the units. On Pellon Manor we saw people received good support, however we saw people in one dining room on Birkshall Mews left with food in front of them for long periods and others struggling to eat without the assistance they clearly needed. On two mealtimes we saw one person, who in their attempts to eat, was dropping food and drink down their clothing and getting the food in their hair. People were being served breakfast without a drink and not all people were offered clothing protectors.

One person had a dish of pureed food in front of them for over half an hour before staff came to assist them. When we asked the member of staff if the food was still warm they put their finger in it to check and said they would microwave it.

We saw meals lacked in nutritional value. Lunch on the first day of our inspection was tomato soup, fish fingers and chips or sandwiches and tinned peaches and cream for dessert. People who required a soft diet were given fish fingers, mash and spaghetti hoops which arrived already plated. Those who required a pureed diet had the same food which was separated into three small pots or mixed together in a bowl. We asked the manager why staff were using blenders on the units to blend meals for people. The manager said they did not know.

At tea time staff were unsure what the different meals were and had to ring the kitchen for clarification. The menu stated there would be mixed salad, yet there was none. We asked one person if they had enjoyed their tea and they replied, "It's not over brilliant, bit flat, not very tasty." We saw one person shook their head and made a grimace face when their meal was presented to them. A member of staff reported to us one person had said the meal 'looked like baby sick' and said the only thing they would eat was the pie crust. The unit manager rang the kitchen and requested an alternative meal for this person.

One relative told us they had complained to the manager as the food sent for their relative was not suitable for the type of diet they required. They said the manager arranged for staff to go out and buy a suitable meal for the person, however staff then cooked the meal in the microwave for too long which meant only a small portion of the meal was edible. Another relative told us how cross they were about the standard of food and said they had complained to staff and the manager.

Staff told us there was a lack of fresh fruit for people. They said one person really liked fresh fruit but the only fresh fruit sent to the unit was bananas. The chef told us they could sometimes order grapes, but not always, and never items such as strawberries, pears or citrus fruit.

Staff also commented about the snacks sent which they said were not enough and told us sometimes there was only half a chocolate bar for each person.

During the morning on the second day of the inspection we saw one person was walking around and each time they entered the lounge they helped themselves to biscuits which were available on the table taking three or four each time. We saw over a 45 minute period the person ate a large number of biscuits. We saw this person's meal from the previous evening was still on a table in their room with only a small amount having been eaten.

We did not see any provision of finger foods for people who, due to their dementia, found it difficult to sit at

a table to eat. A small number of people were provided with snack boxes.

On the first day of our inspection it was one person's birthday. We asked staff if anything special was done. Staff told us people used to have cakes but said the kitchen did not provide them anymore. One staff member went out and bought a birthday cake from a local shop. Staff decorated it with candles and brought it in when the person's family arrived and sang happy birthday, which made the person smile.

We were concerned people were not always receiving sufficient to eat and that staff were not always fully aware of people's dietary requirements. For example, on the first day at lunchtime we saw one person struggled to use cutlery, yet staff did not seem to be aware of this. The person was given their soup in a bowl with a spoon and ate none of it, but after a while eventually lifted and drank some of the soup from the bowl. They were given a slice of bread and butter but did not eat this. Their main meal was fish fingers and chips. They tried to use a fork but gave up and ate the meal with their fingers. Staff left salt on the table next to them. The person's care plan stated they liked to put salt on their food but said this needed to be monitored carefully by staff to ensure they did not have too much salt due to their medical condition. We observed there was no monitoring by staff. We saw this person just before tea time, we asked if they were hungry and they repeated twice, "I am very hungry." This person's care records showed they had lost over 3kgs in weight between 5 April and 13 May 2017 and were on a fortified diet. There was no evidence to show their lunch time meal had been fortified as the same food was served to everyone.

Another person's care records showed they had lost 1kg between 23 April and 14 May 2017 and their BMI was 18. Their care plan stated they required a pureed diet and food should be fortified by adding full fat milk, sugar and cream to meals and they were also prescribed nutritional supplements. At lunchtime we saw this person was given pureed peaches for dessert but no cream was added.

A further person's care records showed they had lost over 5kgs in weight between 10 March and 14 May 2017 and their BMI was 19. Their care plan showed they were prescribed nutritional supplements and were on a soft moist diet.

We found there was conflicting information in people's care records about the type of diet they required, or the reason if a special diet was needed and staff were not clear about the consistency.
The head chef was unable to tell us how many people were diabetic, but said they made diabetic alternatives. They told us they could not do that at the moment as there was currently no sweetener in stock, although showed us a list which stated a delivery was due the following day. We saw there was diabetic ice cream in the freezer.

People's weights were monitored. Although we did not see high amounts of people losing weight we were concerned that food served was high in calories but low in nutritional value.
Due to the seriousness of our concerns about the quality of food we spoke with the nominated individual for the company who assured us they would take immediate action.

People identified as being nutritionally at risk had their food and fluid intake recorded. We found the charts used for recording this difficult to follow as many were undated and had not been completed correctly.

We saw fluid charts for a person who was suffering with a chest infection. On one day the record showed the person had received only 50mls of fluid between midnight and midday. Another person's fluid chart indicated they had not been offered a drink between 17.50 and 09.30 the following day.

There was little evidence of review of food and fluid charts to make sure people received the amounts they

needed.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Everybody we spoke with felt that there was good access to other health care professionals. A relative told us, "She sees the doctor when she needs to and the chiropodist comes in" and that their everyday needs were catered for.

There was evidence of other professionals' involvement in people's care. We saw evidence in care plans where staff had contacted GPs, district nurses, the Quest matron, the falls team, the dietician and SALT team where specialist advice was needed.

Inadequate

Is the service caring?

Our findings

At our last inspection in November 2016 we found people's dignity needs were not always met. We said improvements must be made.

People we spoke with told us they were happy with the standards of care. One person said the staff were "Kind caring and compassionate" and a relative said of the staff "They love them and cuddle them, they are very responsive". People felt that they were treated with respect and dignity a relative told us "They talk properly to her with respect and look after her dignity" and that generally their privacy was respected. One person said "They knock on the door and respect my privacy".

We observed some kind and caring staff interactions with people and it was clear staff knew people very well and their individual likes, dislikes and social histories. On many occasions staff acknowledged people by name and took time to ask how they were feeling, then waited patiently for people to express themselves in their own time. Where some people were unable to communicate verbally, staff were observant of their non-verbal cues, such as their facial expressions and body language and made effort to try to understand what people were trying to say.

We saw people hugged staff and staff responded affectionately and there was appropriate banter. One person said "I don't really know where I am, this is my home now, I'd like it to be". Another person said "They're alright these lasses. I get a bit worried sometimes but I can talk to them".

We saw examples of staff taking action to maintain people's dignity. For example when one person had spilt food down their clothes staff approached the person, knelt down so they were at eye level and quietly asked them if they could take them to their bedroom to change their clothes and explained why. The person made it very clear they did not want to go and the staff member said, "That's fine. Shall we leave it for now and I'll come back later."

We saw another staff member assisting a person to walk, they had their arm round the person's waist to steady them and held their hand while walking at the person preferred pace. They gently guided the person to a chair and made sure they were comfortable before leaving them.
We saw when staff came to the assistance of a person in the lounge whose clothing was disarrayed and exposing parts of their body, staff tried gently to persuade the person to let them help but the person steadfastly refused and started to shout. Staff retreated and brought the person a blanket which they asked if they could put on, the person agreed and their modesty was protected. A short time later staff approached the person again and this time the person quite happily went with staff to get changed.

At our last inspection in November 2016 we found people were not consistently treated with dignity or respect and the service did not always have due regard for the protective characteristics under the Equality Act 2010 and said improvements must be made.

On this inspection we observed several occasions when people's privacy and dignity had not been

maintained. We went into one person's bedroom just before tea time. The person was in bed and had been all day. We found dried faeces on the seat of the armchair in their room and the crash mat next to the person's bed was stained and sticky. We showed this to the nurse who asked a staff member to clean this up and this was done straightaway. The nurse could not explain how the faeces had ended up on the chair seat, although at the feedback session the manager said they thought another person may have gone into the bedroom and defecated on the chair without staff noticing.

We observed some staff taking care to discuss people's needs privately and not in front of others. However we observed other instances of staff speaking openly about people in front of others. For example, a person had been ill on the morning of the first day of our inspection and staff spoke openly about this in the dining room where other people were having their breakfast.

On another occasion we saw a person in their bed with the door propped open. The person was not wearing pyjamas and had pushed the bedcovers off, resulting in their underwear and incontinence pad being on display. We brought this to the attention of staff. When we returned a short while later we found the person's door had been closed and the curtains drawn in their room. As this was early evening and the sun was shining, the actions taken by staff had resulted in the person being isolated rather than maintaining their dignity.

At a mealtime we saw one person blowing their nose on the tablecloth and, although we were aware staff had seen this, we had to ask staff for a tissue. The person was given a paper hand towel. When the manager intervened and asked of there were any serviettes, a member of staff said loudly "she can't have that, she'll eat it".

One relative told us they had requested a bigger bed for their family member last year. The larger bed had arrived and was in place, but the same mattress was being used. We saw the mattress did not extend the full length of the bed. The relative showed us a bumper which had been provided to fill the gap but they explained this was not satisfactory as it kept falling through which meant their family member's feet were left hanging over the end of the mattress. They said they had raised this issue but it had not been resolved. We raised this with the manager at the feedback session on the first day. When we returned two days later and asked if this had been addressed we were told no action had been taken to resolve this. The manager contacted us the following day to say a new mattress had been ordered.

We saw a number of pairs of dirty glasses on a shelf in the lounge on Birkshall Mews. We asked staff who they belonged to and why the people were not wearing them. Staff said they thought some were old glasses and not the current prescription. On checking, staff found some of the glasses were current prescriptions and should have been worn by the people they belonged to. These were cleaned and given to the people who needed them.

This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We saw people's rooms were personalised with their own items and family photographs as well as information about their preferences and social histories. We saw one person had a religious ornament on their wall and there were memory boxes containing items of personal significance outside people's rooms. We saw for some people there was a pen picture with key information about a person's life on the wall outside their room, although it was not clear whether they had chosen to display this information.

We saw there were Do Not Resuscitate (DNACPR) forms in some people's care records and staff we spoke

with knew whose files these were in, with indication on the side of each file and the form stored at the front. We saw one person's DNACPR form stated 'senile dementia', another stated 'advanced Alzheimer's disease' and another was ticked 'lacks capacity' but all other sections were blank, other than a signature. The care plans we looked at contained little in the way of people's end of life wishes. We saw there was similar information between care plans, such as '[person] would like to be made comfortable and surrounded by people they love' but there was little evidence this had been discussed in a person centred way. There were practical details recorded, such as who to contact in the event of a person's death. Staff we spoke with said they supported people and their families at this stage in people's lives and they felt bereaved when a person died. Staff told us they were mindful when a person died, this impacted on other people living in the unit and they tried to offer support and comfort.

Inadequate

Is the service responsive?

Our findings

At our last inspection in November 2016 we found care was not always appropriate to people's needs. We said improvements must be made. The unit manager on Brackenbed View told us they worked with the intermediate care team to make sure care plans were accurate and person centred. We found the care files on this unit easy to follow and contained clear information about the person and their assessed needs.

We found a lack of person centred approach to care planning on both Pellon Manor and Birkshall Mews. For example in the communication section of one person's care record it stated 'I can no longer communicate through talking', but it did not state what the person could do or how staff could support them to communicate.

Care plans had not been developed with a person centred approach and had not been updated to reflect the individual's current needs, preferences and wishes. Some care staff told us they did not ever look in people's care plans whilst others told us they looked at them very occasionally. This meant staff may not be aware of people's assessed needs and risks and the actions they needed to take to meet them.

On Birkshall Mews we found care records were not up to date or accurate and often contained contradictory information. For example, one person's care summary which was undated stated the person had a category 4 pressure ulcer and was unable to sit in a chair. This was also stated on the information board in the staff office. Staff told us the person's pressure ulcer had healed, and this was confirmed in the most recent care plan review. The person was in bed when we inspected on the first day, though the daily records showed this person had a specialist chair and had been up in the last few days. We saw photographs in the care records which showed this person had a sore on the left foot in March 2017 but there was no information to show whether this had healed or was still being treated. We asked the nurse who said they weren't aware of this and did not know if it was still present.

Another person's pain assessment completed in November 2016 had a body map showing where the person had pain and stated they were prescribed a pain patch to be applied every 72 hours and showed a dressing had been applied. This assessment had been reviewed on 16 May 2017 and stated no changes, however the medicine care plan showed the person was prescribed a different pain patch which was to be applied weekly and there was no reference to any dressings. In addition, the moving and handling plan identified the person experienced pain in a different part of the body to that shown in the pain assessment.

On both days of the inspection we saw one person's eyes were watering and matted with pus. Staff and relatives told us the person's eyes were always 'sticky' and said the person sometimes had eye drops to treat this. The nurse told us the person's eyes should be bathed daily with normal saline although they said the person would not always let staff do this. We checked the person's care records and found no information about the person's eye care and no evidence to show that staff had attempted to bathe the person's eyes.

A number of people were prescribed thickening agents to be added to their drinks, and we found conflicting information about how much thickener should be used for each person. For example, one person's care

records showed they had been seen by the speech and language therapist (SALT) on 6 March 2017 who had recommended one and a half scoops of thickener to be added to 200mls of fluid. The nutritional care plan stated, '1 scoop to 200mls' and the sheets where staff recorded the thickener stated, '2 scoops to 200mls'. Our discussions with staff showed they were not clear either as one staff member told us they put in two scoops and the other said they put in between one and one and half scoops.

Another person had a care plan in place which said they were continent. However monthly reviews showed the person's needs had changed over the previous six months and they now needed support to manage their incontinence. The care plan had not been reviewed to reflect the person's current needs.

This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We spoke with a nurse who told us about the actions they had taken in researching the affects a person's medicines were having on their general wellbeing. This positive action resulted in a marked improvement in the person's quality of life.

People we spoke with said there were no real restrictions on friends and family visiting times. One person said "Visitors can come in at any time but not meal times". People did not raise any concerns about the provision of activities.

We spoke with the activity organiser who told us they had been employed in the role for six months and worked 16 hours a week on Birkshall Mews. They told us they had received no training for the role. They said training had been arranged but cancelled and they had not been told when it would be rearranged. They also worked as a care assistant covering any absences. They told us their activity hours were being increased to 32 hours per week in the near future.

They told us people's individual interests and hobbies were recorded in a 'My Choices' booklet and from this information they organised group and one-to-one activities to meet people's needs. They said all activities were recorded in 'My journal' booklets which were kept in people's rooms. They told us activities included events such as arts and crafts, movie afternoons, pampering sessions and singing, as well as outside entertainers who visited on a monthly basis. We asked if there were any opportunities for people to go out. They said there was a trip to a social club every Monday between 1pm and 4pm which involved a quiz and bingo. We asked how many people attended and they said two people used to be able to go but now they could only take one person as there were not enough staff available to allow another person to attend. We asked how they decided who could go and how they travelled. They said they tried to offer it different people and took a taxi to the social club which the person attending had to pay for. They told us there used to be organised trips out for people but there was no minibus and the outings did not happen anymore.

We looked at people's 'My Choices' and 'My Journal' booklets and found little evidence to show the hobbies and activities people had expressed an interest in were being fulfilled. For example, one person records showed they liked watching cricket and rugby league, liked going to church, was a keen walker and loved nature. The journal suggested putting bird feeders in the garden close to the person's bedroom window. We looked in the person's bedroom and there were no feeders outside the window. We looked at the activities this person had undertaken since the beginning of 2017 which amounted to ten entries and did not include any of the interests the person had stated they enjoyed. The last recorded activity was on 27 April 2017 when it said staff had talked with the person about the activities they would like to do.

In another person's journal we found no recorded activities since February 2017 and in others we found the

information about the person to be out of date.

On the first day of our inspection on Birkshall Mews we found there was little to stimulate or interest people apart from the television or radio with either one or the other on continuously in the lounge the whole day. Although staff were kind and caring with people and tried their best, interaction was limited to short conversations and we found staff lacked the knowledge and skills to know how to occupy people in a meaningful way.

On one occasion during the morning we saw one staff member sat with one person doing some sewing and the person was fully engaged smiling and laughing and clearly enjoying themselves. Two other staff then brought in a birthday banner and started to blow up some balloons. However, there was no attempt to involve the other four people in the lounge. The balloons were then left on the floor at the edges of the room and a short time later one of them burst which made people jump.

On Pellon Manor staff told us there was a planned entertainer due to visit, and people from the downstairs unit came upstairs to join in. However this entertainer was unable to attend and staff had to improvise. We saw staff sang with people and played games such as skittles and table football. People were encouraged to take part although some people chose not to. We heard staff chatted with people about their occupations and what they had done in the past. It was evident staff knew people well as individuals.

On Pellon Manor and Birkshall Mews we saw pop music was being played through the television. When we asked staff on Birkshall Mews if this was the choice of the people who lived there, staff changed channel to a television programme although none of the people in the lounge were asked what they would like to watch.

The televisions in Pellon Manor and Birkshall Mews lounges were positioned so that people at the opposite side of the lounge could not hear it, and would be unable to enjoy a programme as people continually walked in front of them. People sitting at the same side of the room as the television could hear it but not see it.

On Pellon Manor we saw one person remained in their bed we asked staff the reason. Staff told us the person had been mobile until recently when they had been confined to bed and although they had tried to support the person to sit out of bed, it was apparent from their body language this was not wanted and so the person had been in bed since. We saw the person was unable to move themselves and their view was of their ceiling or their wall, with little to stimulate them. There was a television adjacent to the person's bed but they were unable to see this because of their position. The television played for the whole of the day and the person was unable to say whether this was wanted or not. We saw little interaction between staff and this person; staff told us when they carried out personal care they chatted with them, but we saw no attempts to engage the person at all. We spoke with the person and although they did not communicate verbally, they were smiley and clearly enjoyed the interaction.

We looked at the person's care record which stated 'I enjoy company' and 'now spends all [their] time in bed due to dementia', 'remains in bed, continues to enjoy interaction' and '[person continues to enjoy [their] usual activities'. Information stated the person enjoyed attending a social club each week. There was no information in the care record to explain why the person had deteriorated in mobility and was now confined to bed, what had triggered the decline or what attempts staff had made to support the person's social and emotional well-being. We found this person's record this was significantly out of date and did not contain person-centred information.

This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities

2014) Regulations.

In contrast we saw another person spent time in their room and enjoyed listening to their favourite music. They showed us their CDs and staff we spoke with knew what they liked to listen to.

One relative we spoke with told us of concerns they had raised about their family member's bed and the food. We also saw in the person's care records that the relative had raised recent concerns about the person always being left in their room and not being supported to exercise.

We looked at the complaints file. There was no record of the complaints mentioned above. The file showed six complaints had been received since January 2017, two of which were ongoing. We saw action had been taken in response to these complaints. However we did not see any record of the complaints made in relation to the food. We were told these were managed separately as part of the company reporting system. It is important that all complaints are managed through the complaints procedure with evidence of response to the complainant.
We recommend the provider makes sure all complaints received are managed through the complaints procedure with evidence of response to the complainant.

Some people and relatives we spoke with said that they did not know the formal complaints procedure but this was not an issue as they did not want to make a complaint but would feel comfortable in raising issues. One person said "I haven't made a formal complaint but I would find out how if I needed to". Another relative told us they had made complaints which we saw had been responded to.

Inadequate

Is the service well-led?

Our findings

At our last inspection in November 2016 we found the service was not well led. We issued a warning to the provider in respect of these findings.

Since our last inspection in November 2016 there had been a change of manager at the service. The person registered as manager at that time had left and a new manager had been appointed in December 2016. The new manager has not completed the registered manager process with the Care Quality Commission.

Staff we spoke with said the home manager was visible at times and would help out in an emergency if needed. They said they felt valued by their immediate managers but not by the organisation and definitely not by senior managers present during the inspection. They described these senior managers as rarely seen, and did not feel they were supportive of them. They said senior managers never gave praise for work done well.

Relatives we spoke with knew who the manager was and spoke positively about them. One relative said, "The manager's approachable and a lot better than what we had before." However they also said communication between staff was poor which they felt in part was due to the high level of staff turnover.

The manager told us they had received support from an external consultant, also very new to the service, in their first two weeks and that further support had been provided by senior managers within the company but this was intermittent and the manager had needed to ask for more support. We also noted the manager had not yet completed the provider's induction course for managers. We concluded the support provided to the new manager was insufficient.

People we spoke with and their relatives were largely satisfied with the service. Throughout the inspection we witnessed some good practice and staff appeared caring. However we concluded staff were in need of leadership and guidance in their work to improve the quality of care provided.

At our last inspection in November 2016 we identified five breaches of regulation and issued warning notices to the provider in respect of two of these breaches. On this inspection we found the provider had failed to take sufficient action to achieve compliance with the regulations and we found further breaches.

The breaches of regulation we identified, and in particular the failure to achieve compliance with those identified at the last inspection should have been prevented through the operation of robust systems.

Quality checks in areas such as care plans, infection control, health and safety and medicines management were in place. The manager also completed daily walk arounds. However we concluded these were not sufficiently robust as they had failed to identify the issues we found during the inspection.

For example, issues around lack of overview of food and fluid charts, issues relating to DoLS conditions not being adhered to, inaccurate and out of date care documentation and lack of meaningful activities had not

been identified.

Although the problems with the catering department and quality of food had been known for several months, sufficient action had not been taken to make sure people received appetising and nutritious food and this had not been raised at an appropriate level within the company.

Although a staffing tool was used which used dependency scores calculated to inform staffing levels, this had not been used in conjunction with observations of care to determine the availability of staff to maintain people's safety and meet their needs including recreational and social needs.

We saw the manager had started to complete a monthly summary and analysis of accidents and incidents. However, it was difficult to determine from the documents we were given by the manager how this information was used to prevent recurrences or shared with others to look at lessons learnt.

Relatives we spoke with said they had attended meetings and had been involved in giving feedback through questionnaires. One relative told us "We go to the meetings as a family, they are useful to us" and they said that they could raise issues and that they would be listened to.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.