Cedarcare (SE) Ltd

Pelham House Residential Care Home with Dementia

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

Pelham House Residential Care Home with Dementia is a residential care home providing accommodation and personal care to up to 30 people in one adapted building. The service provides support to people with a range of health care needs, such as dementia and diabetes. At the time of our inspection 27 people were using the service

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

Medicines were not always administered or stored safely. The clinical room and enclosed cupboards where medicines were stored were left unlocked and unattended. This meant there was a risk of people consuming medicines that they were not prescribed. There were some risk assessments in place, however risks were not always properly assessed or didn't contain enough information to enable staff to support people appropriately.

Risks to people were not always managed effectively, including people's health needs. These included that people lived with diabetes and used a catheter.

Staff had not always recognised potential safeguarding incidents and lack of management oversight meant these had not been reported to the local authority in line with the providers policy. Some people told us they felt safe. One person said, "I do feel safe. There are enough people that make sure I am. If I needed anything I, would ask".

There were sufficient staff deployed, however, the provider did not knew what staff were being sent from the agency or what skills and experience they had. This meant that there was a risk of staff being deployed to areas of the service without having the necessary skills to support people appropriately.

There was a lack of oversight of the quality and safety of the service by the provider. There were not adequate systems and processes in place to monitor the quality of care or sufficiently robust to identify any shortfalls or concerns. .

People told us positive things about the care they received from staff. One person said, "I think the staff are caring and look after me well. They are all very kind and patient".

People gave feedback about the service using surveys and questionnaires, but people said they hadn't completed them for a while.
People told us that they used their call bells if they needed assistance and these were responded to in a timely fashion.

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 requires improvement (published 6 December 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected

We received concerns in relation to the care people received. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

The inspection was also prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of specific health needs. This inspection also examined those risks.

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pelham House Residential Care Home with Dementia on our website at www.cqc.org.uk.

The overall rating for the service is requires improvement based on the findings of this inspection.

Since the inspection, the local authority has carried out a number of quality assurance visits and to date, report that the provider has engaged with them in addressing the shortfalls that are set out in this report.

You can see what further action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding and good governance. Please see the action we have told the provider to take at the end of this report.

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

This service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Pelham House Residential Care Home with Dementia

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
The inspection was undertaken by three inspectors.

Service and service type
Pelham House Residential Care Home with Dementia 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. Pelham House Residential Care Home with Dementia 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of the inspection there was a registered manager in post. However, they were not present at the inspection.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (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 reviewed information of concern we had received about the service. We used all this information to plan our inspection.

During the inspection
We undertook observations around the service and at different times. For example, we observed people's interactions with staff during activities and during meal times. We spoke with three people and five relatives about their experience of the service. We spoke with the admin manager, the provider, two care staff, and the cook. We also spoke with two visiting healthcare professionals. We reviewed a range of records including four care plans, medication records and two staff files. We looked at various records relating to the management of the service, including policies and procedures.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained 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 had failed to ensure that medicines were managed safely. This was a breach of regulation 12(2)(g) 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

Using medicines safely

- Medicines were not always recorded, stored and managed safely.
- Medicines were not stored safely because staff had left the medicine storage room unlocked and unattended. This was not in line with the provider's medicine policy or best practice guidance. We observed that some people were in the vicinity of the unlocked storage room and there were no staff nearby to ensure medicines were secure.
- We observed a staff member administering people's medicines. Whilst doing so they left the clinical room where medicines are stored, unlocked. Some medicines were left out on the work top and were easily accessible. The staff member told us, "I haven't got the code for the door so I can't lock it." This meant people in the vicinity, could access the medicines in the room, or that medicines could be misappropriated.
- Systems for recording medicines received at the service were not robust. Some medicines, including medicines prescribed for end of life care, had not been recorded in a timely way when they were delivered to the service. This meant there was a potential risk that medicines might not be accounted for and people would not have access to medicines when they needed them.
- Some people were prescribed medicines as required (PRN) and staff checked with people if they would like medicine to relieve pain, for example. At the last inspection PRN protocols were not in place to provide staff with guidance on how and when to give this medicine. At this inspection practice had improved but there remained some medicines that did not have a PRN protocol in place. This meant that staff did not have access to consistent, clear guidance for administering PRN medicines.
- Medicines administered in the morning were carried out by night and day staff. Night staff covered the first floor at 0700hrs and day staff covered the ground floor at 0800hrs. There were no systems in place to ensure effective communication between the two floors. If someone declined their medication during the 0700hrs administration, there was a risk of them not receiving their medicine as day staff may not be aware. For people that required timely medicines this was an additional risk. There was no evidence of this having happened previously but during the inspection one person did not receive their medication until much later than the prescribed timings. There was not a robust system in place to ensure that delayed administration of medicines would be effectively communicated. During the inspection, we were told that this process of medicine administration was to change with immediate effect.

The administration of medicines was not managed safely. This is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;
● Risks to people were not managed consistently. Risks were assessed and plans put in place to help staff support people with specific health needs. However, this practice was inconsistent. One person had a catheter fitted. There was not sufficient guidance for staff to support this person. For example, there was no guidance of what to look for if the catheter was not working as it should be and what signs to look for. Records showed that this person sometimes compromised the catheter by pulling it out. There was no guidance for staff if this happened. Staff recordings around catheter care was not consistent. This meant the provider could not be assured that catheter care was being delivered effectively.
● People's health was not effectively monitored, and staff did not take appropriate steps when people's health deteriorated. Some people were assessed as needing their blood glucose levels monitored to control the effects of diabetes. One person had been admitted to hospital due to unstable blood glucose levels. A staff member told us, "It was off the scale, the GP told us to ring 999." Risk assessments lacked sufficient information about what actions need to be taken if glucose levels were too high or too low. Advice from the GP surgery included that blood glucose levels needed to be monitored daily to ensure they remained within a specified range. This was not included within the care plan and there was inconsistent recording of blood glucose levels. One staff member told us, "Blood monitoring had taken place, but this wasn't recorded." This meant that the provider couldn't be assured that the necessary steps had been taken to ensure people's blood glucose levels were effectively monitored.
● There were no risk assessments in place for people with mental health needs and staff didn't have the guidance to help them de-escalate periods of heightened anxiety. We observed people experiencing higher levels of distress for longer than they needed and other people had a much less enjoyable experience with personal space being compromised as staff dealt with attempts to de-escalate the situations.

Risks were not assessed effectively, and risks practically mitigated to ensure people were kept safe. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong;
● Systems were not consistent in protecting people from abuse and ensuring learning from incidents and accidents.
● Records identified 3 incidents in the last 6 months when people had unexplained bruising and scratches. Staff had recorded these incidents but there had not been appropriate escalation and investigation in line with safeguarding procedures. This meant the provider could not be assured people were protected from abuse or improper treatment. This was fed back to the provider to address immediately .
● Some people who were living with mental health conditions and dementia, could become distressed and anxious. This had a negative impact on their well- being and that of other people living at the service. We observed how a person's distress escalated causing other people living at the service to show signs of becoming distressed and anxious. Staff told us these incidents were not unusual but there was a lack of clarity about strategies to support the person and reduce their anxiety. There were systems in place to record and analyse these incidents, but this was not happening consistently. This meant there had been a failure to support the person's needs and to protect other people from the physical and psychological impact of their distress.
●There was a lack of analysis to identify any patterns, trends or triggers following incidents. Care plans and risk assessments had not always been reviewed following incidents. This meant the provider could not be assured that lessons were learned and appropriate actions had been taken to support staff understanding

and reduce risks of further incidents.

The failure to ensure there were effective systems to protect people from abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received training in safeguarding and staff told us they knew the different types of abuse and what to do if they suspected people had been subjected to them. One person told us, "If I saw something, I would get the person to safe place and tell a senior member of staff straight away."

Staffing and recruitment
●There were not always sufficient suitable staff deployed to meet most people's care and support needs.
● The provider had ensured shifts on the staff rota were covered by using agency staff.
● We were not assured that staff on duty were being deployed appropriately to support people or that they had the skills and experience needed to meet people's needs. Our observations were not all staff were confident in supporting people when they became distressed and anxious. We observed how the atmosphere at the service, especially the lounge area, was at times, chaotic. Staff appeared to be unclear in their approach about how to support people when their level of distress increased. We spoke with the provider about this and they confirmed further training was to be implemented as soon as possible to help staff manage these situations more effectively. Ensuring that staff have appropriate skills, training and knowledge to meet people's needs is an area of practice that needs to improve.

Following the inspection, the provider changed to a new care agency. The provider assured us that regular agency staff are now being used to provide effective, continuity of care. The provider has also made steps to ensure current up to date profiles that are sent by the agency, correspond to the staff that arrive for work. This ensures skills can be appropriately managed and deployed around the service.

●Records relating to staff training, skills and experience were not all clear. This meant the provider could not be assured that staff were deployed effectively to meet people's needs.
● People spoke positively about the staff. One relative told us, "In my view [relative] is cared for extremely well. There are three or four staff members milling around while I am there usually." A person told us, "Staff are generally on hand." Another person said, "Yes there are enough staff, although sometimes at weekends there are less".
● New staff were recruited safely. All necessary checks were completed, including Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
Visits to Pelham House were in line with government guidelines. No restrictions were in place and visits took place during the inspection process.

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)

● 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.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained 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's auditing systems were not effective in identifying shortfalls and driving improvement. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Actions had been taken following the last inspection and some improvements had been made. People's medicines were more organised. However, not enough progress had been made to fully embed and sustain these improvements and the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had an external auditor visit every four weeks. They had identified shortfalls with many areas of the service. Action plans were created but these had not been addressed or completed. For example, risk assessments were highlighted as needing more detailed information for staff to support people more effectively. This was not completed. The provider said, "I was not aware that these plans had not been actioned."
● Shortfalls in practice and records had not been identified through the provider's audit system. For example, audits of care records had not identified where risks were not assessed or that some risk assessments did not have enough information and guidance for staff to able to support staff effectively.
● Governance systems had not identified shortfalls in the safe storage of medicines.
● A lack of management oversight meant incidents of potential safeguarding had not been identified and there had been no analysis to identify patterns and trends that could support improvements in practice.
● The provider did not have systems in place to ensure that agency staff were appropriately skilled to enable effective deployment of staff. The staff rotas did not have names of agency staff members. Therefore, the provider could not identify which staff were working and be assured that appropriate staff were deployed. During the inspection, the provider told us that they will be changing the current agency and ensuring staff are suitably trained before working at the service.
● The provider told us questionnaires were completed by people but not since in June/July 2022. Feedback then was positive about the management of the service and care provided. A relative told us, "We were asked for feedback in the last year but not recently." This meant the provider could not be assured that people's views of the service had remained positive.

Systems were not effective in in assessing, monitoring and improving the quality and safety of the service.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Audits relating to infection prevention and control, fire safety and environmental checks were effective.
● Refurbishment was in progress at the service, some rooms had been freshly decorated. The provider told us that more work is planned and efforts to make the service more dementia friendly is a priority.
● The registered manager was not available at the time of the inspection. The provider had ensured a manager from another service will be overseeing the service and a new manager will be in post by mid-April.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● People received personalised care that met their needs. Care plans contained personal information that included people's likes, dislikes and how they would like to be supported with personal care.
● People were supported by kind and caring staff. One relative said, "The staff know his medical needs and know my father quite well. When I talk to staff they all seem very caring of him." Another said, "My Mum is ravaged by Alzheimer's and it's amazing what they do for her."
●Since the inspection we have received notifications that are required by law to be sent to CQC

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● One relative said they were listened to. "We asked for more information about what Mum was getting up to. Last Summer the registered manager did actually send some WhatsApp and videos of Mum walking around the garden and enjoying herself."
● People's diverse needs were catered for. Information on topics, such as safeguarding and mental capacity, was provided for people in an easy-read format and were seen in file holders in people's bedrooms.
● Staff felt supported by the management team. One staff member said, "I liaise more with the registered manager, If I can't go in for example. I have good relationship with her, I can ask her anything and she is very accommodating."

Working in partnership with others
● The service worked in partnership with a variety of health and social care professionals. District Nurses were at the service on the day of inspection.
● The provider said, "We also receive help from Cuckfied GP and it is great. They come in if anyone is unwell, we email or call them and they come out". We received feedback from health care professionals following the inspection. Whilst they acknowledged the service was responsive and involved the GP regularly with people's care there were some concerns that the service needed to respond quicker when people's health was deteriorating. Health care professionals and the service are working to improve this especially the arrangements to monitor specific health needs.
● Staff worked in partnership with the local authority. One staff member said, "They have recently attended to review people's care to ensure people are being looked after and we don't mind that. It's important."

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 Risks were not assessed effectively. Medicines were not managed and stored appropriately to ensure people were kept safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to ensure there were effective systems to protect people from abuse and improper treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective in in assessing, monitoring and improving the quality and safety of the service.