Ms Gene S Mangold

Pinewood Tower Rest Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 and 6 May 2016 and was unannounced.

Pinewood Tower Rest Home is a care home for up to 14 adults and specialises in caring for people who are living with dementia or other mental health conditions. Nursing care is not provided. When we inspected, there were 11 people using the service. Rooms are on the ground and first floor, which is accessed by stairs and a stairlift. There is a communal lounge dining room on the ground floor, with access to the garden through a patio door.

The service had a friendly, homely atmosphere. People received the care and support they needed from staff who understood their needs and knew about their backgrounds, achievements, strengths and preferences. People's health needs were met; where necessary, advice from health and social care professionals was sought and acted upon.

There were sufficient staff on duty to provide care safely and effectively, in an unhurried way. Although busy, staff spent time with people and encouraged them to get involved in individual activities they might find meaningful. They treated people with respect and dignity.

Staff morale was good and staff described the provider as supportive. Staff received the support they needed through training and regular supervision to be able to perform their roles. The provider worked closely with staff, overseeing their practice, providing constructive challenge and ensuring that any necessary improvements were made.

People, relatives and staff felt able to raise concerns with the provider and had confidence that she would take the appropriate action to address these.

Whilst the provider made checks when recruiting staff to ensure they were suitable to work with people in a care setting, she had not always been able to obtain detailed references from former employers. It is not unusual for employers to provide references that state only when an employee started and finished work with them. However, the provider had in one case accepted a reference from a candidate's colleague rather than their line manager or other person authorised by the former employer to give a reference. We have made a recommendation about obtaining references from former employers.

The premises and equipment were clean and well maintained. The provider was able to tell us about their plan for emergencies such as damage by fire, flooding, utilities failure or inclement weather. However, they had not clearly written this down. We have made a recommendation about having written emergency plan.

The provider and staff had an understanding of the requirements of the Mental Capacity Act 2005. Where a person lacked the mental capacity to consent to aspects of their care, the appropriate people had been consulted and decisions made about the care that should be delivered in the person's best interests. These

best interests decisions had been recorded, but the process of assessing the person's mental capacity had not been. The provider agreed to seek advice about a suitable template for recording mental capacity assessments. We have made a recommendation about recording mental capacity assessments.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff on duty with the right skills to care for people safely and effectively.

Medicines were managed safely.

Premises and equipment were clean and well maintained.

Is the service effective?

Good

The service was effective.

People were supported by staff who were themselves well supported through training and supervision.

People's healthcare needs were met. The service sought and acted upon advice from health and social care professionals when necessary.

People were encouraged to eat and drink and received the support they needed to do so.

Is the service caring?

Good

The service was caring.

People received care and support from staff who knew about their personal background, interests, strengths and preferences.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People and their relatives were confident in the quality of the care they received.

People's needs were assessed and they received care and support to meet those needs.

Is the service well-led?

Good

The service was well led.

People, relatives and staff felt able to tell the provider about any concerns, in the confidence that something would be done about them.

Staff morale was good. Staff were motivated and understood what was expected of them.

The provider kept close oversight of the service and had systems in place to ensure that quality was maintained.

Pinewood Tower Rest 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 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.

The inspection took place on 5 and 6 May 2016 and was unannounced. It was undertaken by one inspector.

Prior to the inspection we reviewed the information we held about the service, including notifications of incidents over the past 12 months. Before the inspection, 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 it does well and the improvements they plan to make.

During the inspection we talked with two people who lived at the service, three visiting relatives and a visiting health professional. We also spoke with three care staff, one of the ancillary staff and the owner of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. As well as observing staff supporting people in communal areas, we reviewed three people's care records, including assessments, care plans, daily records and medicines administration records. We also reviewed records relating to how the service was run, including four staff files, staff rotas, complaints, accidents and incidents, premises and equipment maintenance, audits and a local authority contract monitoring report.

Good

Is the service safe?

Our findings

People said they felt they or their relatives were safe living at the home, and we saw that people looked comfortable in the presence of staff. For example, a person told us that if they had any problems they would go to the staff.

People benefited from a safe service where staff understood their safeguarding responsibilities. Staff had training in safeguarding and understood how to identify and report signs that someone might be experiencing abuse or neglect. Appropriate action had been taken to keep people safe, including referring concerns about possible abuse or neglect to the local authority.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. People's risk assessments covered areas that would be expected in a care setting, such as the risk of developing pressure ulcers, malnutrition screening and moving and handling. Risk assessments also covered risks particular to individual people, such as the risk of self neglect or behaviour that challenged others.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. The provider reviewed accident and incident forms and care plans were updated where necessary following accidents or incidents. Staff observed people following falls, using a checklist that prompted them to check various aspects of people's safety and wellbeing, such as their level of alertness, whether they were positioned comfortably, whether they were in pain or needed the toilet, and whether they had a call bell and any other equipment they needed in place.

Occasionally people became upset, anxious or emotional. Some people could behave in a way that challenged others and on occasion needed safe holding in order to receive care. Staff were trained in safe holding, so that they could do this safely and in a way that respected the person's human rights. Safe holding was used as a last resort, after other less restrictive interventions had been tried. Care plans made clear the circumstances in which safe holding could be used and specified what staff should do beforehand to try and avoid the need for it.

The building had been maintained and was kept clean. Radiators were covered and wardrobes were fixed to the wall, to reduce the risk of someone pulling them over. Most upstairs window openings were restricted, to lessen the risk of someone falling from them. An upstairs bathroom window opened fully; we pointed this out to the provider, who arranged for their maintenance contractor to fit a restrictor. Staff had fire training and drills were undertaken periodically. Fire equipment and alarms were checked regularly by staff and periodically by a fire contractor.

The provider told us about the arrangements in place to keep people safe in an emergency, such as fire, flooding, utilities failure or staff sickness. However, these were not written down so that staff could access them if there was an emergency and the provider or her deputy manager were not available.

We recommend that arrangements for emergencies such as fire, flooding, inclement weather and utilities failure are clearly documented and are easily accessible to staff.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. A regular visitor said that generally there were enough staff and that they were happy that staffing levels were sufficient to meet their relative's needs. Staff confirmed that staffing levels were generally satisfactory. There were two vacancies for care staff; one replacement had been appointed and the other was still sought. Gaps in the staff rota were filled by existing staff working extra hours or agency staff. The provider informed us that where agency staff were used, these were generally staff who regularly worked at the home.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Before they started work, criminal records disclosures were obtained from the Disclosure and Barring Service to make sure staff were suitable to work with adults in a care setting. Staff files included an application form and CV, proof of identity and entitlement to work in the UK, and records of interview. The Regulations require providers to keep each staff member's full employment history, together with a satisfactory written explanation of any gaps. By the end of inspection, the provider had ensured the staff files contained continuous records of staff employment prior to staff taking up their posts at the service.

References were sought, but in one case were obtained from a former colleague rather than the candidate's line manager or employer. The provider explained they had sometimes experienced difficulty in obtaining detailed references from employers and so had accepted references from colleagues.

We recommend that references are always sought from a candidate's employer, and that references from others, such as colleagues, are in addition to this.

There were safe medication administration systems in place and people received their medicines when required. Staff who administered medication had been trained to do so and their competence in handling medicines was assessed. Some people lacked the mental capacity to understand the implications of refusing medicines and needed them concealed in food or drink. This was only done where it was assessed to be in the person's best interests, after consultation with the person's GP, community mental health professionals, family or advocate where involved, and a pharmacist.

Good

Is the service effective?

Our findings

A person who had a condition that was to some extent reversible praised the support they had received from the service, which had led to an improvement in their condition and gains in their independence. Relatives commented positively about the effectiveness of the home. For example, one said of their family member who they thought had benefited from living at the service, "You couldn't meet anybody that was more happy". This person looked comfortable and smiled a lot during the inspection.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff told us they had the training they needed when they started working at the service, that they were supported to refresh their training and that the training was of good quality. A new staff member said they were working towards the Care Certificate, a nationally recognised qualification for staff who are new to care. Staff training records showed that staff had training on a range of topics. These included safeguarding, moving and handling, food hygiene, infection control, the Mental Capacity Act 2005 and dementia awareness. Most staff training was provided face to face by external trainers who specialised in social care. Training was also provided from time to time by visiting health professionals. For example, the local mental health in-reach service had recently led a session on managing behaviour that challenges others and a dietician would soon be delivering training in nutrition and malnutrition risk screening.

People were supported by staff who were well supported by the home's management and their colleagues. Staff had supervision meetings with their line manager every three months. New staff each had a mentor whom they met each week. Staff confirmed they had regular supervision meetings that enabled them to discuss any training needs or concerns they had. A staff member commented that they were supported to understand why they did particular things, and said, "[Provider] does support you. If you need training, learning, she supports you. If you ask she provides".

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 as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. People or their legal representatives were involved in care planning and where possible their consent was

sought to confirm they agreed with the care and support provided. Daily care records reflected people's choices being respected, for example in relation to food and assistance with personal care. Where people lacked the mental capacity to agree to aspects of their care, the provider ensured the care delivered was in the people's best interests. The provider understood the principles of the MCA regarding assessing people's mental capacity in relation to specific decisions but mental capacity assessments were not clearly recorded, although best interests decisions were documented. The provider acknowledged that recording could be improved and agreed to obtain advice about how better to record mental capacity assessments.

The provider had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body and had a system to prompt them when authorisations needed to be renewed.

People were encouraged to eat and drink. At mealtimes people were supported to have a meal of their choice by organised and attentive staff. Snacks and drinks were provided between meals. For example, on the first morning of the inspection we observed people sitting in the garden around a table with drinks in front of them, eating pieces of fruit. Other people were in the lounge and staff were giving them food they could pick up with their fingers. It was cut up so that it looked inviting and would encourage people to eat. Throughout the inspection, people had drinks to hand and staff prompted them to drink.

People's dietary needs and preferences were documented and known by the cook and staff. The cook was aware of people's needs, likes and dislikes and confirmed that staff kept them up to date with any changes. The cook was aware of people's usual preferences but asked them what they would like before preparing the meal. People's risk of malnutrition was assessed at least monthly, for referral to the GP if staff thought the extent of unplanned weight loss indicated assessment by a dietician or speech and language therapist was needed.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Care plans reflected advice obtained from health professionals. The provider highlighted that people at the service nowadays tended to have high needs and needed support from mental health services.

Since the last inspection, changes had been made to make the garden more inviting for people to use. A conifer hedge had been cut down, which made the garden and lounge/dining room lighter. A shelter had been built for smokers. There was a lawn, garden furniture, containers of plants and a pond, which was fenced off with a barrier at waist height to keep people safe.

Good

Is the service caring?

Our findings

People looked happy and contented when staff spent time with them. Those people who could told us staff were kind and caring, as did people's relatives. For example, a person said of the staff, "They're very [caring], all of them. I can't complain about any of them". Someone else commented that their family member fitted in well and felt that staff respected their relative as a person. Another visitor told us their relative had died some time before but that they still liked to visit and were made welcome. A staff member, who had previously worked with a care agency commented they found staff at this service were particularly caring.

People were treated with kindness and compassion in their day-to-day care. All the interactions we saw were positive, reflecting the way staff respected people as individuals. Staff spoke with people in a respectful manner, talking clearly and allowing people time to respond. They listened to people and respected their choices, such as where they wanted to sit. People's care was not rushed and staff spent time with them. For example, staff assisted people to eat lunch, working at their pace and talking about the food. When people became upset or confused, staff showed concern for their wellbeing, calmly establishing what was the matter and reassuring them.

People received care and support from staff who had got to know them well. People's records included 'This is me' information about the person, their background and their preferences that would be helpful and important for staff to know, and assist them to view the person as an individual. Staff were clearly familiar with people's interests and preferences. They were able to tell us things about people's backgrounds and preferences, and we observed them using this in their interactions with people. For example, a person told us that staff knew they liked to keep busy and do some of the washing up; staff explained and we saw that the person washed the medicines pots. Staff knew another person particularly liked to spend time sitting in the garden with their feet up and made it easy for them to do so safely, ensuring they had a suitable chair and a sun hat. We also observed a staff member speaking with someone in their native language, which the person responded to by smiling and engaging in the conversation.

Throughout the inspection, people's dignity was respected by staff. People received discreet assistance from staff when they needed personal care, such as help to change clothes. People were assisted in private with getting washed, changed and using the toilet. The privacy of people's information was respected and staff did not talk about people in others' earshot.

People were given the information and explanations they needed, at the time they needed them. A relative told us, "If anything goes wrong I know immediately". There was a clearly visible clock in the lounge above the fire place. In the dining area there was a noticeboard which displayed the correct day and date and set out key information, such as mealtimes and when the hairdresser, chiropodist and library service were next visiting. As people were living with memory difficulties, staff explained what they were doing and prompted people as to the time of day, for example, explaining when lunch time was approaching. Each person had a key worker who oversaw their care and where appropriate kept in contact with their families. For example, a key worker called someone's son weekly with an update. Visitors were welcomed whenever they wished to visit, with no set visiting times.

Good

Is the service responsive?

Our findings

People were complimentary about their or their relative's care. For example, a relative commented that their family member had had outstanding care. People and relatives talked about activities being available. A regular visitor commented that most people spent their time in communal areas where "plenty happens".

Care plans were personalised. People had their needs assessed before they moved in to ensure the service could meet their needs, and then in more detail after their admission. Information was sought from the person, their relatives and other professionals involved in their care. Information from these assessments was used to develop individualised care plans. The examples seen reflected people's needs and choices. They covered activities of daily living with which people needed support, such as washing and dressing, oral hygiene, continence, mobility, eating and drinking, managing pain and physical health conditions. Care plans also addressed people's psychological and emotional needs, such as communication, making choices and decisions, and mental health conditions. Care plans were kept under regular review and updated as required. The provider checked them each month to make sure they accurately reflected people's needs and contained the required information.

People received the care they needed. Staff were familiar with and followed people's care plans. They were able to tell us about the care people needed.

People were supported to take part in activities by an activities worker and care staff. This was more on an individual and low key basis rather than in organised groups, which took into account people's interests, preferences and advancing dementia. A person who liked to be busy told us they looked forward to having a trip out each week with the activities worker, and enjoyed going to the shops in Westbourne nearby. Someone else told us they wanted to go out, and the provider later explained that this person would be going out later on with the activities worker. The inspection took place during sunny weather and we observed people sitting in the garden with a member of staff, some leafing through magazines. A person who enjoyed gardening spent time looking at and tending container plants. Indoors, some people sat holding objects such as dolls. Other people were involved in familiar household tasks such as folding laundry.

Information about how to make a complaint was displayed in the hallway. There were no complaints on file since the last inspection and the provider confirmed that no complaints had been received since then.

Good

Is the service well-led?

Our findings

People and their relatives expressed confidence that the provider would listen to and deal with any concerns.

The service had a sense of being relaxed and informal. A family member described the home as having a "family atmosphere". A staff member commented, "We try to make it relaxed". They described the home as "a good home" and said it was managed in an open way.

People and those important to them had opportunities to feed back their views about the home and quality of the service they received. The provider had found that meetings for residents and relatives were not well attended. Instead, they talked informally to people and their relatives, which was easy for them to do as the home is small and they saw them regularly. We observed this happen during the inspection. A quality assurance survey was in progress; questionnaires had been sent out to relatives.

People benefited from staff who understood and were confident about using the whistleblowing procedure. Staff told us morale was good. They said they found the provider and deputy manager very open and could talk to them if they had concerns, in the knowledge that any problems would be sorted out. They were also confident that the provider would challenge them in a constructive manner if there were concerns about their practice.

Prior to the inspection we were advised that there had been an employment tribunal. As a result we reviewed whether any staff were sponsored by the provider to work in the UK and whether they had appropriate training and supervision to undertake their roles. The provider confirmed there were no longer any staff under sponsorship. Records showed that staff had received satisfactory training and supervision.

The provider had notified CQC about significant events. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The provider managed the home herself. She spent much time working alongside staff, which gave her an insight into the way staff worked and the quality of the service they provided. There were regular team meetings, at which staff discussed practice and how it could be improved. Some staff were allocated responsibility for particular areas such as infection control and health and safety. They undertook audits related to these responsibilities, such as building health and safety checks, wheelchair safety checks, checks of slings used for hoisting people, mattress audits, infection prevention and control audits and staff hand hygiene checks. Staff took these responsibilities seriously. Their audits were overseen by the provider and any matters arising were discussed at team meetings.