HC-One Limited

Pennwood Lodge Nursing Home

Inspection report

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Date of inspection visit: 6 and 7 January 2015
Date of publication: 19/03/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Inadequate

Overall summary

The inspection was unannounced. When we last inspected the service in September 2014 we found there were three breaches of legal requirements. These were in respect of safeguarding adults, notifications not being sent to CQC and care records. We took enforcement action against the registered provider and registered manager in respect of two of the breaches. When we returned in October 2014 improvements had been made. We have checked during this inspection that the improvements to the other area, care records have been made.

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 44 people in residence. The home has four 15 bedded units, each with

Summary of findings

their own communal lounges and dining rooms and bathrooms. One unit is for people with personal care needs (residential care) and the other three units being for people with dementia and nursing care needs. All bedrooms were for single occupancy and the majority of rooms had en-suite facilities.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The leadership and management of the home needed to be improved. The systems in place to monitor the quality and safety of the service were inadequate. Although there was an improvement plan in place the registered manager was not steering the improvements as to their own set timescales. Since this inspection the registered manager has resigned from post and the service is being managed by an interim manager. This manager will be making application to the Care Quality Commission to be registered.

Although the registered manager and staff team were knowledgeable about safeguarding issues there have been a number of occasions where there has been a delay in incidents being reported to the relevant agencies. This meant that people may not have been protected from harm.

Staff did not understand the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS) and how to apply this to their role. Staff were unsure what actions to take if people were unlawfully deprived of their freedom to keep them safe. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people were assessed as not having the capacity to make a decision, a best interest decision was not being made. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People were being deprived of their liberty however the correct processes had not been followed to ensure this was done in line with the law.

Staffing numbers on each shift have not been consistent and there have been shifts worked with reduced numbers of staff. There has been reliance upon agency staff to fill the gaps although this was reducing as new staff were recruited. Staff were provided with regular training and were supported by their colleagues to do their jobs. There were good relationships between people and the staff who looked after them. As many of the staff lived locally they had shared life experiences and were able to talk and support people's wellbeing. Relatives told us the staff were kind and friendly and always made them welcome. People's privacy and dignity was maintained on the whole but we told the registered manager about two examples where improvements were needed.

People received care and support that met their specific needs. Medicines were administered to people safely. Risks to people's health and safety were assessed and appropriate management plans were in place to reduce these. People were satisfied with the food and drink they were provided with and the catering staff regularly asked people for feedback. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

For people living in the service their relatives or people who acted on their behalf were encouraged to express their views and opinions. In general, the staff listened to them and acted upon any concerns to improve the service.

We recommend that contact is made with dementia care agencies regarding the best environment to aid wellbeing.

We recommend that HC-One undertake a high level review of the management and leadership of this home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

People, and those who acted on their behalf, were not provided with information about the other agencies they could contact if they were concerned about the safety of their relative. The registered manager had not ensured the appropriate actions were taken when concerns had been raised.

Risks to people's health and welfare were generally well managed but some risk assessments recorded incorrect information.

The recruitment of new staff followed robust procedures and ensured only suitable staff were employed.

Medicines were generally well managed with some areas of improvement required.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always follow the Mental Capacity Act 2005 for people who lacked capacity to make a decision. Capacity assessments had only been completed for a few people and were inadequate. Applications under the Mental Capacity Act Deprivation of Liberty Safeguards had not been made.

Staff sought consent from people before helping them. Where people lacked capacity their rights were not properly recognised, respected or promoted. We found the home was not meeting the requirements of the Deprivation of Liberty Safeguards.

People were looked after by staff who received training and had the necessary knowledge and skills. The staff were well supported.

People were provided with sufficient food and drink that also met their individual requirements. Where people were at risk of poor nutrition or dehydration, there were measures in place to monitor and manage the risk.

People were supported to see their GP and other healthcare professionals as and when they needed to do so.

Is the service caring?

Requires Improvement

The service was caring but improvements were required.

People were generally treated with respect and kindness but relatives provided examples where this had not always been the case. People were at ease with the staff and had good relationships with them.

Summary of findings

People were looked after in the way they wanted. Staff took account of their personal choices and preferences. People were supported to make decisions about how they were looked after if they were able to express their views.

Is the service responsive?

Good 

The service was responsive

People received the care they needed because their care plans were reviewed and kept up to date.

There was a varied programme of activities appropriate for people living with dementia.

People, or those acting on their behalf, told us they were encouraged to make comments about the care provided. Relative meetings were held regularly. People and their relatives were listened to.

Is the service well-led?

Inadequate 

The service was not well led.

People, relatives and staff felt that the registered manager needed to be more visible within the main parts of the home and provide opportunities to listen to their views.

Although there was a programme of audits these were not always completed regularly, or not finished. The systems in place to learn from any accidents, incidents or complaints was not followed, therefore no learning could take place. There were significant shortfalls in the leadership and management of the home.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

On 5 September 2014 serious concerns were reported to us and we undertook a focused inspection on 9 September 2014. We took enforcement action against the provider and the registered manager in respect of safeguarding and notifications. We returned on 21 October 2014 and found appropriate action had been taken. We also asked the provider to tell us how they would improve care records. They submitted their action plan and said they would achieve this by the end of November 2014.

At this inspection the inspection team consisted of two adult social care inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in respect of people living with dementia.

Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also analysed the outcomes of safeguarding concerns that had been raised with the local authority. We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

Prior to the inspection we contacted and got feedback from two GP practices, district nurses, the continuing health care team, Gloucestershire County Council commissioning team and two social workers.

During the inspection we spoke with 11 people and 10 visitors. We also spoke with 20 staff, including the registered manager, the assistant operations director, nurses, care staff and other ancillary staff.

Not every person was able to express their views verbally therefore we spent some time observing how people were being looked after. 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 tell us about their life in the home.

We looked at seven care records, three staff personnel files, training records for the whole home, staff duty rotas and other records relating to the management of the home.

We found a number of breaches of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Requires Improvement

Is the service safe?

Our findings

When the nurse in charge or registered manager had been made aware of safeguarding issues, these had not always been reported to the local authority, the Police (if appropriate) or the CQC in a timely manner. Several incidents had not been reported to us or the local safeguarding team promptly. The registered manager had failed to report an incident they found out about in December 2014 until 7 January 2015. The registered manager said that the delays in reporting to CQC were an oversight on her part. These failures meant the registered manager had failed to respond appropriately when allegations of abuse were raised and had therefore failed to safeguard people. The registered provider informed us that disciplinary proceedings were in place as a result of this incident.

Information to advise relatives and other visitors to the home about what to do if they had concerns about 'elder abuse' or the safety of people was not prominently displayed. There was a pile of leaflets produced by Gloucestershire County Council in a display box but this had been placed 'out of sight' on a high shelf. In the last six months there had been occasions where relatives had concerns but had been unaware of other agencies they could have contacted to report their concerns.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safeguarding information files had been introduced, following the previous inspection and were located on each of the four units. The files contained the provider's safeguarding policy and safeguarding procedure, copies of the county councils policies, guidance, protocols, and forms that were to be completed by the staff when safeguarding concerns were alleged, witnessed or suspected. Safeguarding tracker forms were used to record progress, discussions and updates for each safeguarding incident. For those events that had been reported appropriately the documentation and tracking had been completed correctly. The procedures that had been implemented were not followed in the case of the example referred to above.

All new staff were expected to complete safeguarding training within the 12 week probationary period and thereafter an annual update. Ninety-four percent of the staff team had completed the computer-based safeguarding training programme. The registered manager and the deputy had completed the Gloucestershire County Council level two safeguarding training. Two of the unit leads had already been booked to attend the same training in March 2015, and the other two unit leads would then follow.

Staff said their safeguarding training was up to date and were aware what constituted abuse. They said it was about the way people were treated, how staff spoke to and handled people and also the interactions between people who lived in the home. One staff member said they were there to make sure people were safe and not harmed and that this was particularly important if a person was immobile, unable to communicate verbally or had behaviours that were likely to upset others. Staff said they had been instructed that any safeguarding concerns had to be reported to the registered manager, deputy or nurse in charge. However, some staff were aware they could report directly to the Gloucestershire County Council safeguarding team, the Care Quality Commission and the police.

Not all people were able to tell us whether they felt safe, therefore we spent time observing their interactions with the care staff. People were relaxed and calm and we saw examples of people being spoken with in a kind and sensitive manner. One person said, "They are all so kind" and also "I always feel safe here". A Relative said, "I have never worried about the safety of my father. The staff are fantastic".

We checked the recruitment procedures by looking at the pre-employment checks that were completed. Each staff file contained all of the required checks and information. The registered manager explained they looked for and discussed any gaps in employment history. The measures in place ensured that only suitable staff were employed.

For each person risk assessments had been completed in respect of moving and handling, the likelihood of developing pressure ulcers, falls, continence and nutrition. Where risks had been identified care plans were written stating how that risk was managed and what actions the care staff had to take. Person specific risk assessments and plans were developed where other risks were identified, for example the risk of choking, or the risks relating to a person's behaviour. Detailed moving and handling assessments and plans were in place. Details included the type of hoist and sling and the number of staff involved.

Requires Improvement

Is the service safe?

Monthly reviews of those plans were completed. One person's plan was out of date but care staff looking after that person knew precisely what they had to do. When asked, staff knew who the moving and handling trainer was and said they could ask for help, support and guidance at any time.

The service had a plan in place in the event of any emergency. A copy was kept in the information files in each of the units. The plan contained all the contact details for other agencies that may need to be contacted in the case of an emergency (for example loss of utility services and severe winter weather affecting staff availability). Staff had completed personal emergency evacuation plans for each person and these were kept in the same information file. In the main entrance foyer, emergency information was stored for the fire service to refer to.

People were cared for in a safe building. The maintenance person ensured the premises and facilities were maintained in good working order. Several areas of the home were shabby and in poor decorative order. A refurbishment programme was due to start for completion during 2015. Records were maintained of checks of the fire alarm systems, fire fighting equipment, fire doors, the specialist beds and the hot and cold water temperature checks. Hoisting equipment and the call bell system were regularly serviced and maintained. There was a programme of daily, weekly and monthly checks to be completed and the records evidenced that these had all been completed. Staff recorded any maintenance issues in a log book kept in the main reception and staff signing in area. We looked through this record. Whilst most entries had been actioned within a couple of days, we noted that two tasks were outstanding from 21 November, one from the 5 December and one from the 7 December 2014. Following our visit we were advised that the records had been signed off as completed

The kitchen staff had completed all the required daily temperature checks of the fridges and freezers. There were cleaning schedules in place for daily weekly and monthly tasks and these had been recorded as having been completed. Environmental health services had last visited the service in January 2014 and had awarded the full five stars.

There had been difficulties in providing consistent staffing (care staff and housekeeping) over the previous four months because of the number of staff leaving and also last minute staff absences. There was reliance upon agency staff to cover shifts however records we looked at showed that since the beginning of December 2014 there had been a gradual reduction in this. There had been some recent recruitment of nurses, care staff and catering staff but there were still vacancies for one nurse for night duty. The registered manager told us there was a "recruitment open day" planned within the next month. The provider's recruitment coordinator was supporting the registered manager in setting up the open day.

Nurses and care staff generally worked all their shifts on one of the four units. Some staff had recently been moved to work on other units. One relative commented, "This has had a real impact upon the care of my husband" and "was unsettling". Other relatives we spoke with had not felt there were any concerns regarding staff changes.

There was no formal staffing level assessment tool in use. The registered manager said they reviewed staffing levels in response to changes in people's dependency or if staff identified challenges in providing the care required. Staff said the workload at times was "very heavy", "demanding" and "There have been so many short staffed shifts recently. We just have to get on and manage". Care and nursing staff were supported by an administrator, a maintenance person, an activity organiser, catering and housekeeping staff.

We looked at the management of medicines including the medicine administration records for 20 people. We observed two nurses giving people their medicines. Both nurses were kind and patient allowing people time to take their medicines. We found that overall people's medicines were managed safely.

Safe arrangements were in place to obtain, administer and record people's medicines. Although we found that two people's medicines had not been available for a period of time the service had taken action to obtain new supplies. Medicine records were signed for administration or a reason was documented to explain why a medicine had not been given. When people were given a medicine prescribed as 'when necessary or when required' the reason the medicine was given was not always documented. In particular we found this for two people prescribed a medicine to be given when required for agitation. Although there was good supporting information available to enable staff to make a decision as to when to

Requires Improvement

Is the service safe?

give the medicine for agitation we found that there was not always a record to explain why the medicine had been given. The service told us that this information should be recorded and action would be taken to ensure this is done.

A system of daily medicine checks was in place. This included a random check on five people's medicines each day and a running stock balance of each person's medicines. We found it was possible to check that people had been given their medicines as prescribed. It also helped to identify any problems quickly, which the service was able to deal with to ensure medicines were handled safely.

The majority of medicines were stored within the recommended temperature ranges for safe medicine storage. However, one liquid medicine was stored at room temperature and should have been stored in a refrigerator. This meant that the medicine might not be effective. On showing this to a nurse, we were told that the medicine would be disposed of and a new supply ordered immediately.

Any medicine errors were dealt with immediately in order to learn and prevent the error happening again. There was an open culture of reporting medicine problems. We also found that there was shared learning between nursing staff to ensure the error did not happen again.

Inadequate

Is the service effective?

Our findings

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff were expected to complete MCA and DoLS training (a computer based training programme plus an off-line assessment of understanding).Training records showed that 86% of the staff team had completed this training but staff told us they did not feel fully informed about what was expected of them.

The legal rights of people who lacked the mental capacity to make decisions about their care were not protected. We looked at whether the service was following the MCA and applying DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there were restrictions on their freedom and liberty, these were assessed by professionals who were trained to assess whether the restriction was needed. The registered manager had received formal MCA and DoLS training and knew the correct procedures to ensure people's rights were protected. There were no deprivation of liberty authorisations in place at the time of our inspection, although some people were cared for in a way that should have led to a formal assessment. Two people received one to one care and were under continuous supervision. No DoLS applications had been made. The registered manager said they would be submitting applications for everyone in due course. The registered manager was not able to give us a timescale when this would be completed.

The registered manager said capacity assessments were in the process of being undertaken with each of the 44 people. There was information in two people's care files to show that an assessment of their mental capacity had been started. The quality of the assessments was poor, there was no indication who had completed the assessment, when the assessment had taken place or whether the assessment was finished. The registered manager told us they had only managed to complete the assessment for eight of the 44 people who lived in the home. The registered manager did not have a plan in place to get the remaining assessments done.

Procedures for the administration of medicines to people who lacked capacity to make an informed decision were not always followed. We looked at five medicine administration record (MAR) charts which stated the person was to be given their medicines concealed in food or drink (covert administration of medicines to people without their consent or knowledge). The service had a covert administration of medicines procedure dated April 2014 which detailed the procedure to follow. However, we found that best interest procedures had not been followed, with little or no evidence of signed agreement between all interested parties. Four people had no multi-disciplinary team best interests meeting. The record of one best interest meeting was unsigned by the professionals involved in the meeting and did not state who they were. One person's MAR chart stated they were to be given their medicines covertly; however the nurse said the person was able to take their medicines without it being hidden in food or drink. The information on the MAR chart was therefore incorrect. One nurse said they would like more training on understanding the covert administration of medicines and the MCA.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with said they would ensure that people agreed to being helped before they started to support people. They said they would try and coax people who were reluctant to accept personal care and if that did not work they would return later and try again. If this did not work they would ask for help and guidance. One staff member said, "It is all about approach, and once we find out what works best with a person, it is so much easier".

There was a programme of staff training and the computer printout dated 6 January 2014 showed that 82% of staff had completed all courses. Between 83 - 88 % of staff had completed modules one, two, three and four 'open hearts and minds' dementia care training. Other training included food safety, health & safety, infection control, safer people handling, equality and diversity and safeguarding adults. There was one moving and handling trainer who held practical training sessions with the care staff: the registered manager aimed to get two more moving and handling trainers trained (one to cover the night staff and the other for day staff). Staff had received training to meet people's needs and said, "We are reminded to complete training when it is coming up for renewal". Staff said they had the skills and knowledge to effectively support people.

We spoke with one new member of staff who had been employed for seven weeks. She said they had five super-numerary days at the start and had completed some

of her induction training. They said they had completed fire training, policies and procedures, equality and diversity, health & safety and had to complete all essential training within 12 weeks.

The registered manager said staff supervision was delegated to the unit leads, nurses and senior care assistant, but they received copies of all supervision notes and checked them over. The HC-One supervision policy had recently been amended and all staff will now receive two formal and scheduled supervision meetings per year. Staff members we spoke with during our inspection said they had been informed that formal supervision would be arranged six monthly. Staff said they were able to discuss any issues they had at other times with the nurse or person in charge. Work performance issues were managed by the registered manager, using the provider's disciplinary procedures however there have been occasions in recent months when this had not happened.

People were supported to eat and drink sufficient amounts to meet their needs and their body weights were recorded on a monthly basis (more often if needed). Food and fluid charts were used to record how much people ate and drank where risks of malnutrition or dehydration were identified.

People's nutritional needs were assessed during the assessment and care planning process. Where risks of choking were identified, specific instructions were detailed in the person's care plan and staff were instructed on the level of support the person needed. People's likes, dislikes and any food allergies were recorded and dietary preference sheets were completed and given to the kitchen staff. There was a four week menu plan. People were provided with a well-balanced diet including meat and vegetarian options. The catering staff also prepared gluten free and vegetarian meals as well as meals of different consistencies to meet people's specific needs.

We carried out an observation at lunch time. Mealtimes should be an important social time for people but we found it to be noisy and disorganised. The dining room notice board displayed the day's menu but this did not match the meals served that day. The font display on the notice was too small to engage and inform them. People were not provided with any visual clues to help them make a meal choice. People were asked to choose between two meals. Some people were confused by this and we heard them saying, "What is this?" and "What did I choose?". In this dining room a badly tuned radio was the background noise throughout this mealtime. Two of these people had special dietary needs - an experienced staff member noticed that one person had chosen a meal containing food items they were allergic too and arranged for them to have the other option. Those people who needed a soft textured diet or their meals to be pureed, were provided with an already prepared meal. The cook told us that they already knew the person's preference. Alternative desserts were offered (yoghurt) if people did not want the dessert on offer or if it was unsuitable for them.

People living at the home had a variety of individual health care needs as well as their dementia. They were registered with one of two local GP practices. The GP was asked to visit when the nurses or the senior carers had identified this was needed. District nurses were requested to visit the home to review people's healthcare needs. We spoke with a district nurse during the inspection. They told us they had been asked to see one person who had a sore heel. They told us that the unit leader of the residential unit communicated well with them, was helpful, always followed instructions and knew what was going on. Any advice that was given was followed. We were told they had no concerns about the care provided to people. We asked both GP surgeries for their views and opinions about how their patients were looked after. One GP commented, "I am very happy with the care that patients get at Pennwood. The staff are caring and attentive to patients. Many of the trained staff and many of the carers have been in post for a long time and know the patients well which is very helpful as many of the patients have severe dementia and can be challenging".

During our inspection there was a medical emergency after lunch but the care staff involved acted professionally and promptly. The staff worked with the paramedic services when they arrived and GP advice was sought.

Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists. The home arranged for occupational therapists (OT) to visit as required. An OT visited during the inspection in order to undertake hoist sling assessments for three people. This liaison with other health care professionals ensured people were looked after in the best possible way.

The premises were well designed for people living with dementia because each of the four units were arranged to support people who were restless and wandering. There

Inadequate

Is the service effective?

were tactile points placed along walking routes. However, there was an absence of visual aids to help orientate people and to enable them to find toilets, the communal rooms or their own bedroom. Some parts of the home were tired and shabby whilst other parts had been redecorated, or been made to look nicer by the staff team. A programme of refurbishment was due to commence in April 2015. One of the ground floor units was due to be temporarily closed so works could be started earlier. A number of the bathrooms were out of action because the assisted baths were irrepairable or the showers were broken. As part of the refurbishment works there will be new bathrooms and wet rooms installed in each of the four units.

We recommend that contact is made with dementia care agencies regarding the best environment to aid wellbeing.

Requires Improvement

Is the service caring?

Our findings

People told us "The staff are all so kind", "The staff are lovely here" and "They look after me like I am family". One person referred to a specific staff member, pointed out the member of staff who smiled back and told her she was lovely too. From our conversations and observations it was evident that staff had built up trusting relationships with the people they were looking after. This was apparent in the relaxed and confident manner people interacted with the care staff. Staff spoke to people with respect for the person and with dignity.

Whilst we were walking through one of the units with one of the care staff they noticed that one person's trouser leg had ridden up their leg and exposed their catheter drainage bag. The staff member promptly attended to the person and we witnessed a period of exchange between the two of them with shared humour.

One of the GP practices we contacted said, "The staff are very caring", "Our patients are very well looked after" and "They have asked not to visit at lunch time so meal times are not disturbed". The other GP practice commented that Pennwood Lodge was a "Caring home with great staff who are kind and responsive to people's needs".

A relative said, "I have been visiting the home for a long time as this is the second relative who has lived here". They told us they visited at different times of the day and different days of the week and care was always "up to the mark". The relative said they had never been worried about the care or safety of their relatives and added "The staff are fantastic".

However, other relatives did not share this view. We were able to sit in on the relative's meeting that was held on the second day of the inspection. One relative told us they had found their relative wearing other peoples underwear and clothes on a number of occasions and that staff ignored a person's preference to have a bath rather than a shower ("because it was quicker for the staff"). Another relative said when they had returned to visiting after a five day break they found evidence of poor oral hygiene and their relatives dentures caked in food. They said they often asked staff to pay better attention to care of dentures but any improvements were short lived.

At the end of the relatives meeting one relative said that they disagreed with everything that had been said in the meeting because "The way the staff look after my mother could not be any more caring and loving".

Care staff engaged with people and supported them in conversation and with activities going on around them. We observed staff using different communication methods to engage with people, for example using touch, their own body language and listening skills to engage with people.

Good

Is the service responsive?

Our findings

People told us that the staff helped them when they needed assistance. They said, "There is always someone around to help", "We get everything done for us here" and "I don't like it when X calls out but the girls do try their best to settle her down". Relatives told us "The staff are always very helpful and prompt in attending to our relative", "If they need help, the staff are very attentive but often have to wait for a second member of staff to be available. Because they use the hoist, there needs to be two staff" and "We wish there were more permanent staff because the agency staff do not know our relative as well".

Staff knew a lot about the people they were looking after, many of them lived locally and knew people before they came to live in the home. Pennwood Lodge employed many local carers and this meant that people and some staff had a common history and shared life experiences. Care staff utilised this very well and were seen using this information to engage and reminisce.

This encouraged people to explore further memories and gave them a sense of identity and purpose.

Staff encouraged meaningful relationships and friendships, and supported people to engage with others. They told us about two people who had developed a strong bond and how this had enhanced their everyday wellbeing.

There was a varied programme of activities for people to participate in. An experienced and insightful activities organiser led the programme. People were offered well planned and therapeutic activities that were appropriate for people living with dementia. We spent time with the activities organiser who said, "I know people well and plan accordingly" and "I know people's hobbies and interests and use this in my planning". On the noticeboard in the lobby entrance, there was a display of photographs from the Christmas festivities and a plan of activities that were taking place that week. There was a 'knit and natter' session, an art club, a sing a long session with an outside entertainer, and a gardening club arranged. There was a two hour period each day when the activities organiser spent time on one of the units and interacted with individuals on a one to one basis. On the first day of the inspection the activities organiser took one person out for a drive and visited the local library, and then had gardening club in the afternoon.

The activity (garden club) was well planned and the room was prepared to promote engagement. Classical music played and comments included "ooh this is lovely", "I love this" and "my favourite". The seating was arranged to promote involvement and interaction. The activity engaged all participants, and everyone was supported to get involved physically and intellectually. Conversation included reminiscence.

Care records we looked at included an assessment of care and support needs completed on admission or after a full review because of significant changes. The assessments covered all aspects of the person's daily life, specifics about how their dementia presented and any nursing care needs. Plans were devised for each person and provided details about personal care needs, mobility, support needed with eating and drinking, wound care management and night time requirements for example. The care plans were generally well written and provided information about how planned care was to be provided.

At the front of people's care files staff had completed a 'Resident Profile': the aim of these was to provide a quick overview of the person. For one person they had written 'I like to be in company' but staff told us the person was room-bound and liked them to pop in and have a chat with him regularly. One care plan had conflicting information recorded in respect of how the person moved from one place to another, however staff were very clear what support was needed. Daily records of care provided were maintained during each shift however they could usefully provide more detail. For example in the records of one person it was written they had been "up since 9.30 but complained of being agitated and unwell at 10am. Medicine (named drug) given at 15.00". There was no indication what had happened in the five hour period or whether the administration of the medicine was effective. Care plans were, on the whole, reviewed on a monthly basis but there were occasions where changes referred to in the review were not updated in the care plan.

Each staff member coming on shift received a handover report from the outgoing day or night staff. Some people were supported by agency staff on a 1:1 basis and when they needed a break, a verbal handover report was given to the staff member taking over so they were made aware of

Good

Is the service responsive?

any issues prevalent at that time. These measures ensured staff received up to date information to enable them to provide the care required by each person and were aware of any changes.

People were asked to share their views or make comments about things that upset them whilst being provided with personal care. However on the whole their relatives spoke up for them and raised any issues as formal complaints. Staff said they knew if people were unhappy with something because of changes in behaviours.

Relatives and visitors were asked what they would do if they were unhappy with their loved ones care. We asked them if they felt confident in raising their concerns. We received a mixture of comments: "Yes I would tell someone, probably the manager", "I know (nurse) well and I trust her, I wait until I see her if I have any worries", "I try not to be too picky as they try to do their best, but I would complain if I was very unhappy" and "If I have any gripes, I wouldn't hesitate to report them". The negative comments we received included the following: "I do not find the manager approachable and I don't think she listens to us", "We are told that the manager has an open door policy, but it is very difficult to find her sometimes. We are often told she is having a break out the back".

Relatives also had the opportunity to discuss any concerns at one of the meetings the home arranged for families. One of these meetings was scheduled for the second day of the inspection and we were able to sit in on the meeting. The previous meeting was held in September 2014, the notes from the meeting were referred to and information was fed back in respect of actions that had been agreed. In the meeting of 7 October 2015 there were discussions about activity plans, the refurbishment programme, the standard of cleaning in a named area of the home and individual care issues.

Inadequate

Is the service well-led?

Our findings

People were not provided with accurate information about the history of the service. On the information stand in the main reception CQC inspection reports were displayed. The report from the May 2013 inspection report was there along with the October 2014 follow up inspection report. This report referred to the improvements that had been made and reported that the essential standards of quality and safety were met. However the report from September 2014 was not displayed. This report had referred to serious failings in safeguarding adults from harm, failures in notifying CQC of events that had occurred and inadequate care records. CQC had taken enforcement action against the provider and the registered manager in order to force improvements to be made. In the relatives meetings folder also displayed in the reception area, the September 2014 meeting notes made no mention of the recent CQC inspection and the outcome. This does not evidence that the registered provider and registered manager are open and honest with the families of people living in the home.

This is a breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Prior to the inspection we had asked the provider to complete the provider information return (PIR). This is a document that tells us how the service is doing and what plans for improvement they intend to make. The form detailed only minimal information and did not provide us with sufficient information for each of the five questions. In respect of the improvements they told us they were going to make there was no clear plan when these were going to be achieved. An example of this was the identification of a nutrition lead. Other lead staff members were referred to and one such staff member was able to tell us about their role.

There were a number of opportunities for relatives to communicate with staff. Relatives said, “We asked for regular relatives meetings and these are now on a monthly basis. It is a pity that they are not better attended by other relatives”, “There is better communication with key staff” and “It is a shame that some relatives are so negative. Relatives have to work with the home staff to get things right”. A number of relatives said the manager spent a great deal of time “out the back smoking”, “in the admin office eating” and “needed to set a better example to the staff team”.

Staff said their day to day support was provided by their colleagues, the nurses or senior care staff. The staffing structure within the home was as follows: a registered manager, deputy manager, four unit leads, nurses, senior care staff and care staff. The care team were supported by catering staff, housekeeping staff and an administrator in order to meet people’s daily living needs. The registered manager held a short ‘flash’ meeting every morning with the heads of department and senior staff. In this meeting discussions were had about care issues, staff issues, tasks that needed to be completed and who the ‘resident of the day’ was. For the resident of the day this meant their care plans were reviewed and they were visited by catering and housekeeping staff.

Care staff said they were left alone “to get on with it” (looking after people) and it was not custom and practice for the mangers to walk around the unit daily. They added “they are busy and know we will tell them if anything is wrong”, “they delegate a lot as they know we can cope” and “they give us responsibility”.

General staff meetings were held regularly and records were kept of all meetings. Unit leads also held meetings with their staff team. Because there had been a number of staff changes recently, with staff being moved from one unit to another, these meetings had not been held as regularly as planned. The registered manager attended regular home manager meetings with the assistant operations director or operations director.

There was a programme of monthly audits that the registered manager was expected to complete and submit to their manager. The registered manager had been asked to complete a number of these audits on a monthly rather than three monthly basis for a period of time. We looked at the infection control audit that had been started in November 2014 but there was no clear outcome of the audit. We were advised that the December 2014 audit had not been finished. The catering audit had been completed appropriately and we were told that this will return to being done quarterly after the January 2015 review. One of the nurses/unit leads had been given the task of auditing falls but had been unable to do this. Although the provider had a programme of audits in place to check on the quality and safety of the service, in practice these were not being completed consistently. Where shortfalls were identified these were not addressed which may put people at risk of receiving a poor service.

Inadequate

Is the service well-led?

Whenever any accidents or incidents occurred, staff completed paper forms detailing what had happened and what immediate actions had taken place. The registered manager was responsible for logging the details electronically but had a large backlog of forms to be entered on to the system. There were 20-25 forms dating back to October 2014 that needed to be entered. We located one specific form as we wanted to see what action had been taken as a result of a fall in which a person has sustained an injury. The form recorded that 'vital signs taken' however these were not recorded anywhere in the person's care file. Because of these shortfalls there was no analysis of accidents or incidents to identify triggers or trends. This in turn meant that preventative actions were not considered.

Although the registered manager was aware when notifications of events had to be sent in to CQC there had again been a number of occasions when this has not been done in a timely manner. A notification is information about important events that have happened in the home and which the service is required by law to tell us about.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Satisfaction surveys had recently been completed by half of the people who lived in the home however they were supported to answer the questions by a member of staff. Survey forms were about to go out to relatives and other interested parties. Because people were living with dementia they relied upon their families to advocate on their behalf to influence any changes. The results of this survey will be made available to people once it is completed.

A copy of the complaints procedure was displayed in the main reception area and stated all complaints would be investigated and responded to in writing. Information was also given to relatives so they would know what to do if they wanted to raise a concern or complaint. The home had received three formal complaints in the last year and CQC had been informed of the same complaints. Electronic records were maintained of all actions taken. However one of the complaints was not logged when the registered manager was first advised of the complaint. The third complaint was from relatives who felt they were not informed of an incident that had happened, in a timely manner. The registered manager told us that when issues were raised informally, they were not logged as complaints. This could mean that the opportunity to learn from any mistakes or incidents and to identify trends was missed.

Following our inspections in September and October 2014, the provider put together their action plan to ensure improvements were made. Procedures were put in place to ensure care documentation was completed properly and nurses or senior care staff checked charts were completed at the end of their shifts. Monthly care plan trackers were introduced to ensure reviews happened. The majority of the actions with a timescale had been met but improvements were still required in some areas.

The registered manager had the following values for the home and for the people who lived there. They wanted people to be treated with respect, kindness and dignity and be safe. They wanted the staff to remember that Pennwood Lodge was people's home, that it should be a happy home and that the staff know the people they are looking after. To a large extent these values were evident and shared by the rest of the staff team. However in the last six months there have occasions where the registered manager has not demonstrated good leadership and has not dealt with situations well.

We recommend that HC-One undertake a high level review of the management and leadership of this home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not safeguarded against the risk of abuse because staff had not responded appropriately to allegations of abuse. They had not reported concerns to the appropriate agencies in a timely manner. Regulation 11 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not have suitable arrangements in place to ensure that people were provided with appropriate information about the service and the support in relation to their care and treatment. Regulation 17 (2) (b).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to monitor the quality of the service delivery.** **Regulation 10(1) (a) (b), (2)(b)(i) and (2)(c)(i)**