

NYMS Services Ltd

Pennine Care Centre

Inspection report

Hobroyd
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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Pennine Care Centre is a residential care home providing personal care to up to 64 people. The service is split into two units, Pennine and Moorland. Pennine supports older people, including people with dementia. Moorland is a male only unit, supporting older people and some younger people with mental health conditions. At the time of our inspection there were 45 people using the service.

People's experience of using this service and what we found

Governance systems were not yet fully embedded to ensure effective action was taken to drive improvement. Further improvements were required to support people to achieve good outcomes and promote person centred care. People and their relatives had opportunities to feedback into the service but did not always feel assured their feedback was acted upon.

Some areas of the service were not cleaned to a high standard. Best infection prevention and control (IPC) practice was not always followed.

People and their relatives were not always involved in their care planning. Further improvements were required to ensure people's personal spaces were homely and people were supported to participate in activities of their choice.

People were cared for by friendly staff. People's privacy and dignity was respected, and people were supported to make everyday choices, such as what outfit to wear.

There were enough suitably trained staff to meet the needs of people. People's long-term health risks were assessed and clear guidance for staff was available to support people safely. People received their medicines as prescribed by competent staff. Accidents and incidents were reported and investigated and people were kept safe from the avoidable risk of abuse.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 inadequate (published 27 May 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 6 April 2022. During this inspection the provider

demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected

We carried out an unannounced focused inspection of this service on 16 and 23 February 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, staffing, dignity and governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Caring and Well-led which contain those requirements.

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 inadequate to requires improvement. This is based on the findings at 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 and Recommendations

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and governance at this inspection.

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

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 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

This inspection was carried out by two 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.

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.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with five people who use the service and 11 relatives of people. We spoke with a visiting professional who works with the service. We spoke with 11 staff, including the nominated individual, registered manager, deputy manager, care managers, care workers, cook and domestic assistant. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We carried out observations of communal areas. We reviewed a range of records including nine people's care records, a number of medicine administration records and some records relating to the management of the service.



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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider failed to ensure people were protected from the risk of avoidable harm and the risk of infections. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Preventing and controlling infection

- The home was not cleaned to a high standard. During the inspection we found some furniture to be soiled, dusty fixtures, stained walls, a worn crash mat which was in place to prevent injury in case a person fell and flooring which needed cleaning. Domestic staff told us when unexpected incidents or spillages occurred, this had an impact on their ability to complete their assigned cleaning tasks.
- Personal protective equipment (PPE) was not always worn appropriately. We observed some staff members not wearing face masks or wearing them below their chins. We found a discarded used face mask outside of building. This placed people at increased risk of infection.
- The medicine room required deep cleaning. Cleaning schedules had been signed to say the room had been cleaned and the bin emptied, however we found the bin to be full. This meant we could not be assured cleaning schedules were completed appropriately.
- The laundry room was untidy and best IPC practice was not followed. We found debris on the floor, the sink was stained, shelving was worn and potentially hazardous chemicals were stored on the floor. This exposed people to the risk of harm and infection.

The provider did not follow safe hygiene practices. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed cleaning of fixtures and the laundry room had been completed.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.

Visiting in care homes

- The service was supporting people to receive visits in line with current government guidance.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient numbers of suitable staff to meet the needs of the people using the service. This was a breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18(1)(2).

- There was enough staff to support safe care. The registered manager regularly assessed people's levels of dependency to calculate how many staff were needed to support them. Rota's were in line with the calculated staffing levels. We observed the number of staff on site to match the rota's during our inspection.
- Domestic assistants were on both units each day. Following our last inspection, the provider made changes to domestic assistants shift to ensure adequate cover. This meant care staff were not required to take on additional cleaning tasks.
- Staff were visible around the home and attended to people's requests for support promptly. When people required two staff to support them, we found they did not have to wait for staff to be available.
- Staff felt staffing levels had improved. One staff said, "Because we have increased staff, we can do our job to a better ability than we were doing when we had minimum staff and we were rushed." Another said, "Now there's more staff in post, this impacts positively on people."
- Safe recruitment practices were followed. This included obtaining two references and completing Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

- Medicines were not always stored in line with the providers policy or best guidance. For example, the medicine trolley lock was broken and cupboards storing medicines were not locked. The keys to access the medicines trolley were not kept securely on the person of a medicine trained staff member. The registered manager responded immediately and assured us these actions had been addressed.
- People received their prescribed medicines safely. We observed a medicine round and saw people were supported to take their medicines by kind and patient staff.
- Medicine administration records (MAR's) were completed appropriately. Where people refused medicine, reasons for this were clearly recorded. We saw the service followed up with the GP when there were any concerns about medicines.
- Guidance was in place for as required medicines. We found staff to be knowledgeable on how to administer as required medicines safely and records showed they were not overused. Staff knew when to contact the GP to discuss concerns with people's medicines.
- Staff were suitably trained to administer medicines. Competency checks were regularly completed to ensure staff practice remained safe.

Assessing risk, safety monitoring and management

- Risks to people were assessed. Staff had appropriate guidance to support people and long-term health risks safely. For example, people who had diabetes had clear care plans and risk assessments for staff to understand what normal presentation was for the person and signs and symptoms of deterioration.
- Guidance was in place to support people who expressed agitation or distress. This meant staff supported people consistently, and in a way that was suitable for the person. For example, one person's care plan identified classical music may help to calm them.

- Action was taken to manage people's risks. For example, one person cared for in bed was at risk of developing pressure sores and required regular re-positioning. We reviewed the daily notes for this person and saw they were re-positioned two hourly as the risk assessment stated.
- Staff felt care plans provided enough guidance. The service used an electronic care plan system which clearly identified people's main risks on the front page. A new member of staff told us the care plans helped them to understand the needs of people using the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were monitored.

Learning lessons when things go wrong

- Opportunities for learning were identified. Staff reported accidents and incidents which were reviewed and investigated by the manager. A monthly analysis was completed which allowed opportunity to identify themes and trends to prevent re-occurrence.
- Learning was shared with staff. Each day a head of department meeting was held which provided staff opportunities to de-brief following any incidents.

Systems and processes to safeguard people from the risk of abuse

- People were safe from the risk of abuse. The manager had made appropriate safeguarding referrals to the local authority and completed thorough investigations.
- Staff we spoke with understood how to recognise abuse. We saw information about safeguarding was available to staff to support them in keeping people safe. Staff had received training in safeguarding.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

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

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

- Staff supported people to maintain their dignity. For example, we observed safe moving and handling practice for people who required equipment to help them mobilise. We saw one person had spilled a drink on their clothing and was quickly supported to go and change.
- Staff respected people's privacy. We observed staff to knock on people's doors before entering and let them know who they were.
- The service worked with other professionals where it had been identified people needed additional support to maintain their independence. We saw one person had been referred to occupational therapy for mobility support. Their care plan was updated to reflect the recommendations and guidance for staff to help the person maintain their independence as much as possible.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives were not always involved in decisions about their care. One relative told us, "I have never seen [person's] care plan and certainly not had any conversations about how they are looking after them and they've been there two years." Another said, "I've not been involved in [person's] care plan."
- People were not always supported to choose how to spend their time. There was an activities co-ordinator employed by the service but they were not on shift during our inspection. We observed limited stimulation for people, with most sitting in the lounge watching television.
- Bedrooms were not always personalised. We saw some people who had lived at the service for several years had few personal items. We spoke to the registered manager who told us they were working with families to collect photos and belongings. Where this was not possible the provider would purchase these for people to make their space more homely.
- People were supported to make everyday choices. For example people made choices about what they wished to wear or eat. We spoke to one person who told us they had decided to eat their lunch in the lounge that day.

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

- People were treated with kindness. We observed caring and patient interactions between staff and people. One staff said, "Since staffing has improved, we can be more available for people."
- Relatives reflected positively on the support staff provided. One said, "One of the carers has really connected with [person] and seems to get through to her." Another fed back, "It is important to me that [person] is having happy moments during the day and this seems to be happening more now. The staff seem to be enjoying their job more too."
- Care records were written respectfully and explored people's diverse needs. Staff we spoke with knew the people they supported. One staff said, "I've recently taken up fishing and I know [person] likes fishing so I've been speaking to them about it."

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 inadequate. The rating for this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection 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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems in place to drive improvements were not yet fully embedded. The registered manager completed a range of audits which identified issues within the service, however effective action had not always been taken to address them. For example, we reviewed an IPC audit which identified the medicine room needed cleaning and a first impressions audit identified poor PPE practice by staff. We found these issues remained present during our inspection.
- The service was undergoing refurbishment. The provider had implemented a modernisation plan however we found some work had not been completed despite being signed off as complete. Some work had not been completed to a high standard. For example, all bedroom doors had been signed off as renewed or repaired, but we found doors in need of repair during our inspection. This meant we could not be fully assured by the providers refurbishment plan.
- The providers system for prioritising refurbishment was not clear. For example, redesigning the avery was assigned as high priority, but replacing faulty basins and taps were assigned as a low priority. The refurbishment plan did not consider the outdoor space, despite feedback from relatives that this was a priority for them.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A positive culture was not always promoted. For example, we saw maintenance work taking place within the communal lounge whilst being used by people who were listening to the radio. This demonstrated a lack of consideration for people and their home.
- Feedback was not always acted upon. People and relatives told us there were opportunities to give feedback, however they were yet to see action taken by the provider. One relative told us, "If I had a magic

wand, I would want them to follow through on promises."

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

The provider responded following the inspection and assured us increased checks and oversight will support the embedding of quality assurance systems. They shared an updated action plan which was comprehensive and identified actions were clearly prioritised.

- Since our last inspection, the provider had commissioned an external consultant to support managers and improve the quality of the service. This demonstrated the provider was taking proactive steps to drive improvement within the service.
- Staff had opportunities to feed back through meetings and supervisions. Staff told us they felt supported in their roles and informed on what was happening with the service.

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 registered manager understood their responsibilities under duty of candour. For example, we saw apologies to people who had complained.
- The provider and registered manager had been honest with people, staff and relatives about the findings at our previous inspection. We saw they had invited people to discuss this with them. We received feedback that communication had improved with the service.

Working in partnership with others

- The service worked collaboratively with a range of external stakeholders and agencies. This included the local authority, commissioners and health and social care professionals. The provider sought advice and guidance where appropriate.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider failed to ensure that people were protected from the risk of infection. The service was not cleaned to a high standard and staff did not always follow safe PPE practice.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to ensure that systems and processes were in place to drive quality and improvements.</p>