HC-One Limited

# Pennwood Lodge Nursing Home

## Inspection report

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05 September 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This unannounced comprehensive inspection took place on 30 and 31 August and 5 September 2017.

Pennwood Lodge Nursing Home provides residential and nursing care for up to 60 people living with dementia. At the time of our inspection there were 38 people living there. The home has four 15 bedded units, each with their own communal lounges, dining rooms and bathrooms. One of the units was closed and due to be refurbished. Of the other three units, one is for people with personal care needs (residential care) and the other two are for people with nursing care needs. All bedrooms are for single occupancy and the majority of rooms had en-suite facilities.

We last inspected the service in June 2015 and we rated the service Good. At this inspection we have rated the service Requires Improvement and we will require an action plan of how and when the improvements will be made.

There was a registered manager. 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.

People were at risk of unsafe care and treatment because assessments of their needs were not always reflective of their current risks and support requirements. People's care plans did not always provide the care staff with clear guidance to follow to know how to support people safely. Care plans were not always personalised to meet people's individual needs when they were living with dementia.

Systems were in place to monitor the quality of the service and risks, however these quality assurance systems were not always effective in driving improvements. The provider had identified improvements were needed in relation to staff supervision and care planning, but timely action had not been taken and we found these areas continued to require improvement.

Medicine practices required improvements to ensure medicine records would always be completed and medicine stock kept would be sufficient to ensure people received their medicines as prescribed.

Some pressure relieving equipment was not used correctly and placed people at risk of skin damage.

People living with dementia did not always have a positive dining experience and we made a recommendation to support the provider to make improvements. People had access to healthcare professionals and their health and welfare was monitored by them.

People made most decisions and choices about their care when possible. When people did not have the capacity to make decisions staff followed the Mental Capacity Act guidance to protect them and helped

people to make choices.

People were treated with kindness and respect. They told us staff were good when they supported them with their care. Staff knew how people liked to be supported. People told us they felt safe in the home. People were supported by staff who were trained and had access to training to develop their knowledge.

Some people joined in with activities provided which included ball games, musical entertainment, visits by the therapy dog, nail pampering, crafts and boards games. There was minibus and the registered manager was looking at increasing opportunities for people to access the community. People and their relative's views and concerns were taken seriously. They completed surveys and contributed in regular meetings. Staff meetings were held monthly and staff were able to contribute to the running of the home. The registered manager was approachable with relatives, staff and people and had plans to improve the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not safe.

Areas of risk were identified and risk assessments were in place however risk assessments were not always up to date or reflective of people's current needs. Care staff did not always have clear guidance on how to support people to manage their behaviour safely.

People's medicines were not always managed safely to ensure people received their medicines as prescribed.

Recruitment procedures operated by the registered manager and provider were correct to ensure staff were of good character.

### Is the service effective?

**Requires Improvement**

This service was not always effective.

Staff had not received adequate individual meetings to discuss their development and training needs.

Improvements were needed to ensure people living with dementia had a positive dining experience.

People made most decisions and choices about their care when possible. When people did not have the capacity to make decisions staff followed the Mental Capacity Act guidance correctly.

People had access to healthcare professionals and their health and welfare was monitored by them.

Improvements were needed to ensure the environment would meet the needs of people living with dementia.

### Is the service caring?

**Good**

The service was caring.

People were treated with compassion and kindness.

Staff engaged with people positively and improved their wellbeing.

People were treated as individuals and their wishes were respected.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Peoples care plans did not provide sufficient detail to ensure staff would know how to support people in accordance with their wishes and preferences.

People took part in some activities but there was a lack of individual engagement and access to the community.

Complaints were investigated and responded to appropriately.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The quality assurance systems were in place but these were not always effective in driving improvements across the service.

Regular staff meetings were held and staff were able to discuss service improvements.

People's and relative's views were sought and additional meetings were implemented for the registered manager to meet relatives and address any concerns raised to benefit people.

# Pennwood Lodge Nursing Home

**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 30 and 31 August and 5 September 2017 and was unannounced. The inspection team consisted of two adult social care inspectors 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.

Before the inspection, the provider completed 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 also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law. We had information of concern raised with us from health and social care professionals in relation to safe care and support. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the registered manager, the area director, two nurses, five care staff, a chef, the maintenance person, the activity organiser, the training coordinator and one volunteer. We spoke with five people who use the service and six relatives. We spoke with two health and social care professionals. We looked at information in seven people's care records, three staff recruitment records, people's medicine records, staff training information, the duty rosters and quality assurance and management records. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe living at Pennwood Lodge. One person told us, "I feel safe here at all times, even at night. I have no unease and no nerves. I have no concerns." Another person said, "I always feel safe, I have been here for a couple of years."

Although people told us they felt safe we found improvements were needed to ensure people would always receive the care they required to remain safe. Risk assessments were not always reflective of people's current needs and people did not always receive care in accordance with their risk management plans. For example, some people were losing weight which put them at risk of becoming malnourished and increased their risk of skin deterioration. One person's risk assessments in relation to eating and drinking identified they were at risk from losing weight and indicated they should be weighed monthly. The person's supplementary records held on the unit's nursing station indicated the person needed to be weighed fortnightly. Guidance received from a healthcare professional indicated the person needed to be weighed weekly. The person had not been weighed weekly or fortnightly their last recorded weight was 5 August 2017 which was more than three weeks before we visited. We showed the registered manager the guidance provided by the dietician and they were unaware of this concern. We discussed the action staff took when they were concerned about weight loss. They told us the registered manager had implemented a weight monitoring document for each unit which instructed staff when to weigh people. However on Laburnam unit, this guidance had not been followed and people had not been weighed as the registered manager had expected. Another person's nutritional risk assessment and care plans did not reflect current guidance received from a healthcare professional in relation to the support they required to remain nourished.

People's individual risk assessments were not always correct and reviewed effectively. For example, one person's care and risk assessments in relation to their mobility and risks of falls had not been updated to reflect the current support the person required to move safely. Another person's malnutrition screening tool had not been updated to indicate the change in their height. A third person's records for weight, incontinence and pressure area care stated the person was at different weights. These assessments informed the guidance care and nursing staff needed to determine people's risks. This meant they might not always have correct information to determine whether people's risks had changed and whether current risk management strategies they had put in place were still sufficient to keep people safe.

At the time of our inspection there were no people with pressure ulcers in the home. When needed people had equipment in place to protect them from the risk of pressure damage. However, nursing and care staff had not always ensured this equipment was used appropriately which placed people at risk of receiving unsafe care. For example, three people's pressure mattresses were not set at the correct pressure for the individual's weight. Additionally there was no guidance to nursing and care staff to follow on which setting the equipment should be kept at. We informed the registered manager of this concern and they told us they would take immediate action.

Some people living with dementia relied on staff to both identify and manage risks relating to their anxiety and associated behaviours. We found we could not be sure people would always receive the support they

needed to stay safe. For example, care staff were recording incidents of behaviours which may challenge them for two people. One person in July 2017 had become resistive to personal care and being assisted with their mobility needs and could at times become physically aggressive. Whilst care staff had recorded these incidents and the actions they took to ensure the safety of the person there was no record that the registered manager or senior member of staff were aware of the concerns and had taken action to mitigate this risk. One member of staff told us they were not assured that the management was looking into this and had not been given additional support or guidance in how to support this person safely.

We discussed how care staff assisted this person to keep them safe. However, we found that a detailed behaviour plan was not in place for this person that addressed all the risks associated with their behaviour. For example their care plan did not inform staff of what might trigger their behaviour and strategies to prevent their behaviour from escalating. Staff had recorded two strategies they used of backing away and offering support to keep this person and other's safe if their behaviour was to escalate. However these strategies had not been incorporated in the person's care plan so that they would always receive the support they needed. The provider's dementia care training was available at four levels but not all staff had completed the training and this required improvement as most people were living with dementia. There was no dementia 'champion' staff to provide further guidance and support.

Another person had displayed behaviours which were not always appropriate. Care staff had recorded four incidents where the person's behaviours challenged them. There had been no action on these incidents. For example, there were no care or risk assessments in place to provide guidance to staff and no record that the person's wellbeing needs were being identified and respected. One member of staff told us they recorded all the incidents on monitoring charts. They said, "We provide care, usually one male, and one female. Only happened once, I've never really thought about it. Don't know what happens with ABC (behaviour monitoring) charts." We discussed this concern with the registered manager and showed them a record of the monitoring charts. They were unaware of these incidents however they assured us action would be taken. Without behaviour support plans in place to support staff to manage the risks associated with people's behaviour, people were at risk of not receiving consistent emotional and behaviour support from staff.

People did not always get the support and reassurance they needed when they became anxious. One member of care staff told us how they supported one person who could become anxious. They told us when staffing levels were good they would spend one to one time with the person and read poems with them. This helped the person with their anxieties. We observed this person on the first day of our inspection calling for attention repeatedly without staff support being given to assure them. On the second day of the inspection a member of staff took time to sit and engage with the person. They ensured the person was taken to the lounge as they were a "sociable lady." This meant the person was not always receiving the support they required to promote their emotional wellbeing.

Accidents were generally recorded and reported to the registered manager. However we found all unexplained bruises on people had not always been reported and investigated. This would determine how these might have occurred and whether any action needed to be taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.

One person told us, "I always have my medicine and tablets on time with no problems." However we found people did not always receive their medicines as prescribed. We counted people's prescribed medicine stocks and found more doses than we expected to find for four people. These people had missed their medicines and had not always received their medicines as prescribed. This put them at risk of their health and welfare needs not being met.

Nursing staff did not always act in accordance with good practice guidelines regarding people's prescribed medicines. Nurses did not always operate good practice in the recording, storage and disposal of people's prescribed medicines. For example, nurses did not keep an accurate record of people's medicine stocks. We were concerned that a number of doses of one person's prescribed medicines were missing. We discussed this concern with the registered manager and asked them to investigate. These medicines had been returned to the pharmacy. There had been no record of this return and if this concern had not been addressed the person would've been at risk of not receiving their medicines, as no stock would be available. Nursing staff did not always date when boxes had been opened or sign when they had administered medicines. Additionally nursing staff did not always keep an accurate record of the temperature of the medicines room and fridge to ensure that medicines were effective for administration.

Where people received homely remedies, nursing staff recorded this support on a piece of disposal paper within a medicine cupboard. We discussed this with a nurse who was unaware of why this record had been kept. The registered manager was also informed and they assured us they would take effective action.

People were at risk of not receiving their topical creams as prescribed. Topical cream records for three people evidenced that staff had not assisted them with support as they did not have the prescribed topical creams in stock. The nurses (who were not responsible for applying topical creams) signed people's medicine administration records; even though they could not confirm that these creams had been applied as prescribed. Nurses could therefore not be assured from people's topical cream records that they had received their creams as prescribed. We discussed this concern with a nurse who told us, "It's what we've been asked to do." The registered manager was also informed of this concern and they informed us this practice would stop immediately and would ensure people's records in relation to topical creams reflected their current needs.

We found on Hawthorn unit people received their medicines as prescribed. We observed staff explained to people what their medicines were for and took time for people to take their tablets. However people's MARs also required improvement on this unit as it was not clear what symbol staff were to use to indicate people's medicines were destroyed or refused. Inconsistent recording could increase the risk of medicine errors occurring.

All the above demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People, staff and relatives told us they were concerned that there was not always enough staff to meet people's individual needs. One relative said, "They [their relative] have the same clothes on for several days and they used to be very particular about their appearance." Another relative said, "I visit a lot at the weekend and they are often short of staff and have only two staff [one unit]" and "I have witnessed distressed people that need to have staff with them." One relative said there is not enough staff to provide individual activities and some people don't go outside at all.

Staff told us they felt that staffing levels sometimes meant they were not always able to support people with their wellbeing needs. Comments included: "We have three staff usually. Three is good, it's the odd day when there are two. We get everything done, its non-stop"; "We get everything done, however we don't get to do much activities and sit with people. In 12 hours we don't have the time" and "We don't get time to spend with people."

The registered manager told us the home had a system to assess each person's dependency, which determined the necessary staffing levels at the home. However we found one person's dependency

assessment stated their dependency as "medium", but their form had been updated incorrectly and should have stated the dependency as "high" and information informing the staffing levels might not always be accurate. The registered manager told us that a dependency tool was completed to calculate the level of staffing required and the provider informed them the staffing they could have. There was a lack of understanding by the registered manager of what the optimum level of staff should be to meet people's needs. The provider's representative told us the staffing levels were reviewed by the Clinical Quality Manager and the Managing Director and they believed the home was staffed above the levels indicated.

At the time of our inspection the service had only two members of nursing staff employed and relied on agency nurses. We looked at staff rotas and agency staff was used regularly to cover staffing vacancies. Staff told us recruitment was ongoing which meant there was less agency staff being used to reduce the impact on people receiving care from staff that might not know them well. During the inspection the registered manager informed us the clinical lead nurse had recently left. It was their intention to recruit another clinical lead to provide nurses with support and ensure their clinical skills were monitored and maintained.

The residential unit had a more stable staff team and although regular agency care staff were used we found they were knowledgeable and knew people well. This meant the unit had clear records and all staff we met knew people's needs.

People and their relatives told us people were safe living at Pennwood Lodge. Comments included; "I feel looked after and safe" and "We've not been disappointed. It's treated like it's her home. No concerns." Care staff had knowledge of types of abuse, signs of possible abuse which included neglect and understood their responsibility to report any concerns promptly. Care staff and nurses told us they would document concerns and report them to a senior or the registered manager. One member of care staff said, "I would go to a nurse, or the manager." Another care staff member added that if they were unhappy with the registered manager's or provider's response they would speak to the local authority safeguarding team or CQC. They said, "I would ring the safeguarding team." If staff felt someone was at immediate risk of harm or abuse they told us they would take immediate action to ensure people were kept safe, including calling the emergency services if required.

Recruitment procedures were followed and correct checks had been made. People were cared for by suitable staff because satisfactory recruitment processes were in place. There were checks of staff criminal record histories using the disclosure and barring service (DBS). People's employment history had been explored and any gaps in employment were discussed. The registered manager told us recruitment had been difficult but now there were recruited nurses on duty during the day for six days of the week. Several staff had left in the last 12 months and agency care staff and nursing staff were used.

The service had recently had a refurbishment and all areas looked clean and well maintained. One person in the residential unit told us, "It's very clean. They come in early morning to clean. No complaints. They clean under the bed. The cleaning staff wear overalls." Another person said, "I am happy with the cleaning, I do a little bit of dusting in my room."

Requires Improvement

# Is the service effective?

## Our findings

People received care from care and nursing staff who were not always supported and did not have access to frequent individual (one to one) meetings with their line manager. Individual meetings allow care staff to discuss their personal development needs, such as training and support as well as any practice concerns. Care staff told us they did not always feel supported. Comments included: "We're not able to go to (management). (Registered manager) is quite nice, they're the only one"; "We have one (meeting) scheduled once a year. Last one was last year" and "No one to ones, (registered manager) is trying their best. No it's frustrating we don't have back up."

We discussed this with the registered manager who had monthly group meetings with staff. They immediately planned individual meetings for staff until the end of the year as part of their development. We saw all staff had two individual meetings planned in the next four months.

At the time of our inspection staff had not received appropriate supervision as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's needs were met by care staff who had access to the training they required. Care staff told us they had the basic training they required to meet people's needs. Staff comments included: "I think I have what I need. We do a lot of e-learning which I am finishing" and "I have the skills and training, I had this before I worked here." New staff completed the care certificate which is a set of national standards that health and social care workers adhere to in their daily working life. One staff member told us they had completed the care certificate and told us the computer training was "really good". The training coordinator told us that 84% of the staff had completed their mandatory training which included for example moving and handling, infection control and fire safety. As well as learning on computer staff had face to face training during their induction which included first aid and fire safety.

The training record we looked at identified that some staff required refresher moving and handling training and eight staff were to complete this in September 2017. There was a clear system for notifying staff when their training was due. Nurses and nursing assistants had their medicine competency checked as required. The registered manager checked agency nurses had updated their medicine competency during the inspection. Ongoing training included the health and social care diploma or equivalent and 25 care staff had completed either level two or three. Nurses had specialised training organised to meet the needs of their role and the validation of their registration.

We observed one lunchtime meal and people were not offered a choice of food or drink. Some people did not appear to know there was a choice of two main meals at lunch time. Staff offered people a choice of desserts ice cream sundae or yoghurt. Some people living with dementia found it difficult to make meal choices from the main menus. There were no pictures to choose from or a visual choice of a plated meal to support these people to make their meal choice.

Some people required physical assistance from staff to eat and drink. We saw staff being attentive to one person's needs and assisted them to eat their meal. However another person was struggling to eat and was using their knife to pick up some cucumber. Some of the person's food had spilled onto the table and they picked up some of the potato salad with their fingers. Care staff had not noticed this person was struggling and did not provide support. The chef told us there were snacks available for people including sandwiches but finger foods for main meals were not on the menus when people could not use cutlery. There was little flexibility with the menus as they were decided by the provider.

We recommend the provider review the dining experience of people living with dementia.

People were asked if they had enough to eat and one person was given extra potatoes at their request. There was a bowl of fresh fruit in the dining room for people to snack on between meals. One person told us they didn't want to have three meals a day and preferred a larger meal at lunchtime. They said their request was granted. One person said, "I asked to change my meal time, it's good and plenty but not before bed" and another person said, "The food is plain and adequate, I can't complain. People are easy to knock everything. I am given a choice and it is nicely presented."

People's cultural dietary needs were identified and met. For example, one person had made a choice not to eat pork. On the first day of our inspection, roast pork was provided as a main meal. The person was provided with a roast turkey dinner which looked similar to the roast pork. Care staff clearly understood and respected people's dietary choices. They knew why the person had this specific diet and assisted them to make choices appropriate to their needs. We spoke to a chef who had a list of people's diets and their food preferences. They knew who needed their food fortified and the consistency of some people's meals for example pureed or mashed.

Where people were assessed as being at risk of choking, guidance had been sought from Speech and Language Therapists (SALT). One person required their drinks to be thickened. Staff had clear guidance on how to assist this person with their drinks.

People were cared for by staff who had completed training on the Mental Capacity Act (MCA) 2005. The 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. Care staff showed a good understanding of this legislation and were able to explain specific points about it. Staff comments included, "We give people choice and make an effort to enable people to communicate their choices. One person has a whiteboard, we use this to communicate and understand their choices"; "When people can make decisions we give them as much choice as possible. We help people make informed choices, show them clothes when dressing and food at meal times" and "when someone doesn't have capacity to make a decision."

An up to date record of each person's consent to care was not always available in people's care plans. For example, one person's care plan contained a signed consent document in relation to their personal care and use of photography. However, shortly after they signed their consent, the person was assessed as not having capacity to consent to their own care. Their care records had not been updated to show that a best interest decision had been made in relation to their personal care and use of photography.

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 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. Where DoLS had been applied for there was not always a record of mental capacity assessments completed. The registered manager was aware of this concern and informed us they were taking action through care plan reviews.

People were supported to maintain good health through access to a range of healthcare professionals involved in their care and rehabilitation which included physiotherapists and SALT. One person had a regular visit form a massage therapist. One person told us, "I have had no experience of needing a doctor. I do have a chiropodist come here every month. I haven't seen an optician (wears glasses) but if I asked I would be able to." Another person told us they had been waiting for "quite some time" for a new hearing aid but was unsure how long. This issue was passed to the registered manager to follow up.

The premises had been refurbished and many of the dementia friendly articles had been removed. This meant the environment was not entirely suitable for people living with dementia. We discussed this with registered manager. They immediately ensured there were objects such as hats and aprons for people to put on and books and games to engage with till further environmental improvements would be made to benefit people.

Good

# Is the service caring?

## Our findings

People and their relatives spoke positively about the care they received and the care staff supporting them. One person and their relative told us, "Staff are very kind to her. She is comfortable here" and "I am happy. The staff are really lovely to me."

Care staff spoke with kindness and respect when speaking about people. They clearly knew people well, including their personal histories, family members and what was important to them. One member of staff discussed how they spent time talking with one person and assisting them to read poetry. They explained the person liked to talk about their family pictures they had in their bedroom. We observed staff were welcoming and very caring towards people. We observed one member of staff was engaged in conversation with a person during afternoon tea and they were happily discussing the person's time in the Royal Navy. One agency care staff member was able to tell us all about people as they had regularly worked at the home.

When one person needed guidance we saw how a staff member relieved them of a fork they had taken from the dining room by talking with them the whole time. One person told us, "My lady [staff member] is very good, very professional and will always answer my questions. If she doesn't know she will find out." Another person said, "To be frank I haven't come across anyone other than kind and gentle and firm if needed. I am not very ill so I don't need or haven't seen or needed this level of care."

People were treated with dignity and respect by care staff. Care staff ensured people received their personal care in the privacy of their room. For example, one person needed assistance with their personal hygiene. A member of staff supported the person to their room, called for support from another member of staff and shut the person's door. Another person was visited by the doctor in the lounge, they were asked by care staff if they would like to speak to the doctor in their room or another quiet area of the home. The person chose to talk with the doctor away from the lounge and their choice was respected.

Care staff told us about the importance of respecting people's dignity. They told us, "Always make sure care is in private and that people are not exposed", "I respect people and their individual faiths, I wouldn't impose my views on people" and "We must always ensure people are comfortable." One person told us, "They pretty much leave you alone, but I can ask and I will be put on the right track. I have very little to query. I was concerned about when I could have a bath as I want my hair washed twice a week, sometimes three. They looked into it and yes I have my hair washed twice a week, sometimes three." Another person said, "The staff are helpful when I do need them." We heard that one agency care staff member was speaking to a person in the language of their country of origin and how happy the person was to hear the language spoken by a staff member.

We saw personalised notices on some people's doors to inform staff to lock the door when their room was unoccupied. Each bedroom door had a 'door knocker'. One person told us, "I have a lock on my door as I like to lock up when I leave." Another person told us, "I was in a different room which was noisy and I asked to be moved, so I was moved to a quieter room after two to five days of being here. The room is much better

and quieter."

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed.

Requires Improvement

# Is the service responsive?

## Our findings

People's care plans were not always personalised, they did not always contain information about people, their life histories, hobbies or interests so that staff would know what was important to them. For example, one person's care plan provided limited details about the person and stated they had a limited ability to speak. Two care staff told us how they had learnt about the person's family and life history and enjoyed long conversations with the person. One member of staff said, "He won't start conversations. No one knows what to talk to (person) about. I spoke to family , that's how I started. I know through their family. The care file is not that detailed. There could be more detail about how (people) like things. There is not much about themselves, their outlook, and their lives."

Care staff did not always keep an accurate record of the support they had provided people in relation to their daily care. For example, care staff did not always record when they had assisted people with their personal hygiene needs, such as with baths and showers. Staff would therefore not know whether people had received the care they required. Additionally staff did not always ensure people's wellbeing was recorded and if the person had been anxious or displayed any behaviour which challenged the staff. One person had displayed inappropriate behaviours and this had not always been reflected in their daily notes. The person's wellbeing needs had not been recorded to see how the staff could support them with their physical desires and wellbeing needs.

Handover between care staff was given verbally at the start of each shift. Nurses had a recorded handover between them which helped to ensure important information was shared and monitored. The nurse's handover records had some information printed about each person but staff handwritten records on handover sheets were not kept for the registered manager to check if information had been effectively communicated. The registered manager told us they were planning a new system where all staff had a more detailed handover record. One care staff member told us they would welcome more detailed written information at each shift so that they would be up to date with people's support needs.

People did not always have opportunities for meaningful engagement during their day. There was little recorded evidence that people had been provided with the option to join in activities in the home or have access to individual social interests and hobbies. The activity organiser completed a weekly plan of activities for example, ball games, musical entertainment, visits by the therapy dog, nail pampering and boards games. However the activity organiser told us they had some difficulty ensuring people had sufficient individual engagement on all three units. Some individual engagement with people took place and was recorded, the activity organiser planned to evaluate these to ensure everyone had regular individual engagements. One person told us, "I don't join the activities but the people here are 'top marks'. Staff told us they did not always have enough time to provide people with meaningful individual engagement and activities outside of the home.

A comprehensive record was not always available of the care people required and the care they had received. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notice boards around the home had craft, colouring in work and photographs of people displayed. Simple activities were planned at the weekend when there was no activity organiser and care staff usually completed them, for example a film afternoon and special afternoon tea. There was no record of what people did at the weekend and we could not be sure they had taken part in these or alternative activities. There were group activities people could join in with in the activity room and care staff provided support there when art and craft work was completed. Recently people had made lavender bags and helped to create pictures on their bedroom doors to identify their own room. One person had indoor plants they helped to cultivate. We observed some activities in the residential unit lounge after lunch where the activity organiser took the lead assisted by two care staff playing catch with people using 'floaty type' footballs. One person was very successfully painting on an acrylic frame. There was music playing and the activity organiser was engaged with a person completing a word search puzzle. One staff member invited a person to dance to the music playing and everyone was very relaxed. One person had fallen asleep and was taken to their bedroom. People appeared to be enjoying the interactions.

The activity organiser was assisted by three part time volunteers throughout the month but one volunteer told us activities had reduced since last year as care staff were unable to be involved as they were busy. The activity organiser attended activity coordinator meetings to exchange ideas and learn about new activities. They were enthusiastic about improving engagement with people and informing care staff which activities people individually benefitted from. The service had the use of a mini bus but only two trips out this year had been organised as there had been insufficient staff to drive the vehicle.

Complaints were recorded and dealt with within time scales and to the complainant's satisfaction. There was a complaints procedure which provided all the relevant information for people and their supporters. Two relatives had recent concerns they shared with us and with the relatives permission these were shared with the manager who agreed to look into them. Complaints were investigated and responded to. The service had received two formal complaints in the previous 12 months. We looked at the responses the service had given and they were detailed and addressed the issues raised. The relatives we spoke with knew how to make a complaint. Four of the five people we spoke with in the residential unit told us they were confident to raise issues with the staff should they arise. The registered manager was aware the service did not have links with the local community. People did not attend local events. One relative suggested there should be more community volunteers to improve the activities for people. One person described their interaction with others and said, "Yes I am quite friendly and I have a lot of fun in here". Another person said the staff had given them confidence to do things and to take part in activities.

We looked at a recent letter of compliment sent in August 2017 from one relative. They thanked the registered manager for looking after their relative in the final months of their life. They said they believed that it was the registered manager who had "turned the place into an excellent facility." They went on to say the way the staff were working at Pennwood was by far the best they had seen and that staff enjoyed working for the registered manager who was highly motivated to do a good job. The relative praised the registered manager for telephone updates outside of their working hours when they were unable to get there and they had great comfort from the detailed information provided.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager and registered provider had systems in place to monitor the care people received and to identify safety concerns in the service. Quality assurance audits had been completed quarterly, monthly and weekly but were not always effective in driving improvements across the service. Care planning audits had been completed to ensure people's care assessments were up to date and accurately reflected their care needs and risks. However, where these audits had identified shortfalls actions had not always been taken to ensure improvements were made and we identified shortfalls in people's nutritional and behaviour care plans.

The provider's area director had identified that staff individual supervision meetings were not taking place during their quality assurance visits to the service in May, June and July 2017. However, action had not been taken to address this shortfall and we found staff still did not receive regular supervision to enable the registered manager to routinely monitor staff's performance and practice.

The service did not operate a comprehensive safety incident reporting system to ensure the provider and registered manager would be informed of all incidents that could indicate people's health and safety were at risk. For example, when unexplained bruising had been identified on people this was not always reported and investigated to determine how these might have occurred and whether any action needed to be taken to remedy the situation, prevent further occurrences and make sure that improvements were made as a result.

People's behaviour incidents had also not been analysed to identify any possible trends of triggers that might alert the registered manager to risk or to support them to understand people's behaviour. During our inspection we identified care staff were monitoring where people's behaviours were becoming more challenging both physically and verbally. However these incidents were not always reported and the registered manager was unaware. This meant that people were not always referred to professionals for review of their behaviours.

Systems in place to monitor quality and risk in the service were not operated effectively. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Clinical indicators were collated on the provider's computerised system and provided monthly detailed information, for example about weight loss, infections, pressure ulcers and medicines to monitor how people's nursing needs were met.

A quarterly falls audits had been completed by the provider. However there was no record of reflective practice after each individual falls, to look at possible preventative measures. Waiting three months to audit people's falls may be too late to identify where improvements could be made to minimise falls. The services Falls Team met quarterly and we looked at the April meeting minutes where six staff attended. One improvement from the meeting was for staff to record the medicine people were taking which may have

influenced the falls. The registered manager told us they had checked and medicine had not been a factor in the recent falls. A new laminated falls protocol flow chart for staff to follow to ensure they recorded the correct information was produced during the inspection and included reflective practice.

The latest infection control audit in July 2017 was scored 59.5% complete. Actions to improve the score had been recorded and the registered manager was working through the remaining actions. The registered manager had audited staff handwashing techniques at a recent staff meeting using an ultraviolet light to spot areas not effectively cleaned. The registered manager had employed another cleaner in response to the audit and planned to employ an additional housekeeper in September 2017. A health and safety audit and a complaints audit had also been completed.

There was a management structure at the service which consisted of the area director, registered manager and deputy manager. Two nursing assistants had been trained by the provider to complete minor clinical tasks and administer medicines. The registered manager who was employed this year told us they recognised the challenges of the service and wanted to ensure systems were effectively audited to improve outcomes for people. They were open, honest and receptive to our comments where improvements were necessary to ensure people's health and wellbeing. Some improvements were implemented immediately. For example regular staff individual meetings were planned and some articles for people living with dementia were made available to engage them.

Three relatives told us the new registered manager had made a positive difference and one said, "The new manager is very good and dealt with a concern immediately, she is the best manager we have had for four years." Another relative said, "The new manager is very good" and they said she listens." Care staff gave us mixed feedback about the management. One staff member told us ''We're not able to go to [management]'' while another told us ''The [Registered manager] is quite nice, they're the only one."

Monthly staff meetings were held and one staff member told us they were able to bring up issues that concerned them which was usually lack of staff. The meeting on 9 Augusts 2017 where 15 staff attended they had highlighted weight loss for people on one of the nursing units should be looked at. Cleaning and maintenance issues were addressed and the registered manager had asked if any staff would like to be a 'dementia champion' to provide support and information to staff. The activity organiser had planned to increase activities on Sundays with a film afternoon.

The provider information return informed us what improvements the registered manager planned in the next 12 months. They planned to complete level 5 qualification in the management of health and social care, restructure the home management team, continue with regular staff meetings and encourage team-building events. They also planned to promote a collaborative approach to reviewing various quality indicators for example, complaints, falls, infections and people's weight.

The registered manager had begun a 'manager's surgery' on a Saturday morning to ensure relatives and peoples supporters who were unable to visit during the week could come and discuss any concerns. The first 'surgery' on 26 August 2017 eight relatives came to speak to the registered manager. We looked at the record of the surgery and relatives had discussed various topics, for example about a hospital treatment, the improvement now the person had moved to another unit and a new nurse was starting to provide continuity of care. The registered manager dealt with any queries on the day and posted information to one relative. The registered manager told us several of the relatives were out in the garden with people for tea on the day.

People and their relatives and supporters had completed surveys about the service in May/June 2017. The

results were mainly positive but improvements were discussed for example, with regard to cleanliness of the home, food and activities at the resident/relatives meeting in August 2017. There was a detailed action plan to address the concerns raised around laundry, the use of agency staff, food and not enough choice of activities. The registered manager had employed additional domestic staff and told us the home was much cleaner. The dryness of the soft food provided and people participating in their care planning was completed immediately and other actions were dated for completion in September 2017. The registered manager told us they were considering having a small café area for people to visit in the home. Lots of new activities were discussed and action included contacting local voluntary groups. Relatives wanted the minutes of meetings and an email address list was to be collated of relatives or supporters to inform them about meetings and to send the minutes to them. One relative told us they had the meeting minutes. Another relative told us the home always kept them informed and they had completed a survey about the quality of the service.

There was also an interactive screen in the foyer where residents, professionals and visitors could "Have their say." A tick box was offered and there was room for people to make comments. This was a new device and had not been used yet. One person said, "As far as I know it's alright" [referring to the running of the home] and they had an awareness of who the registered manager was. Another person told us her cousin visited and was very happy with the standards. Some of the people we spoke with on the residential unit told us their relatives had not experienced any issues communicating with staff and two people said their relatives were happy with the service.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People who use services were not protected against the risks associated with assessing risks to their health and safety, receiving the correct care and unsafe medicine management. Regulation 12 (1) (2) (a) (b) and (g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>People who use services were not protected against the risks associated with the lack of staff supervision and support.Regulation18 (2) (a) |

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 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Systems established to ensure compliance were not always operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The service did not maintain accurate and complete records in respect of each service user. Regulation 17 (1)(2)(a)(b)(c). |

**The enforcement action we took:**

We issued the provider and registered manager with a warning notice for Regulation 17 Good governance. This requires the service to meet the requirements of this regulation by 15 January 2018.