Four Seasons 2000 Limited

Pine Meadows Care Home

Inspection report

Park Road
Leek
Staffordshire
ST13 8XP
Tel: 01538392520
Website: www.fshc.co.uk

Date of inspection visit: 30 September 2015
Date of publication: 11/11/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on the 30 September 2015 and was unannounced. At our last inspection on 1 July 2015 we found that people were not receiving care that was safe and that met their needs this was because the providers quality assurance systems were ineffective. There were insufficient staff deployed to meet the needs of people who used the service and some people were being deprived of their liberty unlawfully. We had asked the provider to make improvements and issued a warning notice in relation to the insufficient staffing levels. At this inspection we found that staffing had been increased and people were no longer being unlawfully restricted of their liberty. We found that there had been some improvements made in all areas of concern since our last inspection, however further improvements were necessary. You can see what action we have told the provider to take at the end of the full version of the report.

Pine Meadows provides accommodation and personal or nursing care to up to 70 people. The service is divided into three living areas. One area called Acorns 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

The service was being managed by an acting manager (for the purpose of this report we will call them 'the manager') and there was no registered manager in post. 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.

People's medication was not managed safely. Previous professional advice had not been followed to ensure systems were safe.

People did not always have their health care needs met as staff did not always follow health professional's advice.

Most people were supported by sufficient numbers of staff, however some people were in the process of having their needs reassessed to ensure that staffing levels were sufficient for them.

When people were at risk, such as falling, assessments were completed and control measures put in place to reduce the risk of the incident occurring again.

People felt safe and protected from abuse. Staff knew what constituted abuse and what to do if they suspected abuse had taken place.

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 (DoLS) 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 followed the guidelines of the MCA to ensure that people were not being unlawfully restricted of their liberty.

People's nutritional needs were met, however specialist diets were not always presented in a pleasing manner. People who had been identified as losing weight were referred to their GP or dietician for advice and support.

People were treated with dignity and respect and their privacy was maintained. Relatives and friends were free to visit at any time.

Care was not always delivered in a way that met people's personal preferences. Staff did not always ensure that people had their belongings which they required.

People were encouraged to engage in hobbies and activities of their choice. New activity coordinators had been employed to support people in their chosen activity.

People were involved in their care. Regular meetings took place for people who used the service and their relatives.

The provider had taken steps to meet the breaches of Regulations following our previous inspections, however further on-going improvements were required. Quality systems had been put in place and were proving effective however the service required a period of stability to embed the systems.

Staff felt supported by the management; however some staff lacked direction due to inconsistent management.

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. People's medicines were not always managed safely.

There were sufficient numbers of staff to meet most people's individual needs and keep people safe. Risks to people's health and wellbeing were managed and reviewed. People were protected from abuse and the risk of abuse.

Requires improvement

Is the service effective?
The service was not consistently effective. Staff did not always know what to do to be effective in their role. People did not always have their health needs met as staff did not always follow health professional's advice.

The provider worked within the guidelines of the MCA to ensure people and their representatives were involved in decisions about their care. People's nutritional needs were met.

Requires improvement

Is the service caring?
The service was caring. People were treated with dignity and respect. People's privacy was maintained.

People's independence was promoted.

Good

Is the service responsive?
The service was not consistently responsive. Some people did not receive care that was personalised.

People's needs were responded to when there was a change to their assessed needs. People knew how to complain and who to if they needed to.

Requires improvement

Is the service well-led?
The service was not consistently well led. There was no registered manager in post. Staff felt supported by the management; however some staff lacked direction due to inconsistent management.

The provider had taken steps to meet the breaches of Regulations following our previous inspections. Quality systems had been put in place and were proving effective.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 September 2015 and was unannounced.

The inspection team consisted of three inspectors, a pharmacist 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.

Prior to this inspection we looked at information we held about the service including the last inspection report and the provider's action plan. We looked at the notifications the provider had sent us, this included safeguarding, death and serious injury notifications. These are notifications that about serious incidents that the provider is required to send to us by law. We had received information of concern from the local authority and were aware of a safeguarding investigation into the service.

We spoke with nine people who used the service and four visiting relatives. We spoke with the area manager, manager, deputy manager, fourteen members of staff and a visiting health professional.

We looked at three care records, staff rosters and quality assurance systems the provider had in place. We did this to check that records were comprehensive and ensured a consistent improvement in the quality of service.

Requires improvement

Is the service safe?

Our findings

We looked to see if people's medicines were managed safely. We found medicines were not always administered safely or stored appropriately. Some staff members were not correctly following appropriate procedures or the provider's medicines policy to ensure people's medicines remained effective and were administered safely. We saw one member of staff directly handling medicine without washing their hands after handing medicine to other people. We saw one person was left chewing their medicine without supervision, this could have led to them choking or spitting the medication out. We saw that two bottles of eye drops were still in use fifteen days after their discard date and insulin was in use was without a date of opening. This meant that people were at risk of receiving medication that was unsafe and ineffective.

We found a broken, open medicine cabinet and the treatment room door was left open on two separate occasions. Medicines were stored in one treatment room, which was not maintained at an appropriate temperature to ensure medicines remained effective. We were assured, and saw an invoice, that air-conditioning units had been purchased and due to be fitted in all three treatment rooms. This meant that people were at risk of taking medicines and using appliances that were not prescribed for them.

Diabetes blood tests were recorded daily but members of staff we spoke to were unclear what to do if results went beyond safe acceptable limits. Diabetes care plans was lacking in detail which meant people could not be assured that their diabetes was appropriately assessed to safely meet their needs. This meant that people were at risk due to the unsafe management of their medicines. We saw people's medicines were administered correctly and stored safely in one section of the home.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously the provider had been found to have insufficient numbers of staff and had been issued a warning notice for a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent us an action plan telling us how they planned to improve. Several people who used the service told us that there were now more staff available to meet their needs. A relative told us: "I think staffing levels are better, there seem to be more staff about and the atmosphere is nice". Following our last inspection we saw that several new members of staff had been recruited and the recruitment process was on-going with prospective new staff waiting for their safety checks prior to starting work.

We observed people's care in all three areas of the service and found that staffing levels had been increased and were sufficient to meet people's needs in Fir Cones and Chestnut areas, however the staffing in Acorns, the residential unit had remained the same. We saw that two people in Acorns required more support than the staffing levels in Acorns supplied. One person was at high risk of falls and was observed to be walking around the area unsupervised for the majority of the day, another person required constant reassurance due to their levels of anxiety caused by their dementia. We discussed this with the managers and they told us that a reassessment of these people's needs was currently being undertaken as they had recognised that they required more support than the residential unit was currently able to achieve. They assured us that with consultation with people, their family and social workers these people's needs would be met through either an increase in staffing or a move to another area of the service.

People were protected from abuse and the risk of abuse. One person told us: "I feel safe here I don't think they would abuse us," another said: "I feel safe. I stay in bed so I can't fall, it's my choice". Staff knew what constituted abuse and who they needed to report suspected abuse to. The manager had previously contacted us and raised a safeguarding referral with the local authority when they had suspected abuse had taken place.

Several people throughout the service were at high risk of falls and at our previous inspection we found that there was no assistive technology available to minimise the risks of them falling. The local authority had raised concerns over the level of falls which had resulted in a high level of fractures over a short period of time and were currently investigating the incidents. The provider had responded by deploying a member of staff to monitor the quality of the service and to analyse the falls to see what could be done to reduce the risk of people falling. At this inspection we found that when people had been assessed as at high risk of falls they now had assisted technology in place such as mats that would raise the alarm if someone fell in their

Requires improvement

Is the service safe?

room. Risk assessments had been reviewed and control measures put in place. One person told us: “If I try to walk without my frame when I shouldn’t the staff always tell me I need it and make sure I use it”.

Requires improvement

Is the service effective?

Our findings

We visited one person in their bedroom and saw that they had a wound which was not covered by a dressing, and was red and sore. We noted in the person's care records that the district nurse had questioned why the person's wound was not being dressed by the nurses at the service. We saw the care records had been revised to reflect the advice provided and a care plan had been updated stating, 'the dressing was to be changed and applied every 2-3 days'. A care worker we spoke with told us: "The nurses do the dressings and I think [person who used the service] rubs it, so the dressing comes off". There was no evidence in the records that the dressing had been changed for two weeks and the nurse was unable to tell us why the dressing had not been put on.

We saw another person who used a wheelchair throughout the day, until a physiotherapist technician came to visit. They were then encouraged by the physiotherapist to use a walking frame. We overheard the person say: "This is the first time I've used my walker today". The physiotherapist told us that there was supposed to be encouraged to use the walker as much as possible. We spoke to staff about this who told us: "The person does use his walker every day when their relative is here, that is every day except today. They are at risk of falls and if not supervised they can forget to use it". This meant that these people's health care needs were not always being met.

People were supported to attend health appointments when required. We saw input from people's GP, community nurses, speech and language therapists and physiotherapists.

At our previous inspection we saw that some people were being unlawfully restricted of their liberty due to being confined to locked areas of the service and sitting in chairs which restricted them from moving. At this inspection we saw that the manager had contacted the local authority and made Deprivation of Liberty Safeguard (DoLS) referrals for several people and was in the process of making several more. The Deprivation of Liberty Safeguards (DOLS) are part of the Mental Capacity Act (MCA) 2005. 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. This meant that the provider was following the principles of the MCA by ensuring that people who lacked capacity to make decisions for themselves were not being unlawfully restricted of their liberty.

Staff told us they felt supported to fulfil their roles. Two staff told us they had received an induction over two days and also a period of shadowing before they were included in the staffing numbers. One staff member told us: "I have previous care experience but I still had to complete the induction which I thought was good". A senior carer told us: "I have recently attended a train the trainer's course for manual handling and train any new staff in manual handling during their induction". However, due to the high level of new staff we saw that some working practices and staff direction required further input. For example, one staff member had been deployed to the dining area in Acorns to support people with their meals, however we observed that they stood and watched people and had not reacted when some people would have benefitted from encouragement to eat. This staff member told us: "I've been asked to go into the dining room at meal times, but no one has told me what I need to do". We also heard a call bell which had been ringing for a period of approximately 15 minutes. We went to see why the call bell had not been responded to. A new member of staff came out of the room next door to where the call bell had been pulled and told us: "I was just making the bed". No explanation was offered as to why making the bed had taken priority over answering the call bell. On two other occasions the call bell sounded for a noticeable length of time, when we went to find a staff member, staff were available but doing completing tasks that could have waited or paperwork. These staff required clear guidance and leadership to ensure they knew what was expected of them. The area manager informed us that individual support and supervision of all staff would be undertaken to ensure that all staff knew what was expected of them.

People were weighed regularly. 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 (SALT) had assessed some people to require a soft diet due to swallowing difficulties. We saw that the dining experiences in Chestnut and Fir Cones had been improved. Two sittings were available to people in Fir Cones to ensure that people required extra support to eat and drink were offered it without being rushed. In Chestnut we observed a pre-plated pureed main meal that had each

Requires improvement

Is the service effective?

food item separately presented, being transferred to another plate by a care staff, with little regard for the presentation of the meal and meaning the person who used the service would not be able to taste the distinct favours of each food item.

Good

Is the service caring?

Our findings

People told us they were treated well. One person told us: "I am very happy and treated well". Another said: "The staff know what I want and don't want and if they have time to sit and chat they do" and another person told us: "The staff care they don't just fob you off, they talk to you with respect and dignity. I was crying the other day and one [staff] came in and asked what I was crying for and brought me a cup of tea". We saw one person becoming distressed over a medical condition they had. This person had dementia and was showing signs of confusion. We observed a member of staff support this person by bending down to their level and speaking calmly and reassuring them at a level and pace they understood. This person then became calm and relaxed due to the interaction they were having with the staff member.

People told us they were offered choices and were encouraged to be independent if they were able. One person told us: "The staff do help me be independent, they leave me for a while but they come and check I've done it right and they always talk normal to me". We saw people walking around their environment freely without being asked to return to an area or sit down. Some people chose to stay in their room and this was respected. One person told us: "They come and check that you are alright in bed and it's a lovely atmosphere. I have never heard anyone raise their voice to any one". Another person said: "It's as lovely atmosphere, we all make it that way and I would change nothing".

People's privacy was respected. One person had a curtain up at their bedroom door as they preferred to have their door left open but not overlooked. People were cared for discreetly when being supported with personal care. We did not see any interventions that compromised people's privacy or dignity.

People's relatives and friends were free to visit at any time. We saw and spoke with several visitors. One relative told us: "I visit often and can do so at any time. I try to avoid mealtimes and don't tend to come at night. The staff are welcoming and friendly and I have no concerns about the care".

Requires improvement

Is the service responsive?

Our findings

Two visitors told us that their relatives had lost personal belongings which meant a lot to them. One relative told us: "They [person who used the service] went that long without them that they can now no longer use them, I found the items in a cupboard as staff didn't know who's they were". The other visitor said: "The [items] have been missing for between eight and ten weeks now and no one seems to know where they are". This meant that people's belongings were not always respected and staff had not responded to the individual needs of these people. The manager told us they would investigate the missing belongings.

One person whose mobility needs had changed due to them being unwell now required the use of a comfort chair when sitting in the lounge. Whilst they were waiting for the chair they had to be cared for in bed or periodically share a chair with someone else when they were not using it. Their relative told us: "It takes such a long time for anything; I have to keep on at them [staff]". However on the day of the inspection the manager received information that a chair had become available and they informed us that the delay in the chair was due to it being made to the person's individual requirements.

Some people were receiving care that was personalised and responsive to their needs. We saw that improvements in stimulation and activity for people had been made in parts of the home, while people were not provided with meaningful activities in other parts of the home. In Fir Cones one person was holding a doll, this is called 'doll therapy'. We observed that the person was calm and relaxed whilst holding the doll and it brought them comfort. An activity coordinator had been employed and several sensory items were available for people to use to stimulate their senses. A game of bingo took place in Acorns during the afternoon and people were seen to enjoy this, however on Chestnut people were not offered anything to do other than watching the TV.

People's current needs were assessed. The manager told us of several people who had been identified as requiring a re assessment of their needs as staff had identified that they may require nursing or more specialised support with their dementia needs. Another person had been found a more suitable placement as the manager and staff recognised they were no longer able to meet their needs at the service.

Meetings took place for people who used the service and relatives. From the minutes it was not clear from the attendance list if any people who used the service were involved. None of the people from Chestnut were listed among the persons present. Copies of the minutes were available on the nurse station but not to people who used the service. One person confirmed they had not been made aware of the minutes. This meant that not everyone was given the opportunity to be involved in the running of the home.

People knew how to complain if they needed to. Several people gave us examples of when they had made a complaint and that they were happy with the outcome. A relative told us: "I know how to make a complaint and feel able to talk to any of the staff about any concerns or problems".

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in post. The previous registered manager had recently left. The service was being managed by an acting manager with support from a newly appointed deputy manager and the area manager. Staff we spoke with told us that they felt supported by the management and were looking forward to a period of consistency as there had been a lot of recent changes in staff and management.

The provider is required by law to display the rating we gave the service following the last inspection. Although it was visible on the provider's website, it was not visible within the service for people who may not be able to access the website. The manager told us it had been moved during redecoration and they would ensure it was displayed on the notice board.

Since our last inspection improvements had been made to the quality of the service ensuring the provider no longer was in breach of the previously identified Regulations of The Health and Social Care Act 2008 (Regulations) 2014. Staffing levels had been reviewed and increased in two areas of the service and procedures had been put in place to reduce staff absence and to ensure sufficient cover at all times. When the service had fell below safe staffing levels the provider had reported it to us and followed their own policy in keeping people safe.

Quality monitoring systems had been reviewed and new systems implemented, however they needed time to embed to become fully effective. We saw that the manager conducted a daily walk around and 'flash meetings', which were on the spot meetings with all staff up dating them on people's needs and sharing relevant information. Staff were positive about the management changes and said they felt well supported, they commented favourably on the new initiatives such as, 'flash' meetings. They also commented that Chestnut needed a unit manager, one staff member said: "It needs clear direction".

Following several falls and injuries to people, the provider had deployed a quality facilitator to analyse and look to reduce the number of falls within the service. The quality facilitator was also responsible for looking at ways to improve other areas within the service. We saw how the dining experience for people had improved in two areas of the service due to the facilitators input.

From our observations we saw that there were several staff that required further direction and support to be able to fulfil their role effectively. This was mainly due to the numbers of new nurses, care staff and change in management. We discussed our concerns about the consistency and support of staff with the area manager and management team. The area manager told us that individual support and supervision would be implemented and monitoring of staff performance would be on going. This would ensure that all staff would become competent in their role or poor staff performance would be identified and managed to ensure a quality service was delivered.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and Treatment must be provided in a safe way for service users.