RochCare (UK) Ltd

Pendle Brook Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Pendle Brook Care Home is a residential care home providing accommodation and personal care for up to 50 people. The service does not provide nursing care. At the time of the inspection, there were 28 people living in the home, most of whom were living with dementia.

Pendle Brook Care Home is a purpose-built home with special consideration given to the needs of people living with dementia. The home is located in the town of Oswaldtwistle. Accommodation is provided over three floors. At the time of the inspection, only the top two floors of the building were being used to accommodate people.

People's experience of using this service and what we found
People living in the home told us they felt safe and that staff treated them well. Relatives told us there were effective systems in place to keep people safe, particularly when they had experienced falls in the home.

The provider had systems in place to monitor the quality and safety of the service. However, these had not been effective as we identified a number of shortfalls during the inspection. The provider had failed to ensure important checks had been regularly completed; these included checks relating to fire safety and the environment. Care records did not always show that people had received the care and support they needed. We have also made a recommendation in relation to recruitment processes.

Staff had received training in safeguarding and knew what action to take to protect people from the risk of harm. We were generally assured regarding the measures in place to protect people from the risk of infection, including COVID-19. People told us the home was kept clean. Relatives told us systems were in place to enable them to safely visit family members in the home. Some staff had not received training in how to put on and dispose of personal protective equipment (PPE). In addition, the provider needed to ensure all visitors to the home, including staff employed at their other locations, completed the documentation they had in place in relation to testing and any exposure to COVID-19,

Although the provider had experienced staffing issues, this had not had a negative impact on the care people received. The provider told us they were in the process of recruiting to the vacant posts. People received their medicines as prescribed.

Staff told us they enjoyed working in the home and were committed to ensuring people received high quality care. They told us the management team were supportive and approachable.

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

Rating at last inspection
The last rating for this service was good (published 9 July 2021).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, recruitment and infection control. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.
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You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pendle Brook Care Home 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 monitor the service.

We identified breaches in relation to the lack of regular checks of the safety of the environment and the lack of effective systems to monitor the quality and safety of the service.

Follow up
We will request an action plan for 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 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.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Requires Improvement

Pendle Brook Care Home

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 Care Act 2014.

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
The inspection team consisted of 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
Pendle Brook Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This meant the provider is 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and the local Healthwatch service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This

is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We completed a tour of the building and carried out observations in communal areas. We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with members of staff including the manager, deputy manager, administrator, three members of care staff and the area manager who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care and medication records and six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The expert by experience spoke by telephone with a further eight relatives and two people who lived in the home to gather their feedback about the service. We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Assessing risk, safety monitoring and management

● The provider had systems to assess risks relating to people's health and safety. However, it was not clear from the records reviewed that staff had always completed the necessary tasks to ensure risks to people's health were mitigated. Records showed people had not always been weighed or received pressure relief in line with assessed risks. Nutritional records were incomplete, and it was not evident from one person's care records how staff had acted on advice received from a dietitian.

● The provider had not ensured required safety checks were regularly completed. This included those relating to fire safety and the safety of the environment. In addition, no fire evacuation drills had been carried out in a manner which took into account night-time staffing levels. This meant the provider could not be certain staff would be able to evacuate people safely at night in the event of a fire or other emergency.

The provider had failed to ensure they were mitigating the risks to people's health or to regularly monitor the safety of the environment. This placed people at 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

● The provider had experienced staffing issues as a result of a number of employees recently leaving the service. However, they assured us they were in the process of recruiting new staff, with several due to start as soon as required employment checks had been carried out.

● People living in the home told us they were aware that the service had been short staffed but said this had not had a negative impact on the care they received. Relatives told us there were adequate numbers of staff to meet their relatives' needs. Comments made included, "I believe there's enough and consistent staff to care for (name of family member)" and "There always seem to be enough staff; the phone is answered pretty quickly."

● Staff had generally been safely recruited although the provider needed to ensure that any gaps in a person's employment history were fully explored. The provider had ensured necessary 'right to work checks' had been carried out. However, they needed to ensure staff responsible for recruitment were aware of any time limits on an employee's right to work so they could check the person's documents again before the expiry date.

We recommend the provider reviews their processes to ensure safe recruitment practices are always followed.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living in the home and that staff treated them well. This view was supported by the feedback we received from relatives. Comments made included, "I feel safe, everyone is good to me", "There is genuine caring at every level", "There are loads of safety protocols in place when I pick up (name of family member). The home is always thinking about the safety of their residents" and "After a fall, the home did a full report of all the new things they have put in place; lowered the bed, crash mat and pressure mats to keep (name of person) safe."

● The provider had systems to protect people from the risk of abuse. Staff had completed training in safeguarding adults. They were aware of the signs of abuse and how to report any concerns. They were confident the management team would team would listen to them and take the required action to protect people from the risk of harm. A staff member told us, "People are definitely safe. They are able to speak with staff if they have any concerns. We have a good and open relationship. We check people regularly. We record everything and report anything we don't feel is right."

Using medicines safely

● Medicines were safely managed. The provider had recently introduced a new electronic system to record the administration of medicines. Staff told us this minimised the risk of errors occurring and any missed doses of medication were flagged by the system to the manager of the service.

● Only senior staff were responsible for administering medicines. They had received training for this task and their competence was assessed.

● Records reviewed showed people had received their medicines as prescribed. The provider had a system to ensure protocols were in place for any 'as required medicines'. These helped to ensure people received these medicines when they need and want them. A relative told us, "A couple of times I have visited during medication time. The staff stay with (name of person) until he has swallowed the tablets. They have also rung me to tell me when he has refused to take them."

Preventing and controlling infection

● We were somewhat 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 somewhat assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● We saw a staff member was not asked to complete a form relating to testing and any exposure to COVID-19, although they were moving between Pendle Brook Care Home and another of the provider's care homes.

● Some staff told us they had not completed training in the correct way to put on and take off PPE. We saw one staff member dispose of PPE incorrectly.

We have signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● The provider promoted an open culture in relation to accidents, incidents and complaints. Lessons learned were discussed at management and staff meetings and where necessary new systems implemented. The provider had a system to review all incidents and accidents to ensure appropriate actions were taken and to determine whether there were any trends or patterns.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- The service did not have a registered manager in post. The previous registered manager had left the home in June 2021 and the new manager had only been in post for 10 days at the time of the inspection. They told us they intended to apply to register with CQC.
- Although the provider had a system of audits, these had not been effective in identifying the shortfalls we found during the inspection in relation to care records and checks regarding fire safety and the environment. We have also made a recommendation in relation to recruitment processes.

We found no evidence that people had been harmed. However, the provider had failed to ensure robust systems and process were in place to monitor the service. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us the management team were approachable and always willing to listen.
- The management team understood their responsibility to meet regulatory requirements and had submitted required notifications to CQC. Staff had access to policies and procedures to ensure they understood their roles and responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- People who lived in the home and their relatives were very positive about the quality of care provided in the home. A relative commented, "When I ring up no matter who answers the phone they actually know how my (family member) is, they don't need to go and check."
- Staff told us they enjoyed working in the home and considered people received high quality care which met their individual needs and preferences.
- The service worked in partnership with other professionals and agencies to help ensure people received the care they needed.

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; Continuous learning and improving care

- The provider understood their responsibility in relation to the duty of candour. It was evident in their response to complaints received that they acknowledged and apologised when things had gone wrong.

● The Nominated individual and management team demonstrated a commitment to continuous improvement. The provider had a home improvement plan in place. The area manager undertook regular monitoring visits to the service, updating the home improvement plan as necessary as a result of their findings.

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

● The provider had systems that engaged and involved people, relatives and staff. These included surveys, meetings and regular conversations with people.

● Staff told us they could contribute to the way the service was run. They said they had regular meetings and supervision with senior staff and were able to express any concerns or suggestions which were always listened to.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure they were mitigating the risks to people's health or to regularly monitor the safety of the environment. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance the provider had failed to ensure robust systems and process were in place to monitor the service.