Four Seasons Homes No.4 Limited

Pellon Care Centre

Inspection report

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Ratings

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

Overall summary

We inspected Pellon Care Centre on 17 February 2015. The visit was unannounced.

Pellon Care Centre is divided up into three units and has a total of 100 places. Pellon Manor has 30 beds and provides residential care for people living with dementia. Birkshall Mews has 35 beds and provides nursing care for people living with dementia. Brackenbed View also has 35 beds and provides nursing care and intermediate care. On the day of inspection, Pellon Manor was following infection control guidance following illness so we had limited access to this unit.

No manager had been registered with the Care Quality Commission (CQC) since December 2014. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been recruited and told us they were in the process of registering for the position.

We saw personalised risk assessments were in place. One person's care plan stated they had been found to be at significant risk of sustaining injury through falls. The initial assessment identified a need for physiotherapy and occupational therapy assessments. The professional

Summary of findings

assessments produced a detailed care plan explaining how the person had to be supported in all moving and handling situations. This showed us health professionals were involved with care planning where appropriate.

Medicines were not always safely managed. Systems were in place to ensure medicines including controlled drugs were stored safely and appropriately. However we found people had their medicines in a mixture of loose boxes and blister packs which could create confusion and increased the risk of errors happening. We also saw some people did not have a photograph attached to their medication documentation. Some people's medicines to be administered as and when required were not always robustly documented.

People told us they enjoyed the food and they could choose what they wanted. We observed a person who was not happy with the choice of food sent up on the food trolley. Further suggestions were made and it was decided the kitchen would make them an omelette and chips. This showed us other options aside from the menu were available.

Staffing levels were not sufficient to protect people from harm. We found communal areas were not adequately supervised and people experienced delays when they requested assistance. People told us staff were very busy and in mornings could be left waiting.

The Care Quality Commission (CQC) monitors the operation of the DoLS (Deprivation of Liberty Safeguards) which applies to care homes. We saw restrictions on people's liberty which could constitute a deprivation of their liberty. The home had referred two people for urgent authorisation for DoLS, both of which expired 29 January 2015. We spoke with the manager and deputy about this. They said they had an understanding of the legal framework in which the home had to operate but agreed no further action had been taken.

We saw care plans indicated some people were using pressure relieving equipment with specified pressure settings for their mattress. We checked their mattresses and saw pressure settings that were different to that stated in their care plans. We asked staff how the pressure settings were calculated and they told us they did not know. We saw another person's care plan indicated a recent drop in weight and they were to be weighed weekly. The staff told us they had not had weighing scales for about three weeks.

We found breaches of regulation 9, 13, 18, 17 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 always safe.

We found medication records were not robustly maintained. Medication policies were not always followed and medication was administered over a long period of time which allowed for inappropriate time gaps between peoples medication and delays in people receiving their medicines.

Staffing levels were insufficient to meet people's needs. Some people told us they had to wait for staff assistance This meant people could not have their needs met in a timely and safe manner.

People had assessments of risk in place. Risk assessments were created from the needs assessment of each person and included information from the person, relatives and professionals.

Is the service effective?

Requires improvement 

The service was not always effective.

Examples of people having been deprived of their liberty were observed. We spoke with the manager and deputy manager who told us two urgent referrals had been authorised but these had since expired. No further referrals had been made. This meant people may be deprived of their liberty unlawfully.

People told us they liked the food and it was hot and plentiful. We saw one person did not like food from the menu and so the chef made an alternative dish. This showed us people had a choice of what they wanted and nutritional needs were met.

Is the service caring?

Good 

The service was caring.

We observed staff knocking on people's doors and speaking to people whilst kneeling down using their preferred name. This showed us people were respected.

People's independence was respected and encouraged. One person said they liked to shave themselves but struggled with some aspects which staff supported them with.

People told us they were able to have visitors whenever they wished. One person said their family came to visit regularly. People were encouraged to maintain family and friend relationships.

Is the service responsive?

Requires improvement 

The service was not always responsive.

Summary of findings

We looked at people's care plans and saw one person had lost weight and their weight was to be monitored weekly. A staff member told us they had been without scales for three weeks. This showed us the home was not responsive to people's needs.

People told us they had chance to speak to staff about concerns or issues in the home. One person said they informed staff it was cold and a heater was brought to them.

Is the service well-led?

Requires improvement

The service was not always well-led.

We found four breaches of regulation which should have been identified and rectified through a robust system of quality assurance. This created a fifth breach. The new manager had an action plan of work to achieve but only some areas were rectified.

People and staff made positive comments about the manager and said they were supportive and dealt with any issues or problems promptly. People told us they were involved in the running of the home through regular meetings for staff, people and family members.

Pellon Care Centre

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

At the last inspection in March 2014, the home was compliant with all the national standards that we looked at.

This inspection took place on 17 February 2015 and was unannounced.

The inspection team consisted of three inspectors, a pharmacist, a mental health specialist and two experts 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. The experts by experience were experts with older people and residential care.

We spoke with 19 people that used the service, three registered nurses, eight care assistants, four senior care assistants, the new manager, two GP's, one community psychiatric nurse, one assistant practitioner, one nurse from the Intermediate Care Team and five relatives. We looked at eight people's care records in detail and other home records which related to the management and auditing of the service such as training records and policies and procedures and meeting minutes.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed all the information held about the provider and spoke with the local authority safeguarding team.

Requires improvement

Is the service safe?

Our findings

People we spoke with felt there were not always enough staff. One person said, "The staff are brilliant but there's really not enough of them. They're running round like scalded cats. It's not right." Another person said, "I think they're could be more staff particularly in the mornings and at mealtimes. I often have to wait for staff to take me to the dining room." This person told us they got up at 7.30am each morning and said they were sometimes asleep when the night staff came in to get them up but the staff woke them. They said, "I know they have to do it otherwise they get behind with their work."

We observed 14 people receiving care. We looked at these people's care plans specifically for information on dependency levels. We found up-to-date dependency ratings for each person. Of the 14 people, ten were described as being in the higher ranges of dependency. Four of these ten people were seen to have increasing levels of dependency over the past four months. Eleven people were identified as needing two care staff to help with getting up in a morning, showering and helping with dressing. The same eleven people required two staff to help with their toileting needs throughout the day. Six people required one-to-one help with eating their meals for part of each mealtime. In addition three people had been identified as needing very close supervision during mealtimes due to food allergies and behaviours that challenged the service. This showed us not enough staff members were available at all times to meet people's needs.

During lunch we witnessed one person asking for help to go to the toilet at 12:25pm. The domestic worker assisting with lunches acknowledged the person's needs by saying, "Just hold on a minute [name] someone will come shortly." At 12:48pm hours the person was in distress and pleading for help with the help arriving at 12:50pm hours. This meant the person had to wait for 25 minutes for assistance despite requesting help from staff twice in that period of time.

We saw one care assistant waiting for another staff member to help them transfer a person in the hoist. There were four care staff on duty. However, the care assistant told us one of the care staff was serving breakfasts in the dining room and the other two care staff were working together as one of them was new and it was their second day of induction. The care assistant told us there was only so much they could do on their own as most people needed two staff to transfer. We saw staff having their lunch breaks at 3pm and staff told us this was not unusual.

We spoke with twelve members of staff. They told us there were times when there was not enough staff. They said there had been occasions when there were only two care staff on duty on one floor and sometimes only one nurse between the two floors. One staff member said, "It doesn't happen all the time. We can have a few weeks when everyone turns in and then weeks when we're short. They try to bring in other staff when it happens."

We found that the service did not have sufficient levels of staff to keep people safe. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed three people being given their medication covertly. This meant their medicine was hidden in their food or drink because otherwise the person would not take it. We looked at the Medication Administration Records (MAR) for these three people and saw no one had a description of how their medication should be administered. For example no person's MAR indicated if tablets should be crushed or not. No MAR stated where tablets should be hidden e.g. in food or dissolved in drink. This meant people could have received their medication in a form not compliant with the pharmaceutical company's guidance.

We saw 'when required' medication was not always fully recorded. For example, we looked at the MAR for one person and saw Diazepam prescribed as '1 or 2 tablets when required three times a day.' This had been recorded as administered but no description of how many or why it was administered.

On one floor we saw no photographs of people in the MAR folder. The Medicines Policy was attached to the wall in the treatment room and stated "On admission, obtain consent to take photograph of client for the purpose of identification". This meant nurses did not have a visual reminder of who required which medicines increasing chances for error.

We found Opti-Pro injection site wipes and Isopropyl alcohol wipes were out of date from 27 July 2014. People's

Requires improvement

Is the service safe?

medicines were delivered with a mixture of loose boxes, medisure compliance packs and blister packs. This made administering and checking medication more confusing and less time efficient. For example, we observed one nurse started administering medication at 8:40am and completed the medication round by 10:30am. This meant some people who required their medicines at 8:00am had them two and half hours later. Some of these people required secondary medicines at 01:00pm, potentially leaving a two and a half hour gap between medicines. This gap of time between medicines being administered was insufficient.

We found that the service had not protected people against the risks associated with administering medication. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff confirmed they had received safeguarding training and were able to describe signs which may indicate abuse was occurring. Pellon Care used a computerised system to track and analyse training records. We randomly selected ten staff and saw all had completed safeguarding training in the previous twelve months. Staff knew the reporting systems and were confident any concerns raised would be dealt with. Staff also knew the whistleblowing policy and assured us they would make use of whistleblowing if necessary. They told us they knew how to contact the local authority Adult Protection Unit and the Care Quality Commission (CQC) if they had any concerns, making reference to guidance notices in the main office.

We saw policies and procedures in place for safeguarding. The policies included the different stages of the process, how to raise a concern, types of abuse and contact numbers. This showed us staff were aware how to act in an appropriate way when confronted with someone being put at risk.

We checked people were assessed for risk and measures were put into place to minimise risk where possible. We saw personalised risk assessments were in place. In one care plan we saw the person had been found to be at significant risk of sustaining injury through falls. The initial assessment identified a need for physiotherapy and occupational therapy assessment. The professional assessments produced a detailed care plan explaining how the person had to be supported in all moving and handling situations. Following a three month review of care needs carried out by the staff of the home, a further professional assessment was requested which produced a refined care plan. This demonstrated the provider was identifying potential risks at the point of admission to the home and taking appropriate action to minimise risks to vulnerable people.

We completed a tour of the premises as part of our inspection. We inspected nine people's bedrooms, bath and shower rooms and various communal living spaces.

We took the temperature of water from taps in areas where people who used the service had access. We found the water temperatures were within an acceptable range. All showers had valves fitted to prevent water above 44 degrees Celsius being released. We saw records of water temperatures were taken prior to people taking a shower. All radiators in the home were covered to protect vulnerable people from the risk of injury.

We looked at five staff files and saw the home operated a robust recruitment procedure. Files contained photographic identification, application forms, at least two references including one from previous employers and Disclosure and Barring Service (DBS) checks. Although DBS checks had been completed, we identified two staff members with previous convictions/cautions but no risk assessment in place to protect the people that used the service. Nurses employed by Pellon Care Centre maintained their professional registrations with the Nursing and Midwifery Council (NMC).

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told that no people were subject to DoLS. The manager told us two urgent referrals had been sent and authorised. We looked at these two referrals and found both had expired on 29 January 2015. No further applications had been referred. We asked the manager and the deputy why no further applications had been referred. They told us DoLS referrals were discussed in a recent head of department meeting but no further action had been taken. They also told us they had spoken with the DoLS team who asked them to send two referrals per week but this had not happened.

We looked at one person's file who had been diagnosed with dementia and who demonstrated a lack of capacity. We saw that a mental capacity assessment had been completed prior to an agreement to administer medicines covertly. The assessment showed this person had a lack of capacity.

We observed staff members made use of a number of methods which constituted a deprivation of liberty. The front door to each unit was locked and internal doors to access each of the upper floors were locked. One person had a sensitivity mat in their room to alert night staff if the person was leaving their bed. This person also had six hours of daytime care provided on a one-to-one basis. We witnessed this person being subject to unauthorised restraint during the lunch time period with the use of a table blocking them in their chair. This showed us the provider was exercising complete control through accumulations of restrictions over this person's care and movements. DoLS had not been applied for this person.

We found that service users had been deprived of their liberty without lawful authority. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed one person in a lounge that was in their own personalised chair that could be tipped backwards. We looked at the person's care plan to find health needs assessments had taken place which identified the need for the person to be observed in this position. The assessment had been carried out by an occupational therapist. Therefore whilst the chairs restricted people's movements they were not being used for the purpose of restraint.

We spoke with a registered nurse who was in charge of one of the units. The nurse told us it was their first day at Pellon Care Centre and they were from an agency. The nurse told us of the detailed handover they had received from the night nurse. We saw the night nurse had written a detailed handover which highlighted key areas for the agency nurse to be aware of. We were also told the night nurse had remained on duty until they were confident the agency nurse had all the information they needed to carry out their duties.

We saw three care plans which recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

People we spoke with said the food was good and there was a choice. One person told us their appetite had been poor but said staff had encouraged them. They described how staff had brought in a plate with an egg on toast to tempt them to eat something. They said, "It smelt so lovely I decided to have some and it was delicious." We met with another person in the afternoon who told us they were hungry, we mentioned this to staff and they brought a tray of food and sat chatting with the person while they helped them with the food. Another person told us they enjoyed the food but said there was not as much variety as when they had been in the home previously. On another unit at lunch time we observed a person who was not happy with the choice of food sent up on the food trolley. Further suggestions were made and it was decided the kitchen would make them an omelette and chips.

Nutritional risk assessments had been completed for all people which identified if the person was at risk of dehydration or malnutrition. This assessment showed us the level of support they required for eating and drinking. To protect people from the risks of receiving malnutrition

and poor fluid intake, staff were required to record and monitor people's daily intake. Daily records told us this took place. A further requirement was to record the person's weight and body mass index (BMI). We saw regular records of people's BMI and weight. This showed us staff followed the care plans.

Records showed arrangements were in place that made sure people's health and social welfare was protected. We saw evidence that staff had worked with various agencies and made sure that people accessed other services in cases of emergency, or when people's needs had changed. This included GPs, hospital consultants, community mental health nurses, specialist nurses in the fields of tissue viability and epilepsy, speech and language therapists and dentists. For example, one person told us a home visit had been arranged with the occupational therapist (OT) so they could assess if they were ready to go home. Another person told us how staff were working with them to build up their strength so they could eventually start walking with a stick again instead of a walking frame. We saw the physiotherapist working with another person who was practising going up and down steps.

On the day of our inspection we saw one person showing signs of distress. The person was at risk of physical harm to themselves and posed a risk to other people. We saw the senior care worker taking action to get professional help for the person. They contacted health care professionals that supported the person to access a suitable environment for their required needs. Our observation showed us the provider was providing staff with the necessary skills and knowledge to effectively care for people by making timely referrals to other health-related services

We spoke with the senior care workers about formal supervisions and appraisals for staff. They told us each member of staff was expected to have one-to-one supervision at least once every three months. Other care staff we spoke with confirmed this to be the case. Staff also told us that focused supervisions took place following a specific incident, support or when a one-to-one meeting was required. Staff also told us appraisals were less common and were not being conducted yearly. The senior care worker we spoke with confirmed appraisals were currently not conducted for most of the staff on a yearly basis.

We looked at the training staff had completed. The service had a training matrix which indicated that nearly all staff had completed mandatory training. The service used a computerised system which alerted management when staff required a refresher course. We randomly selected ten staff member training files. This showed us the training matrix was up to date and people had received their certificates. New staff completed an induction checklist including training before they shadowed another member of staff. Once the induction checklist had been completed, new staff could lone work.

Good

Is the service caring?

Our findings

People were unanimous in their praise of the staff. One person said, "Nothing's too much trouble. All of them are brilliant." Another person said, "Staff are very good and kind." A further person said, "I have to say the staff have been absolutely brilliant, I would have taken myself home if they weren't." Another person told us how they had been encouraged to personalise their room. They said, "There is nothing nicer than having your own bits and pieces around. We were told to make my room as much like home as possible. It's all part of the care – if you feel good about where you live you feel better."

We saw people at the home were at ease and relaxed in their environment. We saw people responded positively to staff with smiles when they spoke with them. We observed staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. People were comfortable, well dressed and clean which demonstrated staff took time to assist people with their personal care needs.

We spoke with two members of care staff to gain an understanding of their knowledge of people's care needs. Answers to our questions showed they had a good understanding of people's needs and knew of the best approaches to ensure meaningful care was delivered.

We reviewed care plans which demonstrated the service ensured that close family members were engaged in the care planning and review process. Whilst we found no people were without the support of family members, senior care staff were aware of their responsibilities to provide advocacy in those circumstances.

Two people told us about involvement in decisions about their care. One person said, "I had a review recently. We talked about my medication and care – I know what I need and was involved." Another person told us, "We had a discussion, me the staff and my partner. We established my needs and balanced my independence and support well." We asked other people whether they felt that they would be able to see any care plans or other records referring to them. One person told us, "There's nothing here to impede my access to my care plan."

During our inspection we observed staff knocking on people's doors before entering, this was done even when doors were open. Within care plans we found directions for staff which related to people's privacy and dignity. For example, we saw where people had made a specific request to be cared for by female staff only. This meant the service had ensured people's privacy and dignity was respected by staff. We saw people's bedrooms were personalised with items of individual importance, such as photographs, ornaments and pictures. We saw staff used people's names when interacting with them, however there was also an equal usage of, "Love" rather than a name when addressing people. Interactions were task based but were warm and genuine. In another unit we heard staff speaking with each other and referring to a person by room number rather than name. One member of staff asked a colleague "Any idea how 34 transfers?" This showed us staff did not always respect people or their dignity.

Two people told us about how their independence was supported. One person said, "I'm going to have a shave later – they bring me a bowl of warm water so I can sit here (their room) and do it. They'll leave me to it unless I ask them for help, that's how it goes." Another said, "They won't just jump in and do something, they ask if I need help first. If I do I get it, if I don't I don't."

People told us they were able to have visitors whenever they wished, and were not aware of any restrictions. We spoke with one visitor who told us, "I come at lunchtime and another relative comes at tea time. We like to sit with our relative whilst they eat." One person said, "You can have as many visitors as you like, whenever you like." We saw quiet lounges that visitors could use on each of the units.

Requires improvement

Is the service responsive?

Our findings

We looked at the care records for eight people. Some people were receiving intermediate care and others lived at the service. For one person who lived on one unit permanently, we found their care plan was detailed but out of date and it was difficult to ascertain the person's current needs. For example, the care plan for mobility was dated November 2013 and recorded how the person transferred with two staff and a frame. Yet an evaluation in January 2015 showed the person was now nursed in bed.

We saw two people's care records referred to pressure reliving equipment they were using and specified the settings for the mattresses and cushions. However, when we checked for one person the setting was higher than stated in their care plan. We asked the nurse and senior care staff how the pressure settings were calculated as we noted that one person had a low weight and yet the mattress setting was high. The staff we asked said they did not know.

Staff told us there had been no weighing scales on the Brakenbed View unit for approximately three weeks as they were broken, which meant people could not be weighed. We saw one person's records dated 2 January 2015 stated they had lost 2.6kgs in the previous month and to weigh weekly. The last weight recorded in their care plan was 30 November 2014.

Staff told us there were not enough chairs for people in the lounges and not all rooms had a chair for visitors. We found this when we went to speak with people in their rooms. We found there was limited storage space for equipment on the unit and saw wheelchairs and mattress being stored in the corridors upstairs.

We found that the service equipment was not always properly used or properly maintained. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had pre-admission assessments completed. People's care plans were created from the pre-admission assessment. The pre-admission assessment covered such areas as mobility, continence, eyesight, hearing, memory, feeding ability and a falls history. The pre-admission assessment also recorded people's diagnosis and a list of all current prescribed medicines. The care plan focussed on the need to maintain a safe environment and promote personal independence and dignity.

On one unit we looked at two care plans. They were person-centred including people's wishes in relation to how their care was provided. The care plans identified how people liked to spend their time and how they liked to be supported. The plans also showed what people or relatives told staff about circumstances which could provoke anxiety. We saw that a life history had been gained from the people or their relatives. Staff we spoke with had a good knowledge of people's past lives.

We looked at care records for two people on another unit who were receiving intermediate care. We saw detailed assessment information provided by the crisis intervention team (CIT) and separate therapy assessments. Staff told us the care plans were generated by CIT and then personalised according to individual need which we saw in the records we reviewed. We saw in each person's room there was information displayed which gave a summary of the support they required. For example, staff and equipment needed to transfer safely.

We asked people about activities in the home. In one unit four people were able to tell us about activities that they had been able to join in with. One person said, "We had an entertainer on Valentine's Day, he was excellent. We had a party with a glass of wine and special chocolates." Another person told us, "Sometimes we make things; we made cards for Christmas and Valentine's Day." Other people were less able to give examples of ways in which the staff helped them to pass their time. One person told us, "I watch television." Another said, "They've done nothing. I just sit in my room and watch television or read."

We spoke with a person visiting their relative and they told us they did not feel that there was a meaningful programme of activities. They said, "If the television isn't on the lounge is often left in silence. There's a stereo in there but I've never seen it switched on." On another unit after we had been there approximately 40 minutes a staff member arrived and asked if people would like to play snakes and ladders. We saw they enjoyed this game and were laughing with the staff member. One person we spoke with said, "There's not a right lot going on. We had a singer last week which was lovely."

Requires improvement

Is the service responsive?

We did not see any activities taking place on Birkshall Mew's unit during our visit. We saw a member of staff playing dominoes with two people in another unit. The same member of staff spent some time in the lounge of that unit speaking one to one with a small group of people and encouraging singing and reminiscence.

We asked people if they had ever raised a concern and how this had been handled by the staff. Five people told us they had informed staff that they found the home cold at times. One person said, "My room was very drafty. They came and had a look and said the window was fine, but I showed them how the curtain was moving. They came and sealed up the window." Three people told us that when they had said that they found their rooms cold a portable heater had been provided for them, and we saw heaters being used in people's rooms. We asked one person why they had this in their room they told us, "It is terrible, my room is cold. I've the heater to make it warmer." We asked if these people felt that the home had taken action which had fully addressed their concerns. One person said, "It can be cold in here sometimes. They told me it's as warm as it can be." One visitor told us, "It can get cold – I sometimes think that they switch the heating off." We asked the staff what happened when people said it was cold. Staff told us they bring additional clothing or portable heaters.

Another person told us about an experience of change being made when it was requested. They said, "When I arrived the bed had a mattress with an air pump, it wasn't comfortable and the noise kept me awake. I put up with it for a week then I said something. The bed was changed straight away."

We saw the home had a complaints policy in place that all staff could access and a complaints file. We saw the home had one recent complaint. There was evidence that the complaint was investigated and responded to with an outcome that could resolve further issues. The manager told us they remained in close communication with the complainant to ensure further issues could be dealt with in a timely fashion.

Requires improvement

Is the service well-led?

Our findings

The home did not have a registered manager in place. The last registered manager deregistered in December 2014. The new manager was present during our inspection and told us they were in the process of registering with the Care Quality Commission (CQC).

We found medication audits had not identified the inconsistency between the three different units in taking photos of the people in the home. People had their medicines mixed between loose boxes and dosset boxes from the pharmacy. When people had 'as required' medication this was not recorded appropriately. We also found evidence of staffing levels not being sufficient to match the needs of the people being supported. This was not identified in audits or surveys being conducted by the provider. The manager told us that despite a recent managers' meeting that discussed DoLS referrals and contact with the DoLS team, no effort had been made to meet people's referral needs. We found a number of breaches of regulation that should have been identified and rectified in a robust quality assurance system.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with two people who were able to tell us about the manager. One person said, "The manager is new but she seems quite nice." Another person said, "I know there's a new manager but I've not seen them." We asked people whether they thought the staff were happy and well-managed. Most people we spoke with agreed that staff appeared happy. One person told us, "I think they're well-motivated – I've never heard them complaining about being here." We asked people what they would do to improve the experience of being in the home. Most people said that they were happy with things as they were. Some people felt that the home was often cold. We spoke with one visitor who told us they would make the home warmer in places. They also told us that they had received a survey but not completed it. They said, "I found it very long-winded. I think the questions were phrased to guide the answers rather than capture responses."

The home had a 'quality monitoring file'. This showed a weekly monitoring visit took place and a report was created. The manager told us this report created an action plan so any issues could be resolved. For example, we saw on the audit report from 23 January 2015 and 26 January 2015 that some staff had not been wearing the correct uniform. We saw supervision notes from one member of staff where the senior staff reinforced the uniform policy and meeting minutes from a staff meeting on 6 February where all staff were reminded about the uniform policy. The manager told us they received allegations about issues during the night. The manager completed night time spot checks to help resolve any issues.

The manager had completed a range of audits of the service. Each audit would look at a different area once a month. These were to ensure different aspects of the service were meeting the required standards. The audits covered a number of areas such as the dining experience, care plans and people's experiences. We saw two completed audits for 2015. The most recent audit completed in February 2015 focused on people's dining experience. The majority of comments were positive about the food and overall experience. We also looked at the 'Home visit report' completed by someone not employed by Pellon Care Centre. This audit was completed on 5 January 2015. This report identified a stained chair in one unit and care plans were looked at. The manager told us a copy of this report was e-mailed to themselves to identify any downfalls. The manager showed us evidence of information being passed out to nurses to address any issues. Unit managers completed daily checks of medication.

Pellon Care Centre provided four opportunities throughout the year for relatives to attend a meeting to offer their opinion/thoughts on general issues. We saw dates for the relatives meeting in February 2015 with one date for each of the units to keep the meeting more personal and effective. We also saw evidence of full staff meetings planned in four times a year, senior meetings four times a year and health and safety meetings planned in four times a year. We looked at notes from a seniors meeting for one unit held on 5 February 2015 where staff asked if more fire drills could be completed to improve quality and another unit's meeting held on 5 February 2015 where staff added general comments to 'Any Other Business' part of the meeting.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The service had not taken steps to safeguard the health, safety and welfare of service users at all times by ensuring there were sufficient numbers of suitably qualified, skilled and experience staff on duty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were not protected from the risks of being deprived of their liberty because appropriate paperwork had not been completed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service had not protected service users against the risks associated with the unsafe use and management of medicines because the provider was not following appropriate arrangements for the recording and administering of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Service users were not protected against the risks of unsafe care as the delivery of care did not always meet people's individual needs.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Robust quality assurance systems were not in place and did not identify breaches of regulation.**