Care Quality Commission

# Pinnacle Care Limited

# Roxburgh House

## Inspection report

Warwick Road
Kineton
Warwickshire
CV35 0HW
Tel: 01926 640296
Website: www.pinnaclecare.co.uk

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## Ratings

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

## Overall summary

We carried out an unannounced, comprehensive inspection of this service on 10 November 2014 where breaches of legal requirements were found. We asked the provider to make improvements because risks to people were not always properly managed at the home and people's records were not always accurate. This meant people were not properly protected and kept safe. As a result of this breach of the legal requirements and the impact this had on people who lived at Roxburgh House, we imposed a Warning Notice for the service to make improvements

We undertook a focused inspection on the 14 April 2015 to check that the service had made the improvements related to the warning notice.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Roxburgh House' on our website at www.cqc.org.uk'. The provider sent us an action plan on 30 March 2015 which explained how they will meet the other outstanding legal requirements. We will inspect the home again to check that the provider has taken further action.

Roxburgh House provides accommodation and personal care for up to 36 older people who may have dementia. Nineteen people were living at the home at the time of our inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At this inspection we found the provider had responded to our warning notice and taken appropriate actions to meet the specific requirements within it. However further improvements were required to meet all the legal

# Summary of findings

requirements and there remained a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

People told us they felt protected and supported living at Roxburgh House. Staff knew how to support people safely.

Improvements had been made in how risks to people's safety were identified, assessed and managed. Staff understood their responsibilities to share information to minimise risks to people.

The provider had taken steps to make improvements by implementing a new quality monitoring system.

Care plan reviews and audits were not always effective because some care plans were not up to date. There were some inconsistencies in the way information about people was recorded in their care plans.

# 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.

Where we had issued a warning notice, we found that action had been taken to improve. The provider had taken action to minimise risks to people's safety by improving ways they identified, assessed and managed risks. The rating for this key question remains 'Requires Improvement' because further improvements were still needed to meet the breaches in other regulations found at our previous comprehensive inspection.

**Requires Improvement**

**Is the service well-led?**

The service was not consistently well led.

Where we had issued a warning notice, we found that specific actions had been taken to improve. However further improvements were required to meet the full legal requirements. The provider had updated their quality monitoring system, however there was no evidence to show if the system was effective because it was new. Care plan reviews and audits were not effective because some care plans were not up to date. There were inconsistencies in the way information about people was recorded in their care plans. The rating for this key question remains 'Requires Improvement' because further improvements are still needed to meet all legal requirements

**Requires Improvement**

# Roxburgh House

**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 unannounced, focused inspection of Roxburgh House on 14 April 2015. This inspection checked the provider had taken action in accordance with the timescale we set out in our warning notice. We asked the provider to take action by the 1 February 2015. We inspected the service against two of the five questions we ask about a service: Is the service safe and is the service well led?

The inspection was undertaken by two inspectors. During our inspection we spoke with three people who lived at the home, the registered manager, the provider, the area manager and three care staff. We observed how people were supported by staff in the communal areas.

We reviewed records of the provider's audit checks, action plans and risk assessments. We looked at how risks were identified, recorded and managed and how the quality of the service was assessed and monitored. We looked at three people's care plans to see how they were cared for and assessed if records were accurate, complete and contemporaneous.

Requires Improvement

# Is the service safe?

## Our findings

At our comprehensive inspection on 10 November 2014, we found there were concerns, about how risks were managed in the home to ensure people were protected and kept safe. We observed an incident where someone's behaviour was not assessed properly and there were no instructions provided to staff on how to keep people safe. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 14 April 2015 we found that the provider had taken action to meet the requirements of the warning notice, in relation to assessing monitoring and mitigating risks to people.

People told us they felt protected and supported. One person said, "I'm very well looked after. Staff are helpful, I've only got to press the buzzer and they are there." Staff were able to tell us about the risks to people and how they supported people to keep them safe. One member of staff said, "I make sure everyone in the home is safe. If I saw a risk I would go to the senior and tell them and ask them to watch."

Staff supported people in ways to keep them safe, for example using good moving and handling techniques to help people move around the home in a safe way. One member of staff told us they felt happy to raise issues to senior staff and confident action would be taken if they found a risk. The registered manager told us they listened to staff when they shared information about people's needs. They told us they identified risks to people by observing them when they came to live at the home and updated their care plans accordingly. They gave an example where one person had recently moved into the home. They continuously assessed the way staff supported the person, made improvements to the person's care plans and saw the person's behaviour change in a positive way.

The registered manager told us and records showed that staff used a communication book to share information about changes to people's needs including changes in risks to people. For example, information about changes to support required at meal times was recorded and shared. One member of staff told us the communication book, "Really helps." Staff told us and we saw information was also shared about risks to people during staff handover. For example, on the day of our inspection staff thought one person was unwell because their behaviour had changed. The GP was contacted to review their health on the same day. One member of staff told us, "There is more information being shared."

Records showed specific risks to people's health and welfare had been identified and assessed. One person had recently moved to the home. Their risks had been assessed and their care plans described the actions to be taken to minimise the identified risks and provide them with support to meet their needs. For example, there was a care plan about the person's preferred footwear and the risks associated with this had been assessed. We found staff followed instructions on the care plan and took steps to minimise risks to the person.

Requires Improvement

# Is the service well-led?

## Our findings

At our comprehensive inspection on 10 November 2014, we found there were concerns, with how the quality of the service was assessed and monitored. We found some checks were not effective because the provider did not always establish if required improvements had been made. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 14 April 2015 we found that the provider had taken action to meet the requirements of the warning notice, in relation to assessing monitoring and mitigating risks to people. However, further improvements were required to meet the full legal requirements.

People told us they were satisfied with the quality of the service. One person said the staff were, “Excellent” and they had, “No complaints at all.” People told us and records showed they were encouraged to provide feedback about the service through meetings. One person told us, “I went to a meeting, it was good.” They told us they raised a complaint and it was dealt with to their satisfaction.

The registered manager told us there was a new monthly evaluation of recorded incidents, where they looked for patterns in related information, such as times of the day when incidents occurred. The registered manager gave an example where they had assessed accident forms relating to one person and found by changing a piece of equipment in the person’s bedroom, further reoccurrences had been prevented. The registered manager said, “The new process is helping.” The registered manager told us that as part of the new quality assurance system they had started to share information about incidents with other managers in the provider’s group. They explained this would help them identify other possible patterns and reduce risks to people.

Staff told us and records showed new daily checks had been introduced which looked at the standard of the premises. Staff told us there had been an improvement in the way maintenance jobs were recorded and completed. The maintenance log showed improvements had been made to the environment within required timescales.

The provider had implemented a new quality assurance system, called a ‘Quality Improvement Plan’ and the first audit had been carried out by the area manager. There was an action plan of improvements to be made within given timescales. Because the system was new the provider could not demonstrate if it was effective. A similar audit carried out by the area manager under the previous quality assurance system had identified specific actions to be completed by staff. For example, changes to people’s care plans to ensure they contained up to date information. The action plan relating to this audit had not been followed up. The area manager told us the action plan had not been checked because the new system had been introduced.

Additional checks were carried out by the registered manager, which looked at areas such as the quality of care plans. Care plan reviews and audits were not always effective because some care plans were not up to date. For example one person’s communication skills had been assessed and recorded as ‘good’ on their care plan. Staff told us and we saw that the way the person communicated was not reflected in their care plan because their communication needs had changed. The registered manager agreed the person’s records were not up to date even though they had reviewed them in April 2015.

The provider told us, "We recognised there were gaps in recording. Therefore all staff have received training on writing a new type of care plan.” Records showed there were still inconsistencies in the way information about people was recorded. For example one person had experienced recent changes to their behaviour. The change had been updated in part of their care plan, but there had been no assessment of risk completed. It was not clear how staff should support the person to protect them and other people from risks relating to their behaviour. The provider acknowledged that further improvements were required to ensure information was clear and concise. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, [now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] In relation to maintaining accurate, complete and contemporaneous records for people and assessing and monitoring and improving their service.

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 17 HSCA (RA) Regulations 2014 Good governance<br><br>The registered person did not operate an effective system to assess, monitor and improve the quality and safety of the service and maintain accurate, complete and contemporaneous records for people.<br><br>Regulation 17(1) and (2)(a) and (c) |