S & M Care Homes Ltd

Pink Panther Care Home

Inspection report

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Ratings

Overall rating for this service

Is the service safe?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

At the last inspection on 20 and 21 January 2015, we had concerns about assessing and planning care and monitoring the quality of the service. We issued compliance actions for these concerns. Each key question was rated 'Requires Improvement' and the overall rating for the registered provider was 'Requires Improvement'.

We undertook this unannounced inspection at 6am on the 23 July 2015 to follow up what actions the registered provider had taken, and what improvements they had made in response to the concerns identified at the previous inspection in January 2015. The inspection was completed with representatives from the local authority safeguarding team; they had received anonymous information that staff started to get people who used the service up too early, at 4am. In line with our new methodology, we do not change the overall rating when the follow up inspection is not completed within six months of the previous inspection. However, the ratings within the key questions assessed have been changed; SAFE, RESPONSIVE and WELL-LED have been changed from 'Requires Improvement' to 'Inadequate.'

Pink Panther Care Home is registered to provide accommodation and personal care for up to 21 older people, some of whom may be living with dementia. However, due to the configuration of shared and single occupancy bedrooms, the service actually has capacity to accommodate 20 people. The service is located in a residential area not far from the centre of Hull. Bedrooms are located on the ground, first and second floors with lift

Summary of findings

access to each floor. There is one sitting room and a dining room which leads into an additional quiet seating area. There are toilets and bathrooms on each floor, although the main bathroom used is on the ground floor.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission [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.

We found the registered provider was in breach of eight regulations of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. These were in relation to person-centred care, safe care, safeguarding people from abuse, staffing levels, obtaining consent and working within the requirements of the Mental Capacity Act 2005 [MCA], fitness of the director and fitness of the registered manager and assessing and monitoring the quality of service provision. We also found two breaches of Regulations 16 and 18 of the Care Quality Commission [Registration] Regulations 2009 for non-notification of the deaths of three people who used the service and of serious incidents that occurred in the service. The majority of these breaches were assessed by CQC as high, as the seriousness of the concerns placed a risk of significant harm on the lives, health or well-being of the people living in the home.

We found risk to people such as falls, skin tears, the use of bedrails and the use of a gate to restrict one person's movement had not been assessed or managed properly. Measures had not been put in place to minimise risks and incidents and accidents had not been recorded and analysed to help find ways to reduce them. Professional advice had not been obtained from the falls team and the fire safety officer.

We found people had not been protected from the risk of organisational abuse; staff assisted people to get up as early as 4am when they woke up instead of supporting them with the immediate care they required and helping them to settle back into bed. The local authority safeguarding team has substantiated an allegation of organisational abuse. During the writing of the report the local authority safeguarding team received another allegation of abuse unconnected to this issue. This is being investigated and will be reported on once concluded.

We found one person who used the service was subject to a restrictive practice which had not been identified or managed in line with the MCA and the Deprivation of Liberty Safeguards [DoLS.]

We found some people had not received their medicines as prescribed. This related to pain relief patches for one person, eye gel for another person and 'when required' medicines to relieve distress and anxiety for two other people. This could potentially affect their health and well-being.

Staff had not provided people with person-centred care that met their needs. Care plans contained some preferences for care but did not describe people's needs properly so staff did not have clear guidance in how to manage them. Some people had behaviours that could be challenging to others; these were not assessed and planned properly.

Some people had not received health professional advice and treatment in a timely way and their changing health care needs were not known and understood by the registered manager. People were at risk of harm because the service failed to respond promptly and appropriately to new care needs.

We found serious concerns with how the service was managed overall by the registered manager and how well it was governed by the registered provider. There was no effective system in place to monitor the quality of the service people received. There were no records of how the registered manager was supported in their role. There were no records of how the registered provider monitored the registered manager's practice to ensure they had the competence, skills and experience to manage the service.

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?

Inadequate

The service was not safe.

People who used the service had not been protected from organisational abuse. The local authority safeguarding team substantiated an allegation of organisational abuse during their visit to the service at the time of the inspection.

Risk had not been managed effectively which had affected the safety, health and welfare of people and could have contributed to accidents and injuries.

People did not receive their medicines as prescribed. The recording of medicines was poor.

There were times when there were insufficient staff on duty to meet people's assessed needs.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person-centred care that met their preferences and wishes. There were insufficient activities and stimulation for people living with dementia.

People's needs had not been effectively assessed and plans of care had not been formulated to provide full guidance in how to meet them. Decisions made in people's best interests had not been carried out in line with legislation and good practice.

Staff had not been fully responsive to changes in people's needs and health care issues.

Is the service well-led?

Inadequate

The service was not well-led.

There were no effective systems or processes to ensure the service provided was safe, effective, caring, responsive or well led.

The staff team and the registered manager lacked appropriate guidance and oversight to ensure people received safe and appropriate care.

Shortfalls in recording of people's care and communication of changes in their needs meant people's care needs were not always met.

Notifications had not been made to the Care Quality Commission for all incidents which affected people's health and wellbeing.

Pink Panther Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to follow up compliance actions issued due to concerns found at the last inspection on 20 and 21 January 2015.

This unannounced follow up inspection took place on 23 July 2015 and was carried out by one adult social care inspector. It started at 6am and two representatives from the local authority safeguarding team accompanied us. They were investigating a safeguarding alert.

Prior to the inspection we checked our systems for notifications that were sent from the service. The notifications help us to see how the service manages incidents that affect the health and welfare of people.

During the inspection we spoke with the registered providers and registered manager, We also spoke with five people who used the service and one of their relatives and four members of staff.

We looked at the care records of six people who used the service including any accidents and incidents, risk assessments, care plans and visits by health professionals. We looked at all 19 people's medication administration records.

We also looked at a selection of records used in the management of the service. These included staff rotas, shift handovers, memos and notices, quality assurance audit checks and minutes of residents meetings.

Inadequate

Is the service safe?

Our findings

During the inspection, two people we spoke with said they would have preferred to have been offered a cup of tea and returned to bed until a more reasonable time; they were not aware of the time or that it was so early in the morning. One person was asleep in the lounge, slumped forward in their chair. One person told us they got up early as it was their choice to do so.

We had not intended to inspect this key question in the follow up inspection but we found people had not been protected from the risk of organisational abuse; we have a duty to report on what we find. The local safeguarding team responded to an allegation that people were assisted to get up between 4-6am. When we arrived at the service at 6am, we found eight of the 19 people who used the service were up and at various stages of having their breakfast. There were two members of staff on duty. Staff told us one person had woken up at 3am and they assisted them to get up and come downstairs. We asked staff whether they checked if people wanted to have a cup of tea following personal care and return to bed when they awoke in the middle of the night or early in the morning. Staff said they would not have time to do this and there were times when it was easier to keep an eye on people when they were up and dressed.

We looked at care plans and found these detailed a preference for rising and retiring for each person. However, the plans were rigid and did not provide clear guidance for staff. For example, one person's care file stated, "Some days I wake up at 5am and I like to get up, then I will need assistance from one member of staff" and "If I am wet anytime from 5am then I would like to be up and washed and dressed." The guidance did not prompt staff to remind people it was still very early, offer them refreshments following attendance to their personal care needs and ask them if they wanted to go back to bed until later in the morning. We also saw in two other people's care files their time preferences for rising had not been adhered to by staff. One care file preference stated, "Anytime from 6.30am" but the daily notes for the day of inspection stated, "Up at 3am due to him getting out of bed". The second person's preference stated, "I like to get up at 7am" However, we saw this person was up and dressed when we arrived at 6am.

The local authority safeguarding team has substantiated the allegation of organisational abuse. During the writing of the report the local authority safeguarding team received another allegation of abuse. This is being investigated and will be reported on once concluded.

We found an incident record in one person's care file that stated another person who used the service had hit them. This had not been logged or discussed with the local authority safeguarding team to check whether they required an alert to be sent. There was no record of the incident in the safeguarding risk matrix folder. The Care Quality Commission had not been made aware of this incident.

Not protecting people from organisational abuse a breach of Regulation 13 [1] [2] [3] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The service did not have adequate arrangements in place to protect people from harm or abuse. We are considering our regulatory response and will report on it in due course.

We found some people had experienced injuries and skin tears due to a failure to manage risk effectively. Risk assessments had not been completed accurately which gave an underscore of actual risk, they had not been updated following accidents and had not been analysed in order to prevent reoccurrence. We found people had not been referred to a professional regarding the risk of falls and in these instances their health care needs had been neglected. The documentation used for falls risk assessments stated, "More than three falls you will need to contact the falls team." We found one person had no risk assessment for the use of bedrails; three incidents had occurred when they had tried to exit the bed whilst the rails were still in place. One of these incidents resulted in the person sustaining a skin tear.

We saw each person had a care plan titled, 'personal safety and risk' but these did not include the risks they had. For example, one person had sustained falls, skin tears, climbed over bedrails and pulled furniture over in their bedroom but their 'personal safety and risk' care plan had no record of these risks.

During a check of the environment, we found a hot water outlet in a communal toilet had very hot water. This could potentially scald people with fragile skin. We also found a large hole in the plaster of one person's bedroom. The hole

was near the electric socket and power box and electrical wires were exposed with a potential risk of electrocution. These two points were mentioned to the registered provider to address straight away.

We found a 'safety gate' had been installed in the door way of one person's bedroom. This had been fitted to the door frame in such a way as to prevent the door from closing. As the door was a fire door, and must be closed at night and not wedged open, this posed a fire risk to the occupant of the bedroom and the rest of the people who used the service. There was also an intumescent seal missing from the door surround. These points were mentioned to the local fire safety officer in order for them to check out.

We observed staff move and assist one person and was unsure if this technique was safe or met their needs. Staff told us the person was able to weight bear and it was safe to use a moving belt and turntable with them. We asked a moving and handling assessor to check the moving and handling skills of staff. Following the inspection we received a report from them stating staff required more in depth moving and handling training. The registered provider told us they would arrange this quickly.

Not providing safe care and treatment to people, assessing risk and doing all that is possible to mitigate risk is a breach of Regulation 12 [1] [2] [a] [b] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The service did not have adequate arrangements in place to protect people from harm. We are considering our regulatory response and will report on it in due course.

We found people had not received medicines as prescribed. One person had not received a controlled drug in the form of pain relief patches at the correct intervals since May 2015. They should have been applied every 72 hours but instead had been applied every 96 hours. Two people were prescribed medicines to be taken 'when required' [PRN] twice a day to calm their anxieties. We found these had been given regularly on a daily basis and for one of the people, twice daily. We checked documentation for both people but any incidents of anxiety that had occurred did not correspond with the administration of the PRN medicines. For example, one person had not had any anxiety incidents since 17 June 2015 but they still received the medicine twice daily. Staff had not contacted the person's GP for advice and guidance. We checked the medication administration record [MAR] in current use for the second person; from 13 July 2015 until the date of inspection which was 23 July 2015, they had received PRN medicine every morning yet two anxiety incidents had occurred in the evening.

We found the registered manager had not obtained a specific cream for one person, prescribed several days prior to the inspection, and had to be prompted by the inspector. We found one person had not received medication to help them sleep for four nights as the service had run out of stock. One person was prescribed an eye gel up to six times a day but staff had been applying this twice a day at set times. There was no record to explain why the person had not received the eye gel at other times. We have contacted a local NHS medicines team who are to visit the service and provide support to the registered manager and staff in order to ensure the safe management of medicines.

We also found serious errors in recording medicines. The registered manager told us they had indicated on the MAR the days when one person's controlled drugs pain relief patch was required. Staff had followed this without question, despite the error in calculation of hours between intervals of application. One person's MARs were completely out of sync with the days of the month and were very difficult to follow; the MAR should have ended on 12 July 2015 and a new one commenced on 13 July 2015 but the old one was still in use with the wrong dates at the top. When the registered manager hand wrote instructions on temporary MARs they did not include full instructions and there was no counter signature used as good practice to prevent mistakes being made. Not all medicines had been signed as received into the service or carried forward to the next MAR when received the previous month. Staff did not always identify how many tablets had been given when people were prescribed a variable dose such as 'one or two'. There were gaps on some people's MARs with no explanation why the medicine was omitted. Some people were prescribed creams but there were no body maps completed to guide staff as to when and where this should be applied.

Not ensuring the proper and safe management of medicines so that people received them as prescribed is a breach of Regulation 12 [1] [2] [g] of the Health and Social

Inadequate

Is the service safe?

Care Act 2008 [Regulated Activities] Regulations 2014. The service did not have adequate arrangements in place for the safe management of medicines. We are considering our regulatory response and will report on it in due course.

We looked at care staffing rotas and found there was a gap in staffing numbers that occurred at weekends. For example, between 2-4pm most weekends there were only two members of care staff on duty during these times. There was a cook on duty 10am to 1.30 or 2pm six days a week and the registered manager prepared the main meal on one day a week. There was no catering staff for the evening meal and no domestic or laundry staff at weekends; care staff completed these tasks during this time. As some people were at risk of falls and required assistance with mobilising, this amount of staff was insufficient to meet people's needs. We had found this when we inspected in January 2015 and the registered provider rectified the staffing issue on the day. However, the problem has reoccurred and needs to be addressed straight away. Night care workers told us they did not have time to offer people a cup of tea and support them to sit and drink it before assisting them back to bed when they woke in the early hours of the morning. This could mean there is potentially insufficient staff available at night to meet the needs of people who use the service and this will have to be reviewed. There was also a gap of between 1-3 hours each day when the registered manager was on annual leave. Usually they worked 8am to 5pm and so were available to plug any care gap Monday to Friday. However, when they completed care tasks, this may not leave them sufficient management hours.

Not ensuring sufficient numbers of qualified, competent, skilled and experienced staff were deployed is a breach of Regulation 18 [1] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The service did not have sufficient numbers of staff on duty at all times. We are considering our regulatory response and will report on it in due course.

Inadequate

Is the service responsive?

Our findings

During the inspection, one person spoken with told us they were happy in the home. They said they were able to please themselves about the time of rising and retiring. They also said they preferred to stay in the quiet lounge and read. They said they liked to go to their bedroom after tea to watch their own television. They said they knew how to complain and would speak to the registered manager if necessary.

At the last inspection on 20 and 21 January 2015, we issued a compliance action as we had concerns that not everyone who used the service had their needs assessed and delivery of care planned. The registered provider sent us an action plan regarding the measures they would take to address this concern.

Since the last inspection, people admitted to the service had an assessment completed of their needs. The care plans we looked at had all been reviewed since the last inspection and there had been an attempt to make the information included in them more person-centred. For example, each person had information about their life history and a personal profile which indicated what was important to them and how staff could support them. There was also a daily routine page for the morning, afternoon and evening and what would be a good or bad day for the person. Information in some care files was detailed, for example one person had clear information about the signs and symptoms of hypoglycaemia [low blood sugar levels]. However, information was basic in other care files. For example, one person's good day was stated as, "For me to be able to walk around the home with a tea towel on my frame" and their bad dad stated, "I don't have a bad day at this moment, I am just happy to be here."

In one person's care file, we looked at assessment documentation and saw this gave basic details about their needs but not how they impacted on them. For example, the assessments for one person stated, "Suffers from water retention, wears incontinence pads." It did not detail what the signs and symptoms were for the water retention, how often this occurred and whether the person had any bowel concerns. We checked the person's care plan titled 'continence' and this confirmed the person 'suffered from water retention' and they wore 'incontinent pads' and staff were to 'assist the person to the toilet regularly day and night'. The care plan for 'personal support' stated, "If I have a urine infection, I tend to want to go more regularly." The information in the assessment and care plans did not provide staff with sufficient clear guidance in how to support the person. There was no information about what signs to look out for that would alert them to 'water retention' and 'urine infections' and what monitoring system was in place or what staff had to do if these health concerns occurred. There was no personalised information about the type of continence aids the person wore, how frequently they were supported to the toilet, how the person was supported with personal hygiene following an episode of incontinence and whether they had any bowel care needs. Staff told us, "We take people regularly to the toilet, five times a day."

We saw one person had not received person-centred care in relation to their mobility, frequent falls, skin tears and behaviour. Their care plan contained minimal information about mobility and no information about how the person mobilised in their bedroom, where most of the falls had taken place. They had not been referred to the falls team for an assessment. They had received 'when required' medicine to calm their anxiety on a regular basis and it was unclear if there was any connection between this and the number of falls they had sustained. There was no care plan to manage their frequent skin tears or for staff to monitor the condition of the person's skin, despite the falls and double incontinence. The person had been provided with an airflow mattress which indicated they were at risk of skin damage despite no recording of this anywhere in the care file. There was some limited information in a care plan titled, 'Mental Health/Challenging Behaviour' regarding how the person could shout out and that staff were to reassure them. However, the care plan did not detail the behaviour recorded in incident records and how staff were to manage this to prevent reoccurrence and injury to the person.

We saw some care plans titled 'dietary requirements/food and drink' did not provide guidance to staff in how to support the person. They provided some preferences and dislikes but not what the person could do for themselves or needed assistance with, for example cutting up food. There was no information about how much fluid staff should encourage people to take.

We saw there were set days indicated on risk assessments and care plans for reviews. This meant staff were not guided in reviewing them in a person-centred way when

needs changed but only at these set dates. The care plans were reviewed every four months and risk assessments every month. Neither was updated and reviewed when people's needs changed. This meant staff did not have up to date guidance in how to support people to maintain their safety.

We saw daily recording of care provided to people focused on tasks such as giving people medicines, meals and personal care. This kind of reporting did not focus staff attention on person-centred care such as how the person experienced their day, whether they enjoyed their meals, how they felt about things, whether they were happy or how their mood affected them.

We saw one person had not received person-centred care in relation to a health care need. A week prior to the inspection, the person had complained to staff they had a 'burning sensation' when they passed urine. There had been no action taken about this. During the inspection, we prompted staff to speak to the person's GP and obtain a urine sample for testing.

We saw people had not received person-centred care in relation to the times of getting up in the morning. They had not been supported to return to bed with refreshments until a more suitable hour for rising. During the inspection we did observe some positive and kind interactions between staff and the people they supported.

We saw two people had not received person-centred care in relation to 'when required' medicines for their anxiety. Both people had received these on a regular basis rather than when needed.

We saw people did not receive person-centred care in relation to the use of products such as toiletries and continence aids. At the last inspection, we spoke to the registered manager about the communal use of toiletries held in bathrooms and used when people bathed, rather than using their own products which were held in bedrooms. We found these toiletries had been moved from the bathroom and placed in a cupboard in the dining room. Staff confirmed they still used them when people bathed. They also confirmed that when continence products were delivered, these were shared out between specific people and some placed in bedrooms and others placed in the same cupboard for communal use. Continence products were prescribed for specific people and were only for their individual use. The registered manager and staff confirmed that they had used continence products on some people who had not been assessed for them. This had affected supplies for other people. This was discussed with the registered manager to address straight away.

We saw there were insufficient activities and stimulation for people living with dementia. Records regarding participation in activities were not up to date. This meant people had either not participated in activities of staff had not recorded them. Care staff completed some activities with people but this could be disjointed as there was no designated activity co-ordinator and they could be called away to assist people.

Not ensuring people's needs are fully assessed and not providing care that is person-centred is a breach of Regulation 9 [1] [2] [3] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The service did not have adequate arrangements in place for assessing people's needs and planning delivery of care in a person-centred way. We are considering our regulatory response and will report on it in due course.

We saw one person had a gate installed in the doorway of their bedroom. There was no record this had been assessed as needed and was not detailed in any plan of care. There was no risk assessment for this and no plan to review whether it should remain in place. The person's care plan stated they could make day to day decisions but would need an assessment to check their capacity and a best interest meeting to discuss important decisions. As the gate effectively restricted the person from entering or leaving their bedroom once in there, this amounted to an important decision. We found the service had not acted within the principles of the Mental Capacity Act 2005; an assessment of capacity had not been completed and a best interest meeting had not been held to discuss options and make decisions in the least restrictive way for the person.

Not working within current mental capacity legislation is a breach of Regulation 11 [1] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The service did not have adequate arrangements in place for assessing capacity and documenting best interest decisions. We are considering our regulatory response and will report on it in due course.

Inadequate

Is the service well-led?

Our findings

Some people we spoke with knew the registered manager by name. We observed one person approach the registered manager for reassurance about their finances. The registered manager told the person their money was held in the safe for security and to reassure them, they took the money out so they could see it.

At the last inspection on 20 and 21 January 2015, we issued a compliance action as we had concerns that the quality of the service delivered to people was not monitored so that improvements could be made. The registered provider sent us an action plan regarding the measures they would take to address this concern. We checked the action plan against what had actually been achieved and found shortfalls in quality monitoring.

During this follow up inspection, we found the service was not well-led. The registered providers told us they visited the service twice a week and this was confirmed by members of staff. They said they spoke with staff and people who used the service and checked with the registered manager that everything was alright. However, the registered provider's visits to the service had not been effective in monitoring and overseeing the quality of service provided to people. They were unable to account for the level of concerns we identified during the inspection.

During this follow up inspection, we found the service was not well-managed. We found the registered manager had not received adequate support or supervision from the registered providers to ensure they had the skills and experience to manage the service. There were no records of regular monthly management meetings to show how progress had been maintained and goals had been set. We found staff lacked leadership and oversight from the registered manager. These points meant that risk was not managed effectively and important care issues were not followed up; this had impacted on the safety, health and welfare of people who used the service. We found this was a breach of Regulation 7 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Requirements relating to registered managers. We are considering our regulatory response and will report on it in due course.

The registered manager showed us a quality monitoring form they had completed in June and one in July. There were daily tasks such as checking the accuracy of medication records, ensuring bedrooms and communal rooms were tidy and greeting people who used the service. There were weekly tasks such as monitoring water temperatures and having management meetings to set goals. Monthly tasks such as reviewing the accident book and taking relevant action. Three-monthly tasks such as person-centred care plan reviews, full staff meetings and 'service user' meetings. There were six-monthly checks which included fire drills and a 'service user room audit'. We found this quality monitoring system was ineffective, had not been carried out properly and had not identified shortfalls in the service. There was no system in place for the registered provider to check these tasks had been carried out.

The accuracy of medication records had not been checked daily or if they had been checked serious errors in recording and administration of controlled pain relief patches, and 'when required' medicines to calm anxieties, had not been identified.

Accidents had not been analysed and appropriate action taken. This meant at least two people did not receive assessment in a timely way. A review of the accident book had not taken place and it was unclear if the registered manager was aware of the number of accidents two people had sustained. There was also a lack of understanding on the part of the registered manager and staff as to what constituted a fall. We were told if a person was found on the floor, this was not recorded as a fall but as an incident in their care file because it was not witnessed. The fact the fall was not witnessed should have added to the concern, as staff would not know whether the person had been knocked unconscious by the accident. As the accident book and individual people's incident records were not checked and analysed, we could not be sure the registered manager and registered provider grasped the extent of the accidents and injuries people sustained.

Risk had not been managed effectively in order to learn from incidents to prevent reoccurrence. This meant that one person continued to use a bed rail when it was unsafe for them and two people continued to have falls without a review of risk.

The registered provider did not have an effective system to monitor the environment to make sure it was safe for people. A hot water outlet in a communal toilet was dispensing very hot water. This could potentially scald

people with fragile skin. There was a large hole in the plaster of one person's bedroom which was near the electric socket and power box; wires could be seen which posed a risk of electrocution. We told the registered provider they must address these points straight away.

Reviews of documentation such as care files had not identified that risk assessments had been incorrectly completed and not updated when people's needs had changed.

The poor communication in handover records added to the problem of registered manager and registered provider oversight. The registered manager had sight of these each day and held them in a handover file. We saw shift handover sheets were completed morning, afternoon and at night but the records did not provide any useful information to staff or management. There was a code by each person's name 'A.W.N.T.R', which the registered manager told us meant, 'all well nothing to report'. We saw staff circled the codes for each person who used the service and also occasionally put the word 'verbal'. The registered manager told us this meant the person could have been noisy or shouting out. We saw the handover sheets had not been used to pass on important information such as when a person complained of a 'burning sensation' when they passed urine or when a GP had prescribed a cream for a person's feet. This had resulted in one person not having their urine tested and one person not receiving a prescription in a timely way. The registered providers said they were unaware shift handovers were reported in this way.

We saw there were notices written as reminders for staff by management, some of which were written with good intentions but were phrased in an inappropriate way. They led staff to observe practices which were regimented and inflexible. These were discussed with the registered providers, who stated they were unaware of them. They told us they would address them with the registered manager and staff.

Not having an effective quality monitoring system is a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014, Good governance. The registered provider did not ensure the service provided was safe, effective, caring, responsive or well-led. We are considering our regulatory response and will report on it in due course.

We found the registered manager was not fully aware of their responsibilities in notifying the Care Quality Commission about incidents that affected the safety and welfare of people who used the service. When we checked our records and those of the local authority commissioners, we found there were three notifications of people's deaths which had not been sent to us. This is a breach of Regulation 16 of the Care Quality Commission [Registration] Regulations 2009 Notification of death of service user. We are considering our regulatory response and will report on it in due course.

When we checked our records we found there were several serious injuries such as skin tears and one alleged physical incident between people who used the service, which had not been sent to us as notifications. This was a breach of Regulation 18 of the Care Quality Commission [Registration] Regulations 2009 Notification of other incidents. We are considering our regulatory response and will report on it in due course.

The registered manager told us that since the last inspection, a new shorter survey had been formulated and 16 had been given to people who used the service. They said three people had completed them unassisted and the remainder had support from staff. It would have been more appropriate for relatives to have assisted people who used the service to complete them. The registered manager told us they would take this on board for the next survey. The results of the survey had not been analysed yet.

We saw there had been two meetings for people who used the service. These indicated people had made suggestions for the menus such as chilli con carne, skinless sausages, bacon including as part of a 'fry up' and in a sandwich, black pudding, savoury duck, saveloys and curry. One person said they would like to have gammon more often and another said they would like to have scampi. We checked the menus to see if the suggestions had been included. We saw scampi and chips was on the menu twice a month and gammon with egg and potatoes once a month for the main meal at lunchtime. There was also bacon, sausage, egg and tomatoes for the main meal once a month. Bacon sandwiches were on the menu at tea-time twice a month, although one of these days was the same day as the bacon, sausage, egg and tomatoes, which would be repetitive for people. There was no record of black pudding, savoury duck, saveloys, curry or chilli-con-carne on the menus. This showed us not everyone's wishes had

Inadequate

Is the service well-led?

been listened to in regard to the preparation of the menus. The menus provided to us to review were repetitive with at least the same four main meals, corned beef hash, fish and chips, meat pie and sausage casserole served every week. This had not been picked up as part of quality monitoring when reviewing records.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: people were not receiving person-centred care. The registered provider did not have adequate arrangements in place for assessing people's needs and planning delivery of care in a person-centred way. Regulation 9 [1] [2] [3] [a] [b] [c]

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's and registered manager's registration to carry out the regulated activity at Pink Panther Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The registered provider did not have adequate arrangements in place for assessing capacity and documenting best interest decisions when people could not give their consent to care. Regulation 11 [1] [3]

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's and registered manager's registration to carry out the regulated activity at Pink Panther Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered provider had not taken steps to properly assess the risks to the health and safety of people living in the home. Care and treatment was not provided in a safe way. People who used the service had not received their medicines as prescribed. Regulation 12 [1] [2] [a] [b] [f] [g]

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's and registered manager's registration to carry out the regulated activity at Pink Panther Care Home.

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 How the regulation was not being met: People who use the service have not been protected from the risk of organisational abuse. This was because inadequate leadership and regimented staff practices have subjected some people who live there to organisational abuse. Regulation 13 [1] [2].

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's and registered manager's registration to carry out the regulated activity at Pink Panther Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered provider did not have effective systems and processes to ensure the service provided was safe, effective, caring, responsive or well-led. Regulation 17 [1] [2] [a] [b] [c] [d] [f]

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's and registered manager's registration to carry out the regulated activity at Pink Panther Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The service did not have sufficient numbers of staff on duty at all times to meet people's needs safely. Regulation 18 [1]

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's and registered manager's registration to carry out the regulated activity at Pink Panther Care Home.