NYMS Services Ltd

Pennine Care Centre

Inspection report

Hobroyd
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Pennine Care Centre is a residential care home providing accommodation and personal care to up to 64 people. At the time of the inspection there were 57 people living there. There are two units, Pennine and Moorland Suite. Pennine is for older people, including people living with dementia. Moorland Suite is a male only unit and supports older and some younger people with mental health conditions.

People's experience of using this service and what we found
The provider lacked oversight and governance arrangements to ensure improvements were made and quality of care maintained.

Audits were in place, however had not been used to make the required changes or to drive the changes to keep people safe. The morale in the home was poor and this led to people receiving inappropriate care that did not respect them or consider their dignity.

There was not enough staff to undertake effective cleaning of the home or to support people whose behaviours posed a risk. Staff had not received the required training to ensure competency.

Infection, prevention and control was not well managed, and we were not assured staff used personal protective equipment appropriately. Visiting arrangements were not in accordance with the government guidance.

Medicines were not managed safely and risk assessments had not been completed consistently for all health conditions. Behaviours plans were not in place to support staff with the guidance they required.

People were not always protected from the risk of harm and safeguards had not been raised following all incidents which had occurred. When safeguards had been raised, they had been investigated and information shared with professionals.

Staff felt unsupported and reported the home lacked structure and clear guidance. People were not enabled to enjoy daily choices or have activities to occupy their time. People had contributed to the menu planning.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 28 August 2021).

Why we inspected
The inspection was prompted in part due to concerns received about infection prevention and control and

the providers oversight. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pennine Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care, dignity and governance oversight this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Pennine Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Pennine Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Pennine Care Centre is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager registered with the Care Quality Commission. In addition to the provider, both are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We spoke with local commissioners and health care professionals and used all of this information to plan our inspection.

During the inspection
We spoke with two staff members, the provider and the registered manager. We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed. We spoke with two people who used the service and completed observations to reflect on the care received.

After the inspection
The inspectors contacted seven members of staff and five relatives to obtain their views of the care provided and the governance arrangements. We continued to seek clarification from the provider to validate evidence found. We looked at training data and further quality assurance records. We requested policies and additional information from the provider.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- People were not always protected from potential risks. We saw an inconsistent approach to risk assessments for diabetes and other long-term health conditions.
- Where people had behaviours which posed a risk to themselves or others, there was a lack of guidance in care plans for staff to support the person or to deescalate a situation. We found plans lacked information or staff took their own action to manage the situation. Staff we spoke with reflected these concerns. Comments shared with us, 'the care plans are not helpful', 'we have to speak with families as the information we have is not a true reflection' and 'I use PRN medicine to manage the behaviour.' This showed an inconsistency in managing people's anxiety levels or behaviours which posed a risk to themselves or others.
- Medicine were not managed safely. We found gaps in the recording of the medicine administration records and these errors had impacted on the levels of stock. Some people required medicine 'as required' PRN, for anxiety or support with digestion, however there were no protocols to guide staff when the medicine should be administered.
- We found some people had not received their medicine as prescribed and there was no explanation for the missed medicine. This placed people at risk of not receiving the medicine they required for their health conditions.
- Topical creams had been prescribed for people's skin, however there was no monitoring process in place. The electronic care records did not record when creams had been applied when personal care was provided and therefore, we were unable to be assured the creams had been applied.

The provider responded immediately during and after the inspection. To address the replacement of mattresses.

Preventing and controlling infection; Learning lessons when things go wrong

- Infection, prevention and control guidance was not being followed to provide us with assurance that measures were in place to reduce risks.
- We found mattresses had not been checked to ensure they were clean and in full working order with no penetration through the covers. Four mattresses required immediate replacement and following a full check of the mattresses more were replaced. This meant we could not be assured of the processes in place to check that mattresses maintained their integrity and were cleaned to reduce the risk of infection.
- Cleaning was not being completed in accordance with the cleaning schedules or guidance from the registered manager and provider. Enhanced cleaning schedules were not always completed daily and monitored for compliance.

● The provider told us after day one of the inspection they had increased the cleaning schedules within the home to encompass the deep cleaning of bedrooms and communal spaces. On day two of the inspection a week later, we found these areas still remained dirty and had not been maintained to a suitable standard. Records we reviewed confirmed a lack of cleaning in all areas of the home, this meant people were not protected from the risk of infection.
● Lessons had not been learnt in relation to cleaning and auditing and this placed people at continued risk of possible harm.
● We were not assured staff were using personal protective equipment (PPE) effectively and safely. We observed staff completing checks on mattresses without using gloves or completing a handwashing routine between mattresses. We also observed staff completing personal care tasks without using aprons or changing PPE after each person had been supported.

The provider had failed to ensure that people were protected from the risk of infections and safety to reduce the risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not always sufficient staff to meet the needs of people or to undertake domestic duties within the home.
● We reviewed the staff rota and found on several occasions over a four-week period the required two domestic staff for each unit was not allocated and there was a lack of staff to cover the domestic role. On the weekends there was only one domestic on each unit. Each domestic shift finished at 3.00pm and this meant further cleaning needs were left to the care staff to complete in addition to their care duties.
● The provider used a dependency tool to reflect the needs of people in relation to the staffing ratio. However, we found the dependency tool did not consider people who had behaviours which posed a risk to themselves and others and the impact this had on the level of supervision required in these areas.
● The provider had introduced a care manager role to the staffing rota, to support with medicines, appointments and care planning. However, staff told us this had impacted on the level of staff to provide the care people needed. One staff told us, "They are busy doing the office stuff they are not actioning things or checking things are being done correctly."
● Staff had received training in a range of subjects. However, we found in relation to medicines, although staff had completed competencies there were many errors identified which questioned actual staff competency in this area.
● We reviewed the providers training in relation to how staff supported people with behaviours which posed a risk to themselves and others. Although staff had received training, they felt this did not provide them with the skills to manage people's needs. The staff we spoke with commented on the impact this had on their role. One staff member said, "It can be like a pressure cooker and that has a domino effect. These people can be difficult to manage." This meant the provider had not ensured staff were not provided with the required skills within their role to support people safely.

Staffing levels were not sufficient to meet the needs of the people using the service, placing them at risk of harm. This was a breach of regulation 18(1) (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Systems and processes to safeguard people from the risk of abuse
● People were not always protected from abuse.
● Staff had received online training for safeguarding and some we spoke with understood what to report. However, many staff reflected the lack of action when internal concerns were raised, and they were not progressed to a safeguarding referral to the local authority. One staff member told us, "We have never been

taught how to safeguard. When we place information on the electronic system it gets removed the next day. Nothing gets done." However, the registered manager had raised some safeguards to the local authority following incidents, but we could not be assured all incidents were reported or investigated.
● When external safeguarding referrals had been raised, we saw these were investigated by the registered manager and information shared with the relevant professionals.

●The provider had a process for ensuring that staff were recruited safely. Records showed pre-employment checks were undertaken prior to staff commencing employment. Staff had Disclosure and Baring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated with dignity and respect.
- We saw several examples of a lack of care and consideration for people needs. One person told us they had requested a blanket during the night as they were cold, and they only had a sheet and no duvet. However, the person did not receive the blanket. We saw another bedroom only had a sheet on the bed. On checking the laundry cupboard, we found no duvets available. Staff told us, "There is always a lack of duvets, pillows and bedding. Often people don't have their own toiletries you have to use whatever is available." This meant there was a lack of consideration for people's individual needs and comfort.
- We saw people were not responded to when they required support with clothing or personal care. One person was walking around the unit in soiled clothing and required support to change their clothes. The inspectors had to alert the staff to provide the support they needed. They also had to direct the domestic staff to clean the two chairs which had become soiled as a consequence.
- At lunchtime we saw institutional practices as people were sat in wheelchairs in a line waiting for the toilet ahead of lunchtime. Staff we spoke with all reflected on the lack of morale and how this had impacted on the level of care being provided. One staff said, "It's difficult to have passion in the job, some staff have high standards, however the bad overrides the good." Another said, "Teams are worn out, running on empty. Some staff have a bad attitude and don't care." This meant people received poor care which was not personalised or respectful to their needs.
- The provider was not following the required guidance in relation to visiting. No relatives had been supported to become an essential care giver which would have enabled them to have access during a COVID 19 outbreak. When visiting was accommodated, it was in a space which lacked privacy. One relative said, "The facilities for visiting were not ideal, I would be sitting there with [name] and there would be staff in and out of the office." This meant we could not be assured people received visitors in accordance with the government guidance.

The provider had failed to ensure that people's dignity was protected. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always encouraged to make their own daily choices.
- There were no opportunities for people to express how they wished to spend their day; we saw people sat

in the communal spaces with no stimulation.

● In the PIR the provider told us, 'We have tailored the [Moorland] unit to provide positive male cultures such as a working bar, sky sports and a garden area that the residents wish to maintain independently. The unit is also decorated to reflect the wishes of the male residents.' We saw the unit was not decorated to a high standard and these activities listed were not available. One person told us, "There is nothing to do we cannot even access the internet." The registered manager told us the internet was accessible in the communal spaces, however it had not been shared with people.

● Staff also related to the lack of activities in both units. One staff member said, "There is not a lot going on with people, no crafts or games." This meant there was a lack of opportunity for people to engage in activities or consider their daily choices.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service was not well managed, and we found limited oversight. In the PIR the provider told us, 'There is a robust quality assurance system in place that is actively used by the Management team and the Home's consultant. The manager undertakes a series of audits to proactively identify areas of good practice and areas of noncompliance.' We found the audits in place had not identified risk or resulted in improvements.
- Audits had been completed for mattresses, these identified seven required replacement. However, these had not been replaced and during our inspection we found further concerns in relation to the quality of some mattresses.
- Audits had been completed for wheelchairs, however we found wheelchairs without footplates and they had not been cleaned. Following our inspection four wheelchairs were taken out of use due to their poor condition.
- In the PIR the provider told us, 'Care plans are reviewed and evaluated each month and any changes are cascaded through to the team via meeting and handovers.' We found the inconsistencies had not been identified through the auditing process. This meant staff lacked the guidance of how to respond to people's health care needs should they change.
- Audits in relation to medicines had not identified the missing photographic front sheets or the missing as required medicine in addition to stock issues. Care plan audits had not identified the inconsistent approach to risk assessments for the same health condition or in ensuring clear guidance for staff in managing behaviours which challenged.
- After the first day of the inspection the provider had implemented additional cleaning hours, however these areas had not been checked and we found the required cleaning had not been completed effectively. This meant the required oversight had not been implemented.

- The provider had an onsite presence at the home; however, we saw, and the staff shared with us, a lack of support for the registered manager. One staff we spoke with said, "I get on well with [name] but they struggle in the managerial post as not enough support." The overall feeling from staff was the inconsistent approach to decisions and actions. One staff said, "I don't think the home is very well run, no structure, no support or no consistency." This meant that staff were unsure of the structure and what guidance to follow.

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

● The culture of the home had been impacted by the lack of direction and leadership provided to staff. All the staff we spoke with told us that morale within the service was poor.

● We saw poor care being delivered and a lack of consideration for people's environments. For example, bathrooms and toilets being left soiled after use. The staff comments we received reflected this, "Staff morale is poor, staff are disheartened, lack of staffing and lots of agency it's a challenge", "It's sad at the centre, it wasn't like it a year ago" and "morale is really poor and this impacts on the care and not meeting their needs like access to having a shave or baths."

● Staff also reflected on the lack of communication. One staff said, "I can have my say, but it does not result in action. Communication could be improved."

● There was a lack of partnership working within the care home and across the two units. Staff we spoke with reflected on the disjointed approach of each role being separate and a lack of team working. For example, the cleaning staff not alerting care staff to a situation or the reverse. Staff told us, "We are supposed to be a team and share the information, but there is a lot of division of the teams. Staff would leave things and don't pass things on so then it gets left." Another staff member told us, "The management are more worried about reports and paperwork and not the nitty gritty." This meant we could not be assured by the oversight to develop and maintain a team approach to the care being delivered.

● This meant we could not be assured of a supportive environment to enable the development of a positive culture.

The provider had failed to ensure that systems and processes were in place to drive quality and improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People and staff were not always supported to be part of the development of the service.

● Staff had not received regular support. We saw staff had not always received regular meetings or supervision. Staff told us, "There is a lack of regular supervisions, no real approach to development." Another told us, "Some of the care staff are not caring, but they are not questioned in their role or any action taken."

● Staff felt they were not listened to. All the staff we spoke to raised concerns about not being heard. One staff said, "We have voiced our concern about the suitability of some people, and nothing is done about it. It's dangerous as at times you need eyes in the back of your head and people are not safe."

● Other staff reflected on the lack of structure or direction. One staff said, "There is a lack of structure and no one is taking the lead." Another said, "Some complaints are raised again and again and not resolved or any actions shared."

● Other staff we spoke with raised concerns about the lack of confidentiality within the office. One staff member told us, "What gets mentioned in the manager's office it's not confidential and action is never taken." This meant we could not be assured safeguards and whistleblowing had been consistently managed to protect people and staff from harm.

● Although people were not supported to have a say in their daily routine or the changes to the home, we did see they had been included in making choices for the new menu. The cook had asked people's views and was to incorporate pork chops, gammon steaks and dauphinoise potatoes.

Working in partnership with others

- Partnership working with health and social care professionals had been established. This related to referrals to different specialist to obtain professional guidance around dietary needs or support with skin integrity.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not always respect people's dignity and this may have an impact on the person feeling valued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient levels of staff to respond to people's needs. The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. Staffing levels had not been continuously reviewed to adapt to the changing needs of people. The provider had not ensured the staff received training at a relevant level to provide them with the skills to keep people safe at all times.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. The provider must ensure the premises used by the service are safe to use and for their intended purpose. Risk assessments and support guidance was not in place.

The enforcement action we took:

Warning notice served on the RM and the provider under Reg 12 to address concerns

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm. Experience of using the service had not been obtained from people. Communication with people using the service and those important to them had not been established to share how the home was being managed.

The enforcement action we took:

WN issued to REM and the provider to address concerns raised