Four Seasons 2000 Limited

Pine Meadows Care Home

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

This inspection took place on the 1 July 2015 and was unannounced. At our previous inspections in June 2014 and September 2014 we had concerns that there was insufficient staff to keep people safe. People were not receiving care that was safe and that met their needs this was because the providers quality assurance systems were ineffective. At this inspection we found that there was still insufficient deployed staff to meet the needs of people who used the service and some people were being deprived of their liberty unlawfully. The provider's quality assurance systems had not been effective in ensuring that the on-going breach in staffing was met and that people were receiving care that was unsafe.

Pine Meadows provides accommodation and personal or nursing care to up to 70 people. The service is divided into three living areas. One area provides residential care, one area called Chestnut provides nursing care and the other area called Fir Cones cared for people living with dementia.

Summary of findings

There was a registered manager in post, they were not available on the day of the inspection. We were supported by the area and peripatetic 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 2008 and associated Regulations about how the service is run.

The Mental Capacity Act (MCA) 2005 is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The Deprivation of Liberty Safeguards are part of the MCA. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The provider did not ensure that people were not being unlawfully restricted of their liberty.

People's needs were not always met in a timely and safe way due to there being insufficient staff deployed throughout the service. Some staff did not like or feel confident working in some areas of the service. People's medicines were not always managed safely.

Risks to people's health and wellbeing were not consistently managed and reviewed. People were at risk of not receiving the care they required through poor record keeping.

Some people were not treated with dignity and respect. Staff practice was not managed to ensure that people were not being abused and that they were treated with kindness and compassion.

People told us there was not enough to do. Some people sat for long periods of time with little or no social stimulation. Limited opportunities were available to people to be able to engage in a hobby or activity of their choice.

Systems to monitor the quality of the service were not effective. The provider used a dependency tool to ascertain staffing levels, however we saw that this was not effective as there were not enough staff to meet people's needs.

People's were supported to attend health appointments supported by staff. The staff responded when they recognised a change in people's health care needs and sought support from other agencies.

We found three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe. There were insufficient numbers of staff to meet people's individual needs and keep people safe. People's medicines were not always managed safely. Risks to people's health and wellbeing were not consistently managed and reviewed.

People were not always protected from abuse as poor staff practice had been identified but was not being managed.

Requires Improvement

Is the service effective?

The service was not consistently effective. Some people were being unlawfully deprived of their liberty. Staff did not always feel confident to do what they were asked to do. The provider could not be sure that people who required food monitoring had their nutritional needs met.

People had their health needs met and were supported to attend appointments.

Requires Improvement

Is the service caring?

The service was not consistently caring. Some staff did not always treat people with dignity and respect. Some people's independence was promoted, however some people were being restricted.

People's privacy was maintained.

Requires Improvement

Is the service responsive?

The service was not consistently responsive. Several people told us there was not enough to do and they were bored. People knew who and how to complain, however some people were still waiting for a satisfactory outcome to their complaint.

People's needs were responded to when there was a change to their assessed needs.

Requires Improvement

Is the service well-led?

The service was not consistently well led. The provider continued to be in breach of regulations of The Health and Social Care Act 2008 following two previous inspections. Poor staff practice once identified was not managed to prevent further incidents. The quality assurance systems and the staffing dependency tool the provider had in place were not effective.

Staff felt the manager was approachable and supportive and that there had been some improvements.

Requires Improvement

Pine Meadows 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 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.'

This inspection took place on the 1 July 2015 and was unannounced.

The inspection team consisted of three inspectors, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at information we hold on the service to plan our inspection. We had received information from the local authority who were conducting a large scale investigation due to the large amount of safeguarding incidents that had taken place at the service. We looked at notifications the manager had sent us and at previous inspection reports.

We spoke with 10 people who used the service, three visitors and relatives. We observed people's care in all three areas of the service. We interviewed staff and observed staffing levels.

We looked at the providers recruitment procedure, staff rotas, and records of six people who used the service . We looked at the systems the provider had in place to monitor and maintain the quality of the service. We did this to see if improvements had been made since our last inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that there was insufficient staff to safely meet the needs of people who used the service. The provider had been in breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to the new Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Call bells were not answered in a timely manner and people had to wait to have their care needs met. We had asked the provider to make improvements. At this inspection we found that staffing levels were still not adequate to safely meet people's needs. Staff worked consistently in the same unit so when they were asked to work elsewhere within the service they did not know the needs of people. The nurse told us: "Staff from the residential unit don't like working in the dementia unit so it makes it more difficult". One staff member told us: "I have to ask before I do anything because I don't know people".

On Fir Cones we saw that people's needs were high due to their dementia. People needed support to eat, drink and with personal care. They needed support to orientate around their living area and to remain safe. We saw that people were left for long periods of time with little or no support or interaction as the staff were busy completing tasks. Several people throughout the service were at high risk of falls. On Chestnut one person who was at high risk of falling told us: "If I fell I would have to wait as no one else could find the staff because they are too busy to tell them".

We observed lunch time and saw that it was very busy and staff were rushed and stressed. The food came up hot on a trolley and we observed that staff were serving the food as well as supporting people. We saw one person come with their plate to staff and ask for his lunch as they became impatient whilst waiting. We saw one person who used the service clearing people's plates from the lounge when they had finished as there were no staff in the lounge where two people were eating. Staff told us they were very busy. One staff member said: "We have people to support in their rooms as well as in here [dining room]. It's so busy, it's always like this." We observed that one person became tearful whilst waiting for their lunch in the lounge but there were no staff in the lounge to respond to their need. We saw that people sat for long periods of time in the lounge or their rooms with no stimulation. Staff did not have the time to sit and talk with people. One staff member said: "I haven't got time to even read the care plans and actually fully understand people's needs.

On Chestnut which was the nursing unit one person told us: "If I ask for a shower I get told there is not enough staff for me to have one, then I ask the next shift and they say not today they are busy, I get one very two weeks, I would prefer to have one more often like I did at home". Staff told us they did not have time to bathe people when they asked and records we looked at supported this.

On the residential unit we saw that people were left for periods of time with no support. We were told by the area manager that one staff member should be present in the lounge at all times. We observed that there were often times when no staff were available in the lounge area and we saw one person was constantly seeking staff support and reassurance. This person experienced periods of confusion and disorientation. When we engaged with them, they quickly responded and became settled.

These issues constitute a continued breach of Regulation 18 of The health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People were not always protected from abuse as staff told us they had reported allegations of abuse in relation to a member of staff and they had not been dealt with. We observed poor practice with the same staff member and reported it to the area manager, this was dealt with promptly. We were informed that some staff had a conflict of interests, which may discourage them from reporting abuse. The area manager told us that they would look into the matter.

People had different experiences of risk management dependent on the area of the service they resided. On the residential unit we saw people taking reasonable risks such a mobilising around the service with their mobility aids and some people with tea making facilities in their rooms. However people living on Fir Cones were not encouraged to be independent due to the lack of staff support available to them. We heard staff asking people to sit down or people were left in the lounge area.

Some people were at high risk of developing pressure sores. We saw staff were not clear about how to provide support and what measures were in place to reduce the risks of pressure sores. For one person this meant that staff

Requires Improvement

Is the service safe?

did not know how long the person should receive support in a seated position. Staff could not agree whether the person should have their lunch whilst seated with others or to receive care in bed. The care records stated that the person could sit out of bed for a period of two hours but different staff members were unsure of what support was needed. This meant this person was at risk of receiving inconsistent care.

People's medicines were not always administered or stored safely. We saw that one person was given their medication and a glass of water and left with it. The person became distressed because they could not swallow them. Another person who used the service offered them reassurance as there were no staff available to support them. We saw that people's prescribed food supplements were left on top of the medication cabinet in the kitchen area where people were having their breakfast. This meant that people were at risk of taking medicines that were not prescribed for them.

The provider followed safe recruitment procedures when employing new staff. We saw that staff had been checked for their suitability to work prior to being offered the job.

Requires Improvement

Is the service effective?

Our findings

Several people who lacked mental capacity were being restricted within areas of the service. People on Fir Cones and Chestnut units were not able to go downstairs or out of their unit without staff support due to keypad locks. We asked the nurse if anyone had a Deprivation of Liberty Safeguards (DoLS) authorisation in place. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict their freedom. The peripatetic manager told us that only one referral had been made to the local authority to legally deprive a person of their liberty, however we saw several people were being restricted without consultation or consent. We also saw some people were sitting in chairs that restricted their movements. Staff confirmed these people did not have capacity to make the decision about their care although capacity assessments had not been completed. We saw people were moved to different rooms in their chair and a decision about whether this was in their bet interest had not been made and whether this was the least restrictive action that the staff could take to keep people safe.

These issues were a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff had a period of induction prior to working alone. Staff told us they received regular supervision from a senior member of staff however some staff told us that they would benefit from more training in behaviour that challenges and dementia as they did not feel confident to work in all areas of the service. We were told that some staff did not like working in Fir Cones. One member of staff told us: "I don't know enough about the people and what they need to work in there".

People who had been identified as losing weight were referred to their GP or dietician for advice and support. We saw that the Speech and language team had assessed some people to require a soft diet due to swallowing difficulties. Soft diets were nicely presented and there was specialist equipment available for people who required it, such as mugs with lids on and lipped plates.

Some people required their food and fluid intake monitoring. We saw staff recorded what people had to eat and drink but did not total the amount of fluids at the end of every day. One person's care plan stated 'ensure the amount of food and fluid is totalled'. We saw that this person's and others people's totals had not been added up. This meant that the provider could not be sure that people were receiving the required amount of fluids and people were at risk of dehydration.

People were supported to attend health care appointments. One person told us: "A carer took me to the opticians the other day". We saw a visiting GP, chiropodist and district nurse attending to the needs of individual people within the service.

Requires Improvement

Is the service caring?

Our findings

We received a mixture of views from people who used the service about how they felt they were treated. Some people told us that not all staff were kind and caring. Two visitors told us they found one member of staff abrupt. One person who used the service told us: "Staff can make me feel silly when I forget and I can see it in their eyes". We observed that some staff did not always interact appropriately with people when supporting them. For example one person was being supported to move with the use of a hoist. We observed that the person looked unsure, however staff did not offer any reassurance throughout the process and engaged only in minimal conversation. Another person was supported from the dining area to their room by one member of staff with no conversation or explanation as to what was happening. We observed that cold drinks such as squash were being offered to people. One person asked the staff for a cup of tea and they were told they couldn't have one. This meant that the person's individual preferences were not being respected.

Some people were happy with their care and told us they were treated well. One relative said: "I come every day, not because I'm checking up, because I want to. The compassion from staff is lovely, the quality of care from staff is marvellous, and they are so caring, they know them so well, they've got their favourites but they [staff] are all fabulous."

Some people were unable to be involved in decisions about their care because of their dementia Staff told us they involved people's relatives in the persons care. One relative said "[Relative] has had two reviews since they've been here and I've been invited and attended both. They always get in touch and tell me what's going on, I visit every day but they still ring me if they need to and tell us about everything, they're great like that."

People told us that staff respected people's privacy. One person told us: "Yes, the staff always knock on my door before coming in". People's daily records were kept in their bedrooms and care plans were kept in a central point on each unit, where only staff had access. This meant that other people's confidential information could not be accessed by other people who were not involved in care provisions.

There were regular meetings for people who used the service and their relatives. One relative told us: "There have been relatives meetings but I had to send my apologies".

Some people were encouraged to be as independent as they were able to be. These people mainly resided in the residential unit. One person had their own fridge and tea making facilities and other people were seen mobilising around the unit and into the garden freely with no support. One person told us: "I can get up and go to bed when I like, sometimes I get up in the early hours and the staff make me a cup of tea, although some staff tell me I shouldn't have one". In other areas of the service, people were confined to their unit and some people were confined to chairs that reduced their ability to be independent.

Requires Improvement

Is the service responsive?

Our findings

People who used the service experienced differing levels of personalised care. Only people with capacity to choose were involved in activities such as bingo. However people in Fir Cones or Chestnut units were not actively engaged in any activity. People were supported to get up, to eat their meals and sit in the lounge with no other activity or hobby of their choice on offer. One person in Fir Cones and one person in Chestnut unit told us they were bored. One person said: "I'm bored, so I sleep all day and then I can't sleep at night". Another person said: "I'm bored; I just sit and watch TV all day". Another person in the residential unit told us: "I'm alright but there's nothing for the others, I entertain myself but some people need more help".

The meal time experience differed throughout the units. People in the residential unit were shown the two meal options available to help them choose. However on Fir Cones, food was served by care staff from a hot trolley and the option to see the food was not available to them, this may have been of benefit to them due to their dementia.

People told us they would complain if they needed to. Some people had complained and told us they had received satisfactory outcomes to their complaints. However some people told us they were still waiting for a response or that the responses were slow. One visitor told us: "I mentioned my [relatives] bedroom door, she can't shut it and she likes it shut, but this was about two weeks ago and we are still waiting". Another visiting relative told us: "I have complained about my mum's diet, she's on a pureed diet and she has limited options, this is still on-going". There were no records of these complaints maintained.

Several people required support to manage their anxiety. One person's care plan for managing their anxieties explained about the person's history and what they may be trying to communicate with their behaviour. It gave staff clear direction of what to look out for, how to manage the behaviour, what to consider and what to talk to the person about. We saw the nurse used the techniques described in the care plan when the person became distressed at the dining table, and that these were successful.

In Fir Cones we saw that a few people had a record of their personal history on the walls in their bedrooms. This gave staff information on what the person had done before coming to the service, such as their chosen career. Staff were then able to use the information to engage with the person and to use to jog their memory of their past life and hobbies.

Requires Improvement

Is the service well-led?

Our findings

At our previous two inspections in June and September 2014 we had concerns that there was insufficient staff to keep people safe. The provider had responded by moving people with nursing needs into one area and defining the different units. However we found that there was still insufficient staff and people were not receiving care that was safe and that met their needs. The provider had told us that it used a staffing dependency tool to determine the staffing levels. This tool had been in use for all previous inspections and was still in use. We were told by the area manager that the tool was used in all of the provider's services, however we found that the tool was ineffective at Pine Meadows and this had not been considered by the provider.

People's records did not always reflect the care that people received. Some people needed regular care interventions and we saw gaps in the recordings. For example we saw one person's repositioning chart had not been signed at the time the person should have been repositioned and people who required food and fluid monitoring did not have a total amount added up. This meant that the provider could not be sure that people were repositioned when required and had sufficient to eat and drink.

We became aware of some individual poor staff practice. We alerted the area manager and peripatetic manager of this. We were told that they were aware of issues relating to these staff, however apart from one generic warning being issued, these staff were not being supervised and managed closely to ensure an improvement in their performance. This meant that the provider was not ensuring that staff knew what was expected of them and ensured that the culture of the service meant that people were treated with dignity and respect.

The provider had several quality monitoring audits in place, however they were not all effective as they continued to be in breach of regulations of The Health and Social Care Act 2008 following previous inspections.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to told us they liked the manager and found them to be supportive. One staff member said: "Things are improving bit by bit". People and visitors said that they thought the manager was approachable. One person said: "You're always a bit wary of new people so at first I didn't really approach her but now I know her. She's very professional; I would feel able to approach her with any problems but I haven't any."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users must be protected from abuse and improper treatment in accordance with this regulation.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.**

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 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

The enforcement action we took:
We have issued the provider with a warning notice to improve.