Queensland Care Limited

The Pines 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 responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service over two days on 28 January and 11 February 2015. Breaches of legal requirements were found in relation to care and welfare, staffing levels, staff training, and quality monitoring. After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook an announced focused inspection on 22 September 2015 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Pines Care Home on our website at www.cqc.org.uk

The Pines Care Home provides personal care and accommodation for up to 30 people, some of whom may be living with dementia. Accommodation is provided over four floors, which are accessible by passenger lift. There are a range of communal facilities including two lounges, a dining room, conservatory and an enclosed garden area. The home is situated close to Harrogate town centre with views over an area of woodland known as the Pinewoods.

Summary of findings

This inspection found that previous breached identified had not been met and the provider had not taken sufficient action to improve the service. The Care Quality Commission (CQC) is now considering the appropriate regulatory response to resolve the problems we found.

Before our inspection the registered manager informed us that they had left the service. The provider had appointed a new manager who told us that they had begun the process of applying to be registered with CQC. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that both the new manager and the area manager were providing management support to other services within the organisation and this had resulted in inconsistent leadership and support at The Pines Care Home. When we visited we found that the nominated individual was no longer working for the organisation. A nominated individual is a person who represents the provider and is responsible for the supervising the management of the regulated activity provided. The provider had not notified the CQC about this change as the law requires.

There had been some improvements in staffing levels. However, we found that the home was still experiencing staffing issues due to staff sickness and staff vacancies and they were reliant on agency staff to cover shifts. Eleven people were identified as having complex health care needs and we found that the way that staffing was organised and managed meant that there were insufficient staff to meet people's care needs. Care staff had domestic, laundry and kitchen tasks to perform in addition to the care tasks they had to complete. Staff said they did not always feel that they had sufficient training to do their job properly and we found that they lacked the appropriate skills to provide people with safe, effective care.

We found that care was not always delivered in line with people's care plans which meant that people's safety and wellbeing could be compromised. During our visit we saw people sometimes had to wait for long periods for assistance with their care needs. People had sufficient food however we saw that the layout of the home impacted on staff ability to deliver quality, warm meals to people in a timely way or offer appropriate support and assistance when needed.

Although there had been some improvement in the activities provided overall the staff lacked the necessary knowledge and understanding to provide people with safe, effective care. Staff training and supervision was out of date and staff told us that the lack of training was impacting on their ability to provide safe, consistent care.

Effective management systems were not in place to ensure people's safety and welfare was protected.

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The focused inspection on 22 September 2015 took place to confirm that the provider had met legal requirements and that the service was now safe, effective, responsive and well led. This inspection found that previous breached identified had not been met and the provider had not taken sufficient action to improve the service. We identified continued breaches of legal requirements in relation to care and welfare, staffing levels and staff

Summary of findings

training, which impacted on staff ability to provide safe, consistent care. Audit and quality assurance systems had not been effective in identifying and addressing problems. The Care Quality Commission (CQC) is now considering the appropriate regulatory response to resolve the problems we found.

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Effective management systems were not in place to ensure people's safety and welfare was protected.

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?

Requires improvement

The service was not safe.

The provider had increased staffing levels. However there was not enough staff on duty to meet people's needs in a timely way.

In addition to their caring duties staff had domestic, kitchen and laundry tasks to complete. Staff were kept very busy and did not have sufficient time to spend with people. Staff vacancies and sickness impacted on staff ability to provide people with safe, effective care and staff support and assistance was not always available to people in timely way.

Despite minor improvements in staffing levels since the last inspection staff were not provided in sufficient numbers to adequately support people and meet people's care needs consistently.

Is the service effective?

Requires improvement

The service was not effective.

We found evidence to show that staff were not sufficiently skilled and knowledgeable to meet people's care needs effectively.

While the new manager had plans in place to deal with training issues we found that staff were not receiving adequate training and supervision to enable them to fulfil their roles effectively.

Is the service responsive?

Requires improvement

The service was not responsive.

We found evidence to show that staff had failed to provide care for people in line with their care plan. Staff lacked the necessary knowledge and understanding to maintain appropriate records and they did not always follow expert advice and guidance when it was given to them.

People were not actively involved in the planning or the review of their care and essential information regarding assessments was not always available to help staff provide care in line with people's wishes and preferences.

We found some improvement in the level of activities being provided but this was at an early stage of development so we were not able to measure progress in this area.

People were at risk of receiving unsafe or inappropriate care because care was not always planned and delivered safely.

Is the service well-led?

Requires improvement

The service was not well-led.

Summary of findings

There was inconsistent leadership and support. The new manager and area manager had spent limited time in the service since they were appointed and we identified continuing shortfalls in relation to quality monitoring and assurance.

The provider had failed to notify CQC about important changes as required by law.

Although the lack of quality assurance was highlighted at the last inspection we found that quality assurance and monitoring systems were still at an early stage of development.

Management systems were not working effectively. Where audits had been completed these contained little detail and did not reflect any evidence of analysis. This meant that the provider was failing to monitor the quality of the service and take action to improve the service.

The registered person did not have effective systems in place to monitor the quality of service delivery.

The Pines 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.

We undertook an announced focused inspection of The Pines Care Home on 22 September 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 28 January and 11 February 2015 had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well led. This is because the service was not meeting some legal requirements.

The inspection took place on 22 September 2015. The provider was given four days' notice because there was a new manager in post and we wanted to be sure that they were available when we visited.

The inspection team was made up of one adult social care inspector 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. The expert by experience had personal experience of caring for people with a learning disability and older people.

Before our inspection we reviewed the information we held about the service. This included the action plan, notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law.

During our inspection we spoke with four people using the service about the care they received. We observed the lunchtime experience and observed care received by another seven people. We looked at care records for three people, checked food and fluid intake monitoring charts and turning charts. We spoke with the manager and the area manager, three members of care staff, the activities organiser, handyman and two health care professionals. We contacted the local authority safeguarding team and the contracts and commissioning team to gain their views about the home and we reviewed the local authority quality monitoring form that followed a monitoring visit on 18 August 2015. We checked records relating to the management of the home including training records, staff rotas and quality monitoring visits, which the area manager sent to us after our visit to the home.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of The Pines Care Home on 28 January and 11 February 2015 we identified a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff were not always provided in sufficient numbers or appropriately deployed to support people in a timely way and to ensure that people's care needs were met. Staff reported working excessive hours to cover shifts and there had been a heavy reliance on agency staff. We observed people were left unsupervised for periods of time and staff were not on hand to be able to offer timely assistance when it was needed at mealtimes because they were working elsewhere in the home. We found that staffing issues were having an adverse impact on staff ability to supervise people properly and to provide consistent, safe care.

After the comprehensive inspection on 28 January and 11 February 2015 the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. They told us that they would complete a dependency analysis by the end of June 2015, which they would use to make sure adequate staffing levels were maintained.

At the focused inspection on 22 September 2015 the manager told us that they had increased the staffing levels and they said this had improved their ability to provide reliable care. However, rotas showed that these levels of staffing were not consistent over time and improved staffing levels had not yet been fully established to meet the needs of the people who used the service.

Care staff hours had been increased from four care staff from 8am to 2pm and three care staff from 2pm until 8pm to four care staff throughout the day (8am to 8pm). Domestic cover was provided over four days per week (between 8am to 4pm or 8am to 12 noon) but at other times care staff also had cleaning duties and kitchen tasks to complete as well as laundry tasks. The manager told us that the deputy manager had recently left the home and there were currently no plans to replace this post.

Staff were kept busy for the duration of our visit and had limited time to spend with people who used the service. Staff said it was difficult to complete their work and one staff member told us, "We spend too much time on cleaning and rushing about." Records showed that another member of staff who had left in May 2015 stated their reason for leaving was because they felt unable to complete the tasks asked of them to their satisfaction.

The manager said that they were currently recruiting to vacancies in the home including domestic hours (30 hours), administrator hours (20 hours), a laundry assistant and additional care staff. However, it was evident that the home was still experiencing staff issues and was reliant on the use of agency staff. When we visited four members of care staff had taken sick leave over the previous seven days and a member of night staff had rung in to report they were off sick that night. Records provided after our inspection visit demonstrated there was a total of 106 hours of sick leave from 3 September to 29 September 2015. The area manager said that they tried to ameliorate the effect of using agency staff by using a single agency. Wherever possible they said they tried to use a small number of agency staff who knew the care needs of people living at the home. However, we found that staff vacancies and sickness were having an impact on staff ability to provide safe, consistent care.

On the day of our visit there were four care staff on duty in the morning, two of whom were senior care staff. In addition there was a chef, one member of cleaning staff, and a maintenance person. We observed one of the senior carers was largely occupied with administrative duties throughout our visit. Kitchen and cleaning staff were due to finish work at 2pm. This meant that for most of the afternoon and in the evening there were three care staff to manage people's care and cope with any ancillary tasks that arose, serve and wash up from tea and deal with any cleaning issues. We identified that the complexity of people's care needs and the layout of the building combined together meant that staff struggled to meet people's needs effectively.

During the inspection staff were not always visible and available to assist people using the service. An example of this was when we heard a person call out from their bedroom on the second floor in the afternoon. When we entered the person's room we found that they were slumped over in their chair. They told us they were uncomfortable and asked to be repositioned. Because the call bell within the person's reach was not working we had

Requires improvement

Is the service safe?

to contact a member of staff to ask for assistance. This meant the person had no means of calling for assistance which would alert staff in different parts of the building from the second floor. This meant that people were left with no support for long periods.

We drew the manager's attention to this issue and they confirmed they had sufficient spare cords to replace the one that was faulty and would ensure it was replaced. A member of the maintenance team also confirmed that they visited each week to deal with routine maintenance issues such as this. However they said that staff were busy and sometimes forgot to put jobs in the maintenance book, which meant routine matters, could be missed. When we visited there was a new manager in post and the rota showed they worked between 8am and 4pm each weekday. The manager told us that since their recent appointment five weeks previously a visitor had also complained about their relative's call bell extension lead not working and yet we found the same situation when we visited. This showed us that effective management systems had not been put in place to learn from incidents so that appropriate action could be taken to prevent a reoccurrence.

Ancillary staff provided the care staff with additional support over the lunchtime period. However we observed care staff were rushed and flustered trying to get everyone served with their meal. The food being served looked appetising with a choice of chicken casserole or minced beef with mash or boiled potato, cauliflower and carrots with gravy. On the day of our visit we observed that staff assisted people into the dining room before 12 noon. By 12.30 pm people in the dining room were asking where their dinner was. When we located a member of staff they told us, "I have started at the top today and working my way down." By the time lunch was served in the dining room just before 1pm it was nearly cold.

During the afternoon another person came through the door and attempted to climb the steep flight of stairs to the attic room on the top floor where the office was located. They were making their way up the steps by holding onto the spindles because they could not reach the banister. The area manager went to give immediate assistance and the person was safely supported to reach the top of the stairs. We sat with the person whilst additional staff were fetched to help the person downstairs. On assisting the person we observed that their clothes and hair were dirty and they appeared unkempt.

We concluded that the arrangements for staffing did not safeguard people or allow staff sufficient time to supervise people and promote their wellbeing. This was a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of The Pines Care Home on 28 January and 11 February 2015 we identified a breach of Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that care staff lacked the necessary knowledge and skills to be able to provide effective care for people living with dementia care needs. Only 30% of the staff team had received dementia awareness training and staff were not aware of best practice guidance relating to dementia care.

After the comprehensive inspection on 28 January and 11 February 2015 the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. They told us that they had completed a training needs analysis following the inspection visit, which had highlighted staff training needs. The provider confirmed that all staff had been asked to complete the care certificate self-assessment tool and this would be revisited in their supervisions between July and August 2015 to ensure that all individuals had a clear understanding of their skills and weaknesses in order to address their training needs. The provider told us that the operations manager would complete a monthly visit on their behalf each month to include a supervision and training audit by the end of June 2015.

When we inspected on 22 September 2015 there was a new manager and area manager in post. The manager showed us the training files, which had been compiled for each member of staff. However, these contained only blank forms and staff had not completed their self-assessments as the provider had said in their action plan.

During our visit we heard staff speak in a kind and respectful manner towards the people living in the home. However, there was no evidence to show that staff were sufficiently skilled at caring for people who had complex physical and mental health care needs. Community nurses reported concerns about the lack of staff training in relation to basic moving and handling skills. One member of staff told us they thought that the service was, “Moving forward.” However, other staff told us that they had not received appropriate training to enable them to provide safe, effective care. Comments we received included, “I feel that we haven’t been trained properly,” “We use sliding sheets and hoists but [care staff] haven’t had moving training.”

Records showed that training on ‘safer people handling’ was booked with an independent provider on 30 November 2015. However the record of monthly provider visits sent to us by the area manager after out visit demonstrated that six staff currently required moving and handling training and nine staff who required moving and positioning training included the manager and one of the three senior care staff.

Rotas did not allow staff time for a handover when they arrived at work. This meant that staff might not receive essential information about people’s care needs in order to ensure that they worked safely and could meet people’s needs. Supervision sessions had not yet been established in order to support staff development. The manager told us about their plans to support staff development and training. For example, they said arrangements had been made with an independent training provider to develop a training programme and records confirmed this was in place. However, records showed that all staff including managers and senior care staff required updated training in a range of topics including dignity, food hygiene, infection control, care planning, dementia, falls, medicines training, nutrition, continence and pressure area care. Information regarding the last date of training was not available. This meant that staff were not being supported to deliver safe, effective care.

This was a continued breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of The Pines Care Home on 28 January and 11 February 2015 we identified a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Person-centred Care.

People were at risk of receiving unsafe or inappropriate care because care was not always planned to meet people's individual care needs. We found that without the appropriate assessments staff could not be confident that they could meet people's care needs before they moved into the home. The care planning around people's dementia care needs were not developed. Appropriate referrals were being made to health and social care professionals however advice was not being consistently followed putting people at risk of receiving unsafe or inappropriate care.

After the comprehensive inspection on 28 January and 11 February 2015 the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. They told us that pre-assessments had been completed and included more detail about people's life history and mental health needs. Activity plans had been completed which evidence the engagement of the people who use the service.

At our focused inspection visit on 22 September 2015 we found that staff did not have the skills needed to provide safe care for people with complex care needs. We found that pre admission assessment was not always available to staff so people could not be confident that they would receive safe care that centred on their individual needs. We identified that staff had not followed people's care plans to deliver safe, consistent care in line with people's needs and preferences.

During our visit we observed some positive interactions. For example, we saw that staff encouraged people to have a mid-morning snack of fresh fruit and cheese and a cup of tea or blackcurrant juice. However the home had people living there who had with complex care needs relating to their physical and mental health. We did not find sufficient evidence that staff had monitored the needs of these people. We saw that people were left in their chairs and in beds for long periods with no position change. For example, between 11.30 am and 1.45 pm we spoke with one person in bed on four separate occasions. Although they were cheerful enough they told us that they were waiting for a member of staff to help them get washed and up. We saw on the person's care plan that they needed assistance to get washed and dressed and needed lots of encouragement from staff to socialise in the communal areas but this was not offered to them on the day we visited.

The person's care plan stated that they could eat independently but their food and fluid intake needed to be monitored because they were at risk of becoming undernourished. We found that documentation relating to their pressure area care had not been completed since 02.30am that morning. Food and fluid charts to monitor intake for 22 September 2015 had not been completed.

On admission the person was weighed on a monthly basis and from November 2014 this had been altered to weekly on advice from the dietitian. Where a loss of more than 1kg was recorded this had been appropriately referred to the GP. Staff told us that the person's weight had since stabilised and they were being weighed each month however this information was not adequately reflected on the person's file which meant that they might not receive the right care to prevent their care needs from becoming more serious. Records showed that the person's last recorded weight was July 2015. The manager told us that this was because they had refused to be weighed but there was no evidence this had been referred to their GP in line with their care plan.

In addition we noted that the curtains in their bedroom were hanging down from the runners at the top. Behind the bedroom door in a heap were boxes of gloves and packets of open continence pads just piled up. Whilst we were in the room the television stopped working and we drew this matter to the attention of the manager who agreed to look into the matter. We observed spillages from lunch left on the person's duvet cover and on the tray was a dish with sponge and custard some of which had been eaten, a cup of cold tea and a half glass of blackcurrant Juice. This showed us that there was a lack of dignified, respectful care. We drew this matter to the area manager's attention and they asked a member of care staff to assist the person.

For another person a healthcare professional reported that they had given staff advice about using slide sheets to protect against the risk of friction burns when their position

Requires improvement

Is the service responsive?

was being changed in bed. They also reported finding that turning charts were not completed. The community nurse submitted a safeguarding alert in response to concerns about the risk of skin area damage owing to poor moving and handling techniques. Whilst there had been some initial improvement the healthcare professional reported that within a week they were finding the same problems putting the person at risk of receiving unsafe care.

Some forms in the care files were not signed and dated making it difficult to identify whether or not the record was relevant. Food and drink charts were not always completed fully and so it was difficult to determine what people had had to eat and drink that day. Although the care plans were reviewed this did not include any input from people who used the service or their relatives which meant that people's wishes and choices were not recorded.

During our inspection visit a social care professional asked to see the care notes for one person. They raised concerns about the person's personal care needs not being met. We observed that staff had difficulty initially laying their hands on the person's care records, which the social worker had requested. This showed us that essential information was not readily accessible to staff. We asked to see the local authority pre admission assessment but the manager told us that he had not been able to access this information because the document was password protected. Because essential information was not made available to staff this had placed the person at risk of not receiving care that met their care needs and preferences.

This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence of activities taking place. A new independent activities co-ordinator was visiting the home for sessions over four days per week. During our visit we observed that the activity for the day was 'colouring'. The activity co-ordinator was placing a colouring sheet and coloured pencils in front of people but was not colouring with them as encouragement to show them how it was done and how nice it could look.

We met with one person who told us they enjoyed doing jigsaws but did not currently have one to work on. We raised this with the activities organiser who said they had not been aware of this person's interests. They explained that they had only just started visiting the home and therefore they were still getting to know people and find out about their likes. The staff we spoke with felt they were kept very busy and would not be able to take people out regularly.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of The Pines Care Home on 28 January and 11 February 2015 we identified a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider did not identify, assess and manage risks relating to health, welfare and safety of people who used the service or the quality of the service. People spoke positively about the registered manager and the staff team. However, owing to staffing shortfalls the registered manager had needed to prioritise staff recruitment and supporting the staffing levels over their other management tasks.

After the comprehensive inspection on 28 January and 11 February 2015 the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. They stated a new Quality Management System was being devised and would be rolled out to senior managers on 18 June 2015 at the monthly managers' meeting. This was to include feedback from people using the service, staff feedback, stakeholder feedback and ways in which these can be implemented.

At the focused inspection carried out on 22 September 2015 we found that the leadership was inconsistent and there was an inexperienced staff team.

There was a new manager and area manager in post. When we visited we found that the nominated individual was no longer working at the service. The provider had not notified the Care Quality Commission (CQC) about these changes as the law requires. The manager told us they had started the process of applying to be registered with the CQC as the registered manager. Both the manager and the area manager told us that since their appointment they had been working away from the home and supporting other services, which meant they had limited time to spend in the home. The area manager was also providing management oversight to another home currently operating without a registered manager.

We found that the planned improvements that the manager told us about were at an early stage and the area manager agreed that they had not focused on the provider action plan, which was submitted after our last inspection. Instead the manager confirmed that they had focused their attention mainly on environmental issues and improvements to the décor. We saw that rooms had been decorated and new mattresses and bed linen purchased.

Care plan audits had been completed but these contained little detail and did not reflect any evidence of analysis. There was no evidence of provider involvement with people using the service or their relatives although a relatives meeting had been arranged for 21 October 2015. A staff meeting had been held on 21 August 2015 but we did not see any evidence of further staff meetings being arranged. Complaints / compliments audits had not been completed. A bed rail audit and mattress audit had been completed and the manager told us this had resulted in the purchase of new mattresses where required.

Following our visit the provider sent us a quality audit titled 'Monthly Provider Visits' dated 28 September 2015, which highlighted areas for improvement in relation to staff training, staff meetings, kitchen equipment, and health and safety checks. The quality audit we saw was purely factual and there was no evidence of analysis or description of how learning or improvement had taken place.

The home's Statement of Purpose stated that The Pines Care Home provided dementia care however care staff lacked the necessary knowledge and skills to be able to effectively care for people living with dementia. The service was caring for 11 people who had a high level of physical health care needs requiring support from the community nursing service but staff were not sufficiently skilled or trained to provide the high level of care that people living at the home required. We found care was not always guided by best practice. For instance people were not always supported and supervised during mealtimes. Staff were not adequately supervised which meant that staff were not receiving the leadership and support needed to maintain high standards.

This was a continued breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.