Care Quality Commission

Pinnacle Care Limited

Roxburgh House

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this inspection on 10 November 2014. The inspection was unannounced. The service provides accommodation and personal care for up to 36 older people who may have dementia. Twenty one people were living at the home at the time of our inspection

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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 and associated Regulations about how the service is run.

At our previous inspection in July 2014 the provider was not meeting all the regulations relating to the Health and Social Care Act 2008. There was a breach in meeting the legal requirements for assessing and monitoring the quality of service provision. There was also a breach in meeting the legal requirements for management of medicines. The provider sent us a report explaining the

Summary of findings

actions they would take to improve and told us the actions would be completed by 08 September 2014. During this inspection we found in relation to assessing and monitoring the quality of the service, that the action plan had not been followed and there were similar continuing concerns with a breach of the regulations. However we found improvements had been made regarding management of medicines.

Care staff understood what their role was in protecting people who lived at the home, from abuse.

We found there were insufficient numbers of care staff to effectively safeguard the health and welfare of people who lived at the home. We observed the lunch time meal and found some people were not supported to eat their meal in a safe way. We saw two people's hot meals slip off their laps, onto the floor and care staff were not aware.

We found the registered manager followed safe recruitment practices and checked care staff's suitability to deliver care to people who lived at the home.

We found that people were not always asked for their consent before care staff supported them. We found some decisions were being made on people's behalf by care staff.

Care staff had an induction programme and training was appropriate to the staff's role. Care staff told us they received supervision from their manager.

People were provided with a well balanced diet. The cook knew people's food choices and any allergies.

We found care staff made appropriate referrals to health professionals when required. Everyone we spoke with told us they were happy with the health care they received.

People told us the staff were caring and visitors were welcome at any time. However we saw some people were not given support to eat independently and in a manner that maintained their dignity.

We found some people did not know how to make a complaint.

We found the registered manager had implemented initiatives to involve care staff to develop and improve the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?
The service was not consistently safe.

People told us that they felt safe however, there were continued concerns about how risks relating to people's health and welfare were identified, assessed and managed. There were insufficient numbers of staff to effectively safeguard the health and welfare of people who lived at the home. Improvements had been made to the management of medicines. However improvements were still required to identify medicine errors. The registered manager followed safe recruitment practices.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Care staff had an induction programme and training was suitable for their role. Care staff made appropriate referrals to health professionals. However we found that care staff did not always seek people's consent before supporting them.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People who lived at the home told us care staff were caring. However we found that people were not always treated in a dignified manner.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

People who lived at the home told us they did not know how to make a complaint. People or their representatives were asked about their hobbies and interests, however there was limited support for people on the day of our inspection to follow their chosen interests.

Requires Improvement

Is the service well-led?
The service was not consistently well-led.

The provider's quality assurance system continued not to be effective, because some improvements to the service had not been identified. The registered manager supported care staff. They had implemented initiatives to involve care staff to develop and improve the service.

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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.

We carried out this inspection on 10 November 2014. The inspection was unannounced.

The inspection team included two inspectors, a pharmacist inspector and an expert-by-experience in people with dementia. 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 provider completed a Provider Information Return (PIR). 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.

We reviewed the information we held about the service. We looked at information received from the public, from the local authority commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with the registered manager, the deputy manager, three care staff and the cook. We spoke with five people who lived at the home. We spoke with a visiting health professional who was at the home on the day of our inspection. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed four people's care plans and checked the records of how they were cared for and supported. We looked at two staff files to check staff were recruited, trained and supported to deliver care and support appropriate to each person's needs. We reviewed management records of the checks the registered manager made to assure themselves people received a quality service.

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Is the service safe?

Our findings

At our previous inspection we found there was a breach in meeting the legal requirements for identifying, assessing and managing risks relating to people's health and welfare. During this inspection we found continued concerns, about how risks were managed in the home to ensure people were protected and kept safe.

People who lived at the home did not feel there were sufficient care staff to support them. Two people told us, "There is not a lot of staff, you don't see them" and "I don't like sitting here doing nothing, we don't see the staff at all sometimes. They bring you a pot of tea and that's that." During our inspection the registered manager told us there should be a member of staff present in each communal living room. We saw periods of the day when there was no care staff member present in communal living rooms. During one of these periods we saw one person became agitated and began banging a table loudly with a book and shouting. Another person in the room became angry and shouted back. There was no member of staff present to support people in this situation and keep them safe. One person told us, "We don't see any staff; I think someone should be in the room in case something happens." One member of care staff told us, "We're short staffed, on the mornings there's sometimes only two staff."

We observed one person who lived at the home displayed behaviour which challenged. We saw their behaviour affected other people who lived at the home. We saw the person tipped another person out of their chair. The person slid out of the chair and was caught by a member of care staff. The person who slipped was visibly upset and cried. They were comforted by a member of care staff. We then observed a similar incident take place directly after the first, where the same person moved another person's chair whilst they were seated. We found the first incident was reported to the registered manager, however the second incident was not identified by staff. This showed the first incident had not been properly assessed, because no action was taken to protect people from similar future risks relating to the person's behaviour. We looked at this person's care records. We found there was no assessment of risk of this person's behaviour in connection to keeping other people safe. There were no care plan instructions for care staff on how to support this person to manage their behaviour in a safe way. This demonstrated not all risks were managed safely to protect people.

We spoke with the registered manager about how risks were assessed to protect people. They told us about an incident which had occurred at the home where the lift had broken down and emergency action was taken to protect someone. We found this had not been recorded in the service's incident log. Following our inspection, the registered manager provided a copy of the missing incident report to us. The incident report did not show how the circumstances of the incidents had been assessed or how risks had been managed. The registered manager did not demonstrate how they had acted to minimise similar future risks for people who lived at the home. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed staffing levels to see if there were sufficient staff to keep people safe and to meet their support needs. There were 21 people living at the home and there were three members of care staff working during the daytime shifts, plus a senior member of care staff. This meant there were three carers and one senior member of staff to meet 21 people's needs. In addition, care staff had other responsibilities including laundry, food preparation and service of meals.

We asked the registered manager how they assessed staffing levels within the home. The registered manager told us, "We don't have a dependency tool, it's more about knowing if people's needs changed." The registered manager told us they would ask the provider for additional staff if required. They told us they currently had, plenty of care staff. There was no evidence available to show that staffing levels had been assessed to ensure they met people's individual needs.

We observed the lunch time meal and found there were insufficient staff to ensure people were supported to eat their meal safely. On two occasions we saw people's hot meals slip off their laps and onto the floor. We observed one person tried to continue eating from the floor. Care staff were not aware of the issue until we brought it to their attention. We saw there was a lack of suitable equipment

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Is the service safe?

to ensure people who chose not to eat at a dining table were able to eat safely. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous inspection we found there was a breach in meeting the legal requirements for management of medicines. During this inspection we looked at the medicine administration records (MAR) for 14 people who lived at the home, including the storage and management of medicines. We found improvements had been made in recording on MAR charts and processes to check medicine stock levels.

We asked people who lived at the home about their medicines. No one we asked had any concerns about their medicines. One person told us, "I get my pills after breakfast; they are there ready for me".

We found that improvements had been made to ensure that the MAR charts were accurate. The dispensing GP practice had provided printed MAR charts to ensure that people's medicines were accurately documented to reduce the risk of a medicine error. We found that improved arrangements were in place for medicine stock checks which helped to ensure that people were being given their prescribed medicines. We saw medicines were stored securely within the recommended temperature ranges for safe medicine storage.

We looked at three people who were prescribed a medicine to be given 'when necessary' or 'as required' for agitation. We found there were no procedures available with their MAR charts to inform staff under what specific circumstances the medicine could be given.

Medicines with a short expiry were not dated when opened. The registered manager could not advise us how long the medicine had been open for and if it was safe to use.

Everyone we spoke with told us they felt safe living at the home. Three people we spoke with who lived at the home told us, "I do, I feel quite safe. If I wasn't I would speak to the boss", "I reckon I feel pretty safe on the whole" and "I do feel safe." We saw information in a communal area advising people, relatives and staff who they should contact if they had any concerns about people's safety.

Care staff we spoke with told us they had received training in safeguarding procedures. They were able to describe different types of abuse, the signs to look for and the procedure for reporting abuse. A member of staff told us, "I would say people are very safe here." We found the registered manager had notified us of incidents when they made referrals to external agencies such as the local authority safeguarding team.

The registered manager followed safe recruitment practices and checked care staff's suitability to deliver care to people who lived at the home. In the two staff files we looked at we saw records of the checks made before care staff were employed. We found information was available from previous employers which gave information about staff's past performance. The identities of care staff were verified. Checks were made with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records.

Requires Improvement

Is the service effective?

Our findings

We observed interactions between people and care staff and asked people if care staff asked for their permission before they were supported to do things. On one occasion we saw a member of care staff enter someone's bedroom without knocking. That person told us, "They don't ask consent they just do it". Another person told us, "They always tell me what pills they are giving me, they don't ask to give them to me". This showed care staff did not always ask for people's consent before they supported them.

Everyone we spoke with who lived at the home told us they did not know what a care plan was. One person who lived at the home told us, "No-one has ever discussed my care with me". None of the care plans we looked at had been dated or signed by the person or a representative. This meant we could not determine if people had seen their care plans and consented to the care and treatment they were receiving.

We saw there were mental capacity assessments completed by senior care staff on all the care plans we looked at. We saw if people were deemed not to have capacity by staff, best interest consent forms were completed for them which identified that specified care staff could make decisions about certain things on the person's behalf. We saw that these consent forms had not been independently reviewed by anyone on the persons behalf if they were deemed not to have capacity. The registered manager told us they did not hold best interest meetings for people involving representatives such as family members or health professionals. This meant decisions were being made on people's behalf by care staff and these decisions were not reviewed by the person or an appropriate representative of the person. This meant there were not suitable arrangements to ensure people consented to their care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. The registered manager told us they knew how to make an application for consideration to deprive a person of their liberty (DoLS). The registered manager told us no-one who lived at the home was deprived of their liberty at that time.

Two people we spoke with told us they made their own choices with support from care staff. They told us, "I can do what I like during the day" and "They look after me quite well. I can do most things myself, they encourage that." We found there were two options available at meal times and people were shown the choices before the meal. Everyone we spoke with in the home told us they liked the meals. Two people told us, "The food is excellent, two choices for main and pudding at the table. Mealtimes are very enjoyable" and "The food is good."

We spoke with the cook and looked in the kitchen area. We found there were adequate stocks of food to fulfil the two week rolling menu and that food was nutritious and could provide a well balanced diet. The cook knew people's food choices and any allergies. They told us, "Food information is verbal, it's not written down." They told us they received advice from relevant health professionals when required. We saw people's food preferences were recorded in their care plans. The registered manager told us care staff sat with people and helped them fill these preference sheets in.

We saw people were offered drinks throughout the day. Two people who lived at the home told us, "They come into my room four times a day with drinks. My daughter brings me drinks as well" and "We get drinks during the day, tea and biscuits are served at 11.15am."

We observed the lunch time meal and saw two people used cutlery inappropriately. One person used a knife to eat from and the other person used a fork the wrong way round. Care staff were not aware of these issues until it was brought to their attention. This meant people were not supported to eat their meal appropriately.

We found referrals were made to health professionals such as the speech and language therapist. For example, the registered manager was in the process of making a referral to a health professional about one person's fluid intake because their needs had changed.

We found all care staff had received an induction which included training and shadowing more experienced staff. We saw training was appropriate to care staff's role and was up to date. For example, all staff had received training on

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Is the service effective?

how to support people to move about safely. During our visit we saw care staff supported people to move appropriately. Care staff we spoke with told us they were happy with the induction they received. We saw care staff had supervision meetings with their manager and attended staff meetings. Care staff we spoke with told us they felt supported by the provider to study for care qualifications.

The registered manager told us about forthcoming training for all care staff about how care plans were changing. The registered manager told us the training had been planned for care staff to become, "More independent and more involved in care planning and this would make the care better."

Care staff we spoke with told us they learnt how to support people from sharing information verbally with other care staff. One care staff member told us, "We learn what people want and need from other staff. We have handover at every shift change." We attended a shift handover meeting between care staff, where people's needs were discussed.

For example, care staff discussed one person's need for increased fluids, however the information was not recorded. The care staff we spoke with told us they did not look at people's care plans. We discussed this issue with the registered manager and they told us they expected care staff to look at people's care plans during their shifts. It demonstrated care staff were sharing information about people's needs on a verbal basis. There was a risk that important information could easily be forgotten if care staff were not looking at people's care plans regularly.

We looked at four people's care records and saw evidence staff made referrals to other health professionals, such as GPs and dieticians. Everyone we spoke with who lived in the home told us they were happy with the health care they received. Two people who lived in the home told us, "I had a pain in my leg a few days ago, they responded quite quickly" and "I see the doctor and chiropodist regularly. I had my eyes tested recently, a lady came round."

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with told us care staff were caring. Two people told us, “The staff are good, not bad; they are quite respectful to me” and “The staff are very caring here.” We asked care staff about their relationships with people. One member of care staff told us, “We put the needs of the residents first.”

We observed care being delivered in the home. We found care staff acted in a compassionate way and responded to people’s needs when they were aware of them. For example we saw one person repeatedly showed signs of anxiety and care staff understood the triggers for this and knew how to support the person to resolve it.

People we spoke with who lived in the home told us visitors were welcome at any time. One person told us, “I get lots of visitors, there are no restrictions.” This showed that people’s relationships with their friends and families was promoted and not restricted.

From our observations we found people were not always treated with dignity. During the morning of our inspection we found the temperature in the communal lounge was very cold. People sat in easy chairs and complained about the cold. Two people told us, “It’s very cold here first thing in the morning. It soon warms when the heating comes on” and “They don’t keep us warm that’s for sure but they are very nice.” We found the temperature did not improve until mid afternoon, when several people were using the room. We saw care staff fetched blankets to put over people whilst the temperature was low. The registered manager told us this was a one off occurrence and that someone must have changed the temperature on the thermostat in the communal corridor. The registered manager told us they would put a measure in place to ensure in future the room temperature remained warm during the day time.

At lunch time we found some people were not given support to eat independently and in a manner that maintained their dignity. We saw two people used their cutlery inappropriately and one person tried to eat their dinner from the floor. Care staff were not aware until we brought these issues to their attention.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people who lived at the home and asked them if they were supported by staff to follow any of their own interests. One person told us, "They play some games, I'm not sure what they are. Music is important to me; there is something musical coming up at Christmas." We observed people doing different things in the home during the day of our inspection. We saw some people watched the television, one person played the organ, one person did some art work and one person was supported to read a magazine.

Everyone we spoke with who lived at the home told us they did not go out. Two people told us, "I don't go out, I've not got anyone to go out with. It's never mentioned by staff" and "I don't do any activities, nothing happens here, I never go out." The registered manager told us at that time there were no day trips because the provider's transport was not accessible for the home to use. The registered manager told us people were supported to take walks in the local community instead.

The registered manager told us, "Day to day I think we're person centred and give choices. For example [name] is involved at the moment because we're making their care plan. We are talking to [name] all the time." Two members of care staff gave us examples of how they gave people choice on a day to day basis. They told us, "We give people choices of their meals and their clothes" and "People are always asked about getting up."

We saw on people's care plans that some people had 'all about me' documents, which described their life history and information about their favourite hobbies or interests. There was also a food preferences document. The registered manager told us these documents were completed by people who lived at the home with support from the staff. This meant people were asked about their hobbies and interests, however we saw limited support for people to follow their chosen interests.

We saw there was a poster explaining the provider's complaints policy which was accessible to everyone outside the registered manager's office. We asked people who lived in the home about how they would make a complaint if they needed to. We found the five people we spoke with did not know how to make a complaint. For example, two people told us, "I would feel okay about complaining, I haven't needed to complain. I don't know about a complaints procedure" and, "It would have to go to the extreme before I complained. I've not felt comfortable enough to make a complaint. I resolve it myself." This showed some people did not know how to share their experiences.

Requires Improvement

Is the service well-led?

Our findings

We asked people who lived at the home what it was like to live there. Two people told us, "On the whole I'm happy with the atmosphere" and "It's quite amenable here."

At our previous inspection we found there was a breach in meeting the legal requirements for assessing and monitoring the quality of service provision. At that inspection we identified concerns with how the quality of the service was assessed and monitored. For example there was no process in place to check if maintenance jobs had been completed. This meant the possible risks of an unsafe environment had not been assessed. We saw examples where audits had been completed but they were not effective because the provider did not have a process in place to follow up any improvement actions where improvements were required. During this inspection we found similar continuing concerns.

We looked at the provider's system to monitor the quality of care they provided. We saw the manager had completed a variety of checks as required by the provider, including a medication audit. We saw these checks were not all effective. For example medicine errors were not always identified. We found one person with gaps on their MAR chart for two evenings for a prescribed medicine. There was no staff signature to record the administration of the medicine or a reason documented to explain why the medicine had not been given. We were unable to determine from the medicine records if the person had been given their prescribed medicine. We found this error had not been identified by the registered manager and was not included in their medicine audit.

We found the single use hand towel stock had run out and some hand washing stations had no facility for people to dry their hands. The registered manager was not aware the hand towel stock had run out. The manager checked on the supply of towels and found there were insufficient to replenish supplies in the home. The manager made an order and ensured that paper towels were available instead in each hand washing facility on the day of our inspection. We found there was no process in place to check these stock levels. This meant the quality assurance system was not effective.

We observed one person was given full support by care staff to eat and drink during their lunch time meal. We looked at their care plan for nutrition which stated they could eat and drink independently. We asked the registered manager about this and they told us they had last reviewed the person's care plans themselves in July 2014. They told us the person's needs had changed around May 2014.The registered manager had not updated the person's care plan with the change in their nutritional needs. They told us, "I did not pick up the mistake". This meant the registered manager had not assessed and monitored the quality of the care plans effectively.

We saw there was no process to ensure portable appliance testing (PAT) or hardwiring checks had been made within suitable timescales to keep people safe within the home. The maintenance log contained some information but it was not clear what had been tested, if the item had passed, if it was safe to use or if it had failed and was still in use. The registered manager told us there was no review or audit of the environment which included these types of checks. They told us they did not regularly review that items in the maintenance log had been completed, although they told us it was their responsibility. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us they met regularly with other managers in the provider's group. They told us they used this time to share ideas and discuss things to improve their service, such as new training.

The registered manager told us the provider's senior management team and external agencies such as the local authority commissioners, audited the provider.

The registered manager told us about the new initiatives they had recently undertaken to involve care staff to develop and improve the service. We found the registered manager had recently issued a staff newsletter asking staff how they would like to feel valued. Care staff agreed on an employee of the month award, which was to begin at the next staff meeting in November 2014. The registered manager told us, "It will be nice for families to see. If we have happier staff we will have happier residents." This showed the registered manager was encouraging open communication with care staff.

We saw the results of a recent quality questionnaire sent to people who lived in the home during October 2014. The registered manager told us care staff or people's representatives had supported people to respond to the

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Is the service well-led?

questions. The registered manager had analysed the results of the survey and drawn up an action plan where comments had been made. For example, the action plan stated, 'In the next resident's meeting I will explain to all what they can do if they are unhappy with their care.' This showed people were involved in developing the service, however we could not see actions had been carried out to improve the service for people. For example, the last residents meetings was held in July 2014, which was after the survey had been carried out and there was no evidence people had been given information about what to do if they were unhappy with their care.

We saw there had been a survey sent out to visiting professionals and people's relatives in 2014, requesting people's opinion about the service. The registered manager told us how they analysed the results of the survey and had addressed comments made. They gave us an example of how someone had complained that the weekly day trip for people who lived at the home had stopped. The registered manager told us they had spoken with the person on an individual basis to discuss their comment and explain why the trip had stopped. We found no evidence that the results of the surveys had been used to make improvements to the service. For example, we could not see that a different type of pursuit had replaced the day trips.

We found the registered manager had not always sent notifications to us when appropriate about important events and incidents that occurred at the home. We found they had notified other relevant professionals such as the local safeguarding authority.

All the care staff we spoke with told us they could speak with the registered manager at any time. A member of care staff told us, "[Registered manager] is open and honest and listens to you. [Registered manager] understands and gives me an answer." The registered manager told us they felt supported in their role, by their own manager. They told us, "The residents are happy, they tell me. We get compliments and feedback from families." The registered manager told us they observed care staff practice, where they monitored their performance. We saw the registered manager carried out care staff supervision. The registered manager told us, "If there was an issue I would talk to the staff." This showed the registered manager supported care staff.

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 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	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity, in order to safeguard the health, safety and welfare of service users. Regulation 22

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not operate an effective system to identify, assess and manage risks to service users and others. Regulation 10(1)(a) and (b) and 10(2)(c)(I)

The enforcement action we took:
We issued a warning notice asking the provider to make improvements by 01 February 2015.