Pinehurst Partners Limited

Pinehurst Residential Home

Inspection report

1-2 Haldon Terrace
Dawlish
Devon
EX7 9LN

Tel: 01626863500

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

What life is like for people using this service:

People told us they liked living at Pinehurst. They said they felt safe and they had a good relationship with staff. The relative we spoke with described the staff as "superb" and "excellent". Staff knew people well and described to us people's likes, dislikes and preferences. Our observations showed people were treated with kindness and respect. There was a relaxed atmosphere between people and staff, with friendly conversation.

Staff understood their roles to protect people from harm and to promote their independence. Records showed action was taken to reduce risks to people's safety and welfare. However, risk assessments and management plans did not include this information for staff about what actions to take to protect people. Care records also required improvements to fully describe people's abilities and needs. This meant people's care needs might not be fully known and understood by the staff, particularly those new to the home.

Recruitment practices were not always safe; some staff had not had pre-employment checks carried out or references obtained from previous employers.

Staff had received the training they required to undertake their role. This included training in health and safety topics as well as those relating to people's mental health needs.

Medicines were being managed safely and people were supported to attend healthcare appointments. Specialist support was provided by the community mental health team.

People's rights, privacy and dignity were protected. Where it was necessary to make decisions on people's behalf, this was done after appropriate capacity assessments had been undertaken.

At the time of the inspection, the home did not have effective systems in place to assess, monitor and improve the safety and quality of the service. Immediately following the inspection, management processes were reviewed and quality assurance systems developed.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We made one recommendation for improvement.

More information is in the detailed findings below.

Rating at last inspection: Good (last report published 9 July 2016)

About the service: Pinehurst Residential Home is a residential care home registered to provide

accommodation and personal care for up to 20 people of all ages who may have mental health issues. The home is a large end of terrace property with access to a private park. Pinehurst is situated within easy reach of the town centre of Dawlish.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: We have issued three requirement notices which can be found at the end of this report.

Follow up: We will continue to monitor the intelligence we receive about the home until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not always safe.

Details are in our findings below.

Requires Improvement

Is the service effective?

The service was effective.

Details are in our findings below.

Good

Is the service caring?

The service was caring.

Details are in our findings below.

Good

Is the service responsive?

The service was responsive.

Details are in our findings below.

Good

Is the service well-led?

Some aspects of the service were not always well-led.

Details are in our findings below.

Requires Improvement

Pinehurst Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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.

Inspection team: One adult social care inspector, an assistant inspector and an expert by experience undertook this inspection. 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 expert by experience at this inspection had experience of mental health services.

Service and service type: Pinehurst Residential Home (known as Pinehurst) is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did when preparing for and carrying out this inspection:
Before our inspection we reviewed the information we held about the home. This included correspondence we had received and notifications submitted by the home. A notification must be sent to the Care Quality Commission every time a significant incident has taken place. Prior to the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the home including what the home does well, and any improvements they plan to make in the future. We also gathered information from the local authority's quality assurance improvement team.

This information was reviewed and used to assist with our inspection.

During the inspection we spoke with 10 people, one relative, five staff and the registered manager. We reviewed the care records for three people and sampled the records for another two people. We looked at how the service managed people's medicines. We also looked at records relating to the management of the service, including two staff personnel files, staff training records, complaints records and how the home reviewed the quality and safety of the care and support provided. We received positive feedback from three healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

Some aspects of safety management were not consistent enough to protect people from risk and avoidable harm.

Staffing levels:

• Recruitment practices were not always safe. Not all staff had undergone pre-employment checks or had references obtained prior to them starting to work at the home. Although these staff were known to the management team, it was still necessary to undertake these checks to ensure the suitability of staff to work at the home. The registered manager confirmed they would undertake checks for all staff who didn't have them in place.
• There were sufficient staff available to support people with their personal care needs and to spend time with people in leisure and social activities both in and out of the home. One person said, "They don't leave staff short, very careful with that."

Failure to follow a safe recruitment process and obtain information to assess a staff member's suitability to work at the home is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management:

• Staff understood how to protect people from risks associated with their mental health needs. However, the records used to describe how to keep people were safe did not reflect staff's understanding or describe the control measures put in place to mitigate risks. For example, one person had an identified risk relating to self-harm. Staff were able to demonstrate the actions they were taking to keep this person safe. However, their care records did not reflect the nature of the person's self-harm, the control measures in place to mitigate the risks or who to contact in the event of an incident of self-harm.
• Some aspects of monitoring the safety of environment were not being routinely checked. For example, the hot water temperature to the baths was not being monitored in line with the Health and Safety Executive guidance. People's individual risk assessments did not review the risk of using the bath; only the use of the sinks had been assessed.
• One of the senior care staff had recently been given the responsibility of reviewing health and safety issues. They were in the process of reviewing the systems in place to assess and monitor the management of risk.
• Emergency plans were in place to ensure people were supported in the event of a fire.

We recommend the home establishes effective systems to ensure care records fully describe people's care needs and provide clear guidance for staff as well as to ensure environmental risks are mitigated.

Safeguarding systems and processes:

• Staff had received safeguarding training and were aware of their responsibilities to report any concerns over people's health, safety and welfare.
• Records showed where staff had identified potential safeguarding concerns, they took appropriate steps to inform the local authority and seek guidance.
• People told us they felt safe living at Pinehurst. Their comments included, "Yeah I feel safe" and "They're always looking to keep you feeling as happy and settled as you should be feeling, they're very good here."
• Where the home supported people to manage their finances, this was done safely.
• Healthcare professionals told us they felt people received safe care and support and that the staff were prompt to alert them of changes to people's health and well-being.

Using medicines safely:

• If people wished to do so, they were encouraged and supported to be independent with their medicines.
• Medicines were managed safely and people received their medicines as prescribed. Only staff trained in the safe administration of medicines, and who had been assessed as competent, administered medicines to people.
• Where people took medicines 'as and when required', staff were provided with guidance about when this should be administered.
• There were safe arrangements to receive, store and dispose of medicines.
• Regular audits by the management team ensured medicine practices remained safe.

Preventing and controlling infection:

• The home was clean and tidy. Staff had access to, and were seen to use, protective clothing such as aprons and gloves to reduce the risk of the spread of infection.
• People said their bedrooms were clean and well maintained.

Learning lessons when things go wrong:

• The registered manager used people's feedback to make improvements to the home.
• The management team were in the process of reviewing the home's monitoring systems to ensure they were effective in supporting the running of the home.

Good

Is the service effective?

Our findings

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on best available evidence.
Assessing people's needs and choices. Delivering care in line with standards, guidance and the law:

Staff skills, knowledge and experience:

• Staff received the training they required for their role. This included health and safety topics as well as topics relating to people's mental health needs.
• Staff new to the home received an induction and were supported to undertake the Care Certificate. (The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of care staff).
• Staff told us they had monthly themes for in-house training, and we saw question papers and answer books in relation to this where staff recorded their learning.
• Staff told us they felt well supported and that they could ask for support and training at any time. Records showed they received regular supervision and annual appraisals.
• The relative we spoke with said they felt the staff were well trained and understood people's support needs well.

Eating, drinking, balanced diet:

• People told us they enjoyed the food provided at the home. One person said, "The majority of the food is very good, but some things aren't my cup of tea. Because obviously you can't like everything. Always get offered an alternative if you don't like what's on the menu on the day, so always get offered something nice even if it's not on the menu."
• Where people had needs in relation to eating and drinking these were described in their support plans. Staff reported how one person had benefitted from staff exploring different foods with them which had led them to make healthier choices.
• People were supported to prepare their own food and drinks should they wish to do so.
• Staff told us people could have something to eat and drink whenever they wished.

Ensuring consent to care and treatment in line with law and guidance;

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation

of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

• People living at Pinehurst had capacity to make decisions about their day to day support needs. Some people lacked capacity to make more complex decisions, such as to receive medicines or to attend medical appointments. Where this was the case, capacity assessments had been undertaken and decisions made in people's best interests.
• At the time of the inspection, no-one was having their liberty restricted. People told us they were free to come and go as they pleased from the home.

Healthcare support:

• People's physical and mental health care needs were being met. One person told us, "I go out to see the doctor, go out to the surgery, if people are really bad they bring the doctor here." Another person said the community mental health team visited them every month.
• Records showed people received support from their GP and the community nurses as well as to attend dental, optician and podiatry appointments.
• Healthcare professionals said the home provided effective support for people. One said, "I have been impressed by staffs' management of their residents becoming acutely unwell. I have found staff forthcoming and communicative; my experience is that they have always been willing and able to engage professionally with community teams."

Adapting service, design, decoration to meet people's needs:

• The premises were suitable for the needs of those people currently living at Pinehurst.
• People had requested that the kitchen be locked when staff were not present. This was to prevent people's own food and drink being taken by others.

Good

Is the service caring?

Our findings

The service involves and treats people with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported:

• People and the relative we spoke with told us the staff were kind and caring. People said they had a good relationship with staff and felt well supported. One person said, "Only been here a few weeks, so all new to me. This place has been a godsend to me. Without the kindness of the staff I don't know where I would be" and another said, "I'm very close to the staff here, certainly couldn't find fault with the staff, and both keyworkers are excellent and so caring."
• The relative we spoke with described the staff as "superb" and "excellent". They said the staff had shown compassion and care towards their relative.
• Our observations showed people were treated with kindness and respect. There was a relaxed atmosphere between people and staff, with friendly conversation.

Supporting people to express their views and be involved in making decisions about their care:

• People told us they were involved in making decisions about their care and regularly discussed their support with their keyworker.
• One person had been nominated as a 'residents' representative', someone who people could speak to confidentially about any concerns and who liaised between people and the management team.

Respecting and promoting people's privacy, dignity and independence.

• Our observations showed people's privacy and dignity was respected.
• People's bedrooms were locked and staff only entered with people's permission.
• People's independence was promoted through engagement in the home as well as in the community. A staff member said, "The staff care, everything we do is always around the individual and what their needs are" and another said, "It's one big family here."

Good

Is the service responsive?

Our findings

People received personalised care that responded to their needs.

Personalised care:

• People received care and support that was flexible and responsive to their needs.
• Staff knew people well and could describe their likes, dislikes and preferences in the way they wished to be supported. They understood how their mental health needs affected their day to day lives. One member of staff said, "Everyone's really different here and we do different things for everyone."
• The home was meeting people's communication needs. For example, one person was provided with a flip chart of pictures and symbols to support their communication.
• However, people's care records did not reflect this level of detail. Following the inspection, the deputy manager said all care plans were being reviewed and updated to ensure they better reflected people's abilities and support needs.
• Staff told us people would not be discriminated against, including in relation to protected equality characteristics, such as sexuality or religion.
• People told us they were free to plan and attend leisure and social activities of their choice in the community, as well as become involved in activities organised by the staff.
• Staff planned trips to local places of interest or to places people had requested to go, and people could choose whether they wished to go or not. One person said they go out "as much as I like" and another said staff had taken them to an "out of the way" church.

Improving care quality in response to complaints or concerns:

• People told us they had no complaints about the home but felt able to raise concerns with the staff and the registered manager if they had any.
• When complaints had been received, these were recorded and the response to the complaint documented. However, there was no system in place to monitor complaints or identify recurring themes. Since the inspection, the management team have included the review of complaints in their team meeting agenda held every two weeks.
• A keyworker system had been introduced where staff got to know individual people well. This had proven beneficial for people to feel more comfortable about sharing concerns. For example, one keyworker relationship had enabled a person to disclose a medical concern, which allowed the staff to obtain help and resolve the problem.
• The residents' representative also discussed issues with people and shared any concerns with the management team.
• People were provided with information about an advocacy service which would provide support and advice independent from the home.
• A healthcare professional told us the home responded well if concerns were raised with them. They said, "When concerns for Pinehurst residents arise, Pinehurst staff promptly contact the client's care coordinator describing the concerns and facilitating follow up contacts."

End of life care and support:

• If people wished to remain at Pinehurst, staff were able to support their end of life care with advice and guidance from the community nurses. Where people's wishes were known, these were recorded.

Requires Improvement

Is the service well-led?

Our findings

Leadership and management did not consistently assure person-centred, high quality care and a fair and open culture.

Managers and staff roles, and understand quality performance, risks and regulatory requirements. Continuous learning and improving care.

• A recent change within the management team had highlighted that systems were not being used effectively to ensure people would continue to receive a consistently safe service. For example, care records did not fully reflect people's care needs and risks associated with their mental health needs. This meant staff were not provided with clear guidance about how to support people. Not all staff had received training in topics related to safety and to people's needs.
• At the time of the inspection, there were no quality assurance system in place to assess, monitor and improve the service provided.
• The home had failed to notify CQC of significant events which effected people's health, safety and welfare of people.
• Following the inspection, the management team introduced a number of audits to assess and monitor safety and quality issues, the results of which will be discussed at the newly introduced management meetings.
• We received positive feedback about the management of the home. People, healthcare professionals and the relative we spoke with all said the home was well managed.

Failure to establish systems and processes to assess, monitor and improve the service and to ensure people's care records are complete, accurate and contemporaneous is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Failure to notify CQC of significant events that effect people's health, safety and welfare of is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promotion of person-centred, high-quality care and support:

• People received personalised care as staff knew people well and had developed good relationships with them. One healthcare professional told us, "I have found the service effective in managing and caring for their residents and providing adequate levels of supervision, care and support including counselling and advice and the management of practical matters."
• The registered manager and staff spoke positively about the people they supported and promoted their independence and welfare.

Working in partnership with others. Engaging and involving people using the service, the public and staff:

• People and staff said they felt listened to.

• People had completed a survey asking their views about the home.
• Regular resident and staff meetings provided people and staff with the opportunity to share information and make suggestions for improvements. One member of staff said, "We work great as a team, we're close as a team. If anyone has a problem we sort it out."
• The home had developed links with the local community.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The home had failed to notify CQC of significant events that effected people's health, safety and welfare. Regulation (1) (2)(b)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The home did not have effective systems in place to assess, monitor and improve the quality and safety of the service. The home did not maintain accurate, complete and contemporaneous care and treatment records for each service user. Regulation 17 (1) (2)(a)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not always being followed. Regulation 19 (2)