Community Health Services Limited

Pinetum

Inspection report

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Date of inspection visit:
09 May 2016
10 May 2016

Date of publication:
06 June 2016

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**

Summary of findings

Overall summary

This inspection was undertaken on the 9 and 10 May 2016 and the first day was unannounced. The last inspection of the service was carried out on the 2 February 2015 and at the time the service met all the requirements of the outcomes assessed.

Pinetum is registered to provide accommodation for up to 45 people who require nursing or personal care. It is located on the Countess of Chester Health Park on the outskirts of Chester city centre and adjacent to the local hospital.

Pinetum had a registered manager in place. 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.

We found that whilst some aspects of the care and support were satisfactory, there were areas which required improvement and did not meet the regulations. You can see what action we told the provider to take at the end of the full version of this report.

Whilst we observed, at times, people received appropriate care, we also saw occasions where people were not treated with kindness, dignity or respect. There were occasions when staff did not ensure that all reasonable steps had been taken to ensure the confidentiality of personal information. This we deemed to be a breach of Regulation 10 of the Health and Social Care Act 2008.

Care plan documentation did not always reflect a person's preferences as to how they would like their care to be delivered. Up to date information was not always readily available. Records did not reflect that appropriate care was delivered consistently. Checks on people's diet and fluid intake and repositioning were not always completed. Inaccurate information meant that there was a risk that care and treatment might not be appropriate. This was a breach of Regulation 17 of the Health and Social Care Act 2008.

People's capacity was not assessed under the Mental Capacity Act 2005 (MCA). We found care records did not consider people's capacity to make decisions which meant there was risk their rights were not protected or that their care was compromised. This was a breach of Regulation 11 of the Health and Social Care Act 2008.

The registered manager had submitted a number of applications under the Deprivation of Liberty Safeguards (DoLS) but had not identified all care practices that could be deemed as restrictive. We therefore made a recommendation that the registered manager review the use of restraint and restrictive practice to ensure that they act in accordance with the MCA and DoLS were appropriate.

The registered provider had a system in place to monitor the quality, safety and effectiveness of the service.

Although this had highlighted where improvements were required, we found that actions were not taken in a timely manner .This meant that this system was not effective in ensuring the risks to people were minimised quickly. This was a breach of Regulation 17 of the Health and Social Care Act 2008.

We found that people at Pinetum were being supported to take their medications. However, we found that some improvements were required to ensure that medicines that were on an "as required basis" were given in a consistent manner and that thickening agents were appropriately recorded and stored.

People spoken with and relatives told us that they felt safe and cared for. They lived in an environment that was clean and maintained. They said that the registered manager was approachable and that they had already made some improvements. We saw that there had been where complaints had been raised appropriate action had been taken.

The registered provider had ensured that staff responsible for recruitment had followed the appropriate recruitment checks. This meant that people were receiving their care from staff that had been thoroughly vetted to ensure they were suitable to do the job. New staff undertook an induction programme that included shadowing more experienced staff.

Staff received training and support appropriate to their roles. Staff also met on a regular basis to discuss issues of relevance, good practice, as well as wider developments in the service.

The views of people who used the service and relatives were sought. Meetings were held where they could discuss issues with the management team. Some people also had the opportunity to participate in a wider survey conducted by the registered provider. This was to seek their opinion as to the quality of the service provided and to look at ways to improve.

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 always safe.

People received support with their medicines and sufficient stocks were available for them. However, improvements were needed in the recording and storage of some medications.

Staff knew about safeguarding adults and risk assessments were in place ensure staff took steps to ensure the safety of the people they supported. Staff had been deemed to be of suitable character to work within a care setting.

People lived in an environment that was safe and clean

Is the service effective?

Requires Improvement

The service was not fully effective.

The mental capacity of people to make decisions was not assessed in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We found care records did not consider people's capacity to make decisions and there was a risk their rights were not being protected.

People were supported by staff who had received appropriate training, supervision and appraisals to ensure they were competent. There was clinical oversight for the nursing staff.

People were provided with meals that met with their satisfaction.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst we observed some positive interactions with staff, we also observed and heard things that demonstrated staff failed to treat people with dignity and respect.

People told us they felt that the staff were nice to them and did their best to meet their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always fully assessed. There was insufficient detail on people's wishes and preferences to ensure that their support was acceptable to them.

Food and fluid intake was not always monitored in line with the requirements of their care plans, which meant there was a risk of dehydration and malnutrition. Records were not kept up to date which meant that there was a risk that health conditions were not monitored and appropriate action take.

People had some opportunity to engage in social activity

Is the service well-led?

Requires Improvement

The service was not always well led.

Although the registered provider had noted the issues we found during the inspection, these had not been resolved quickly. This meant that the oversight and audits were not effective in addressing the issues.

Significant events were reported to the Care Quality Commission.

People and their relatives told us that the registered manager was approachable and
took an interest in them.

Pinetum

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 9 and 10 May 2016 and the first day was unannounced. It was carried out by an inspector from the adult social care team.

Prior to the inspection we gathered and reviewed the information we held on the service. This included compliments, complaints as well as notifications from the registered provider. These included events such as serious injury, safeguarding and changes within the service. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned within the given timescale.

During the inspection we had the opportunity to talk to eight people using the service and six relatives who were visiting.

We spoke with six staff and in addition the registered manager and quality manager. We looked for a variety of records which related to the management of the service such as policies, recruitment, staff and training.

We had the opportunity to observe the interactions between people who used the service and the staff over the course of the two days. We also reviewed the care plans and other relevant documentation relating to twelve people who used the service.

We contacted a number of professionals who visited the service including the local safeguarding team and commissioners. No one expressed any concern about the service.

Requires Improvement

Is the service safe?

Our findings

People who used the service indicated that they felt safe. Comments included "I feel quite safe when the staff are looking after me" and "As much as I would like to go home, I am much safer here". Relatives echoed this view and told us "I never worry about [relative] when I leave as they are safe here".

Staff supported people to manage their medication. Although a policy was in place for determining mental capacity, the assessment tool was not used to show whether or not each person understood the implications of taking or refusing their medicines. Medicines were ordered, administered, and disposed of as per the registered providers policies and procedures. Where appropriate, medicines were stored in a fridge and the temperature was checked regularly to ensure it was correct. We checked the medicines available against the medication administration records (MARS) for five people and found them to be correct. Some people had medicines prescribed on an "as required" (PRN) basis. Nursing staff were able to give examples of these and the circumstances in which they would be used. However, there was insufficient written information available to guide all staff as to when and how these medicines should be given. There was a risk that this could result in people not receiving medicines as required following the inspection, the registered manager confirmed that protocols had been put in place for every PRN medication and these were in the MARS folders for staff to refer to.

Some people were prescribed thickener to use drinks; staff were aware of how this was to be used but the amount required was not recorded consistently in the care plans or fluid charts. The amount of thickener required by each person would vary dependent on how much fluid they drunk and what consistency was required. We also found that in some instances these were kept in people's rooms. Whilst it is important that products remain accessible, all relevant staff need to be aware of potential risks to safety. There is a risk of death from asphyxiation by accidental ingestion of fluid/ food thickening powder.

Staff were aware of their responsibility to keep people safe and to take any necessary actions to reduce risk. Care files showed a range of risk assessments and tools used to enable staff to deliver the support required safely. These included individual risk assessments for areas such as moving and handling and use of bed rails. The registered provider had also introduced recognised risk assessment tools for the monitoring of malnutrition and skin integrity. These were used appropriately. Where an increase in risk was identified, we saw that appropriate action had been taken such as the provision of equipment or referral to an external agency for advice.

The registered provider had ensured that, where assessed as required, people had an air mattress to minimise the risk of developing a pressure ulcer. The mattresses were checked at regular intervals. The required pressure was recorded to enable staff to check whether each mattress was correctly set. The staff were able to tell us how the pressure was calculated and we saw that they were correctly set. Staff understood how to care for people who may be at risk of damage to their skin

Staff were able to describe their understanding of safeguarding and keeping people safe. There were policies and processes in place for staff to follow and staff knew where this information was located. Staff

had received recent training as it had been identified, following an incident, that not all staff were aware of the actions to take if they witnessed potentially abusive practice. Notifications we reviewed as part of the inspection also confirmed that the registered manager understood their role with respect to keeping people safe and notifying the relevant authorities of any incidents.

People's views on the staffing levels varied: some commented that they were sufficient and "There are enough staff" and "If I need help, I get it quite quickly when I ask or ring the bell". Others told us "Sometimes the staff can be really busy with someone else, they will acknowledge me but then they don't come back for what seems like ages". Staff told us that they felt there were enough people on duty to meet the needs of the people they supported. Some people received one to one care basis due their need for constant supervision. The registered manager completed a review of the dependency needs of each person that the service supported on a weekly basis. This informed their assessment of the staffing levels required. We observed, on occasions, that people upstairs had to wait for care and the lounge was not always supervised for long periods. We spoke to the registered manager about this and they acknowledged that the staff deployment across the upstairs unit needed to be monitored and reviewed. We saw that this had been identified on the Service Improvement Plan in April 2016.

Accidents and incidents at the home were recorded by staff for the registered manager to monitor and review. This information was collated and sent to the registered provider so that they could identify themes and trends both for Pinetum but also within the wider service. This meant that staff could understand and make adjustments to the way in which people were supported in order to make them safer: such as increased monitoring or the provision of specific equipment.

We reviewed how staff had been recruited to ensure they were suitable to work at the service and with vulnerable people. We looked at three staff files and saw that the relevant pre-employment checks had taken place. This included a full employment history, appropriate references, interview notes and a check from the Disclosure and Barring Service (DBS): all of which had been received prior to the commencement of work. This meant that people could be confident that the registered provider had taken steps to ensure that they were supported by staff of suitable character and skill.

We looked at the recorded checks kept for the environment, including the bedrooms, lighting, gas, electricity, water and fire systems. Personal Emergency Evacuation Plans (PEEPS) were in place for each person and kept up to date. Any equipment that people used was checked and maintained to ensure that it was safe to use. The registered provider had programme called EMS which generated a report showing the age of each piece of equipment and the number of breakdowns. This allowed them to replace equipment before they become problematic. Weekly water flushes taking place in rooms that were vacant to minimise the risks of Legionella in stagnant water. The kitchen had recently been awarded 5 * by the Environmental Health Department. Emergency plans were in place for such times as the continuity of the business was compromised. Regular checks were carried out by the registered manager, the registered provider and the home's maintenance staff to help ensure a satisfactory and safe environment. There was an improvement plan in place for on-going repairs and refurbishment. This included creating a safe and secure space in which to store equipment as presently some areas of the home were cluttered.

Requires Improvement

Is the service effective?

Our findings

People told us that they were "Well fed and watered" and that "Staff were good at their jobs". Relatives were confident that staff had the "Right skills" and "Temperament" to support people well. Staff told us they felt they provided and effective service. They said that the job was "Challenging", "Rewarding" and "Stimulating".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

Staff told us, and records confirmed that they had received training in MCA and DoLS. Staff expressed a view that this had been "Quite theoretical" and not "Very practical as to how we apply this in practice".

People told us staff asked their permission before they did anything for or to them. We observed staff seek permission before undertaking care tasks such as moving and handling or entering bedrooms. The staff respected and understood the need to gain people's consent to the care they received. Staffs were fully aware of people's right to refuse their proposed interventions, and told us they respected this. This was documented in a person's care plan such as "[name] will refuse care on occasions but has the capacity to make a choice and to understand the consequences of refusing care".

Staff we spoke with did not demonstrate a clear understanding of MCA or DoLS. For example, one staff member told us that you could never give medication covertly and another said that there was never a justification for restraint to be used.

There was little evidence of any 'decision specific' mental capacity assessments in regards to support tasks such as medication or the use of restrictive equipment. Staff failed to carry out a formal mental capacity assessment where people refused interventions and in some instances notes suggested that the person lacked the mental capacity to understand any consequences or risks. For example, we found that two people refused medications on a regular basis and staff indicated in discussion that they did not have the mental capacity to accept the risks. Staff told us that some of these medications were essential to their well-being. There was no assessment of mental capacity in regards to the person's decision to refuse, no risk assessment in place as to the consequences of this and no evidence of on-going discussion or contingency plan with the GP. Another person had been provided with equipment in order to keep them safe in their

chair. Staff had stopped using this and they told us "We can't use this anymore as you are not allowed to restrain someone". Staff did not recognise that this could be considered if they followed the MCA and DoLS. Therefore, people were at risk of not receiving the appropriate level of support and supervision.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because where a person lacks mental capacity to make an informed decision or to give consent, staff must act in accordance with the MCA.

The registered manager had submitted applications under DoLS to the local authority for a number of people who used the service. These were for people they believed could not make a decision, due to mental capacity, as to where they should reside or where they were placed under continuous supervision through one to one care. Only one of these applications had been assessed to date and granted. In this case, the DOLS stipulated a number of conditions that the service had to meet in regards to that persons care. We found that the service was progressing towards meeting these requirements.

However, we identified where the service had not recognised other restrictions in place such as the use of bedrails, lap belts or recliner chairs. Although there were risk assessments in place to demonstrate why they were deemed necessary and that other least restrictive options had been considered, staff had not carried out a mental capacity assessment, recorded a best interest decision and given consideration to DoLS.

We recommend that the registered provider review and monitor the approach to, and the use of, restraint and restrictive practice to ensure that they act in accordance with the MCA and DoLS where appropriate.

People said they liked the food that was on offer and they always had enough to eat. People were involved in the planning of the menus and their suggestions taken on board. For example: jacket potatoes were being 'tried' on the day of the inspection as people had asked for these at the last residents meeting as an alternative to the 'cheesy pasta' . Picture menus showed the choices for that day to assist people who could not communicate verbally. They also assisted people with cognitive impairment to be more orientated around meal times. People were able to have meals in the dining room or in the privacy of their own room. Staff were available to support people and assistance given if this was appropriate. The kitchen ensured that the Allergen's contained within in the foods were recorded. If people required foods of a certain consistency or a special diet this was documented in a person's care plans and the kitchen made aware of their needs. The service had worked with dieticians to explore ways of fortifying meals and drink to increase their calorific value. This had been successful and the amounts of supplements people required had reduced.

People were supported to ensure that their health needs were met. The provider told us that one local general practitioner provided a service to Pinetum. However, people who come to live at Pinetum did have the choice to use this service or to retain their own doctor if they wish. This doctor visited each week and provided notes of their visits directly to the home so that any new treatments could be started straightaway. The doctor was accompanied, where possible, by a nurse practitioner, to provide additional support to the service. When the main doctor was not available, doctors from the same practice were available to visit and provide advice.

Staff received regular training and they were provided with the knowledge and skills required to support people who lived at the service. Staff said they enjoyed the training offered and that it was a good mix of face to face, classroom and distance learning. Staff had training deemed by the registered provider has being essential for the role such as safeguarding, dignity, dementia, nutrition, moving and handling, and health & safety. Staff had undertaken specialised training for the complex care they provided such as the care of a tracheostomy, ventilation and the use of suction. Staff are also encouraged to take on 'lead roles'

for which they attend additional training and/ or support groups such as tissue viability, infection control and end of life.

There was a new induction programme in place for new starters which included learning and shadowing an experienced member of staff. The induction programme had been revised to ensure that it met with the standards required of the Care Certificate. This is a set of standards that all care staff should adhere to.

All staff had the opportunity to obtain qualifications such as the Diploma in Health and Social Care (QCF). One staff member told us that they never thought that they could achieve a qualification but had been encouraged by the registered manager and that they "Felt really proud" of what they had now achieved. The registered provider had processes in place that enabled the registered manager to update training records and identify what training staff required.

The service also supported a number of student nurses providing a suitable placement, oversight and mentorship. Staff said that this was positive and that there was mutual learning between themselves and the students. Students had commented that they a positive placement and that staff had helped to build up their confidence and their skills. Nursing staff felt that this was a good way of keeping up with good practice guidelines themselves.

As well as training staff received supervision; this was done on a one to one or a group basis throughout the year. Staff confirmed that they regularly had the opportunity to sit with senior members of staff to discuss issues of a personal and professional nature. Staff files held records of supervision and a matrix was kept to indicate when this was planned to take place. Sessions had been planned for the remainder of the year. The registered manager was also in the process of completing the annual appraisal of each staff member in order to review their performance and to discuss on-going development for the following year.

The building itself suited the needs of those people who used the service. The corridors were wide and open which allowed people, dependant on wheelchairs, to be as independent as possible within the service. There was an enclosed and private garden area which was accessed from the downstairs dining rooms as well as from a number of individual bedrooms on the ground floor.

Requires Improvement

Is the service caring?

Our findings

People who lived at Pinetum told us that staff were "Patient", "Kind" and "Very friendly". A number of relatives that spoke with us visited the service on a daily basis. They told us that they felt "Welcome" and "Like part of a family" and that "They have a great place here, nothing is too much trouble".

Our observations over the course of the inspection were mixed and that we observed that people were not treated with dignity and respect at all times.

We observed staff talking about issues of a confidential nature in the corridors or lounge area. This was not done discreetly: so the inspector and a visitor present were able to hear. For example, a staff member came to assist someone to go to the toilet: the person asked where they were being taken and the staff member said very loudly that it was "Time to go to the toilet". We also heard staff talking about the progress of someone who was in hospital. This meant that staff had not ensured that reasonable efforts had been taken to ensure that discussions about the care, treatment and support of individuals' were not overheard.

Over lunchtime, one person had been sat away from everyone else in the corner of the room and they were left waiting 35 minutes before a staff member started to assist them with food. The staff member who supported them dropped food on their clothing and on the arm of the chair. They did not wipe the food away but instead scooped it back onto the folk and fed this to the person. We also observed a person being moved and spoken to in manner that was inappropriate to their situation. These issues were brought to the attention of the registered manager.

Some people told us that they often had to wait for their care and that this caused distress. We observed someone ask on two occasions for assistance. On the first occasion they were told "Just hang on, I need to find someone to help me" and twenty minutes later someone else said "I just need to do this and then I will be back". The person had still not received help to go to the bathroom 45 minutes later. Three other people commented that staff answered the buzzer quickly and usually promised to return in five or ten minutes. However, they said "They never do and it seems like a lifetime so you have to ring again". This meant that there was a risk that people were left in an undignified situation.

Whilst some staff followed good practice guidelines for assisting people to move safely, we observed that this was consistent. For example, we saw a person being assisted out of the chair and the care staff member was trying to lift them from underneath the arm. This was not in line with best practice and there was a risk to the person and the staff member of harm and discomfort.

Care should be provided in line with a person's needs and wishes as far as possible. Again, we found that the experience of people varied. Pre-assessments and care plans were robust and not carried out in a timely manner. This meant that a person's needs and wishes may not be known. One person recalled that they called for assistance early as they had "Always been used to having a wash and going to the bathroom before breakfast". Staff come, turned off the buzzer but had still not returned as promised before the person's breakfast had arrived. They said "I just couldn't eat it as I didn't feel fresh and really needed to use

the bathroom". One person we spoke had to use a bed pan as two staff had not been available to assist them to the toilet: they told us this had been upsetting. We were told by one person that staff had suggested the day staff to assist them into their nightclothes as "There are more staff on during the day time and so let's have a bit of compromise". This meant that care was not provided in line with a person's preferences and choices.

These were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not treated with dignity and respect at all times. A person's privacy was not always maintained.

It was noted that access to the service was via a very steep and curved driveway with no pavement. The gradient had been deemed unsafe for wheelchairs. People who used the service and relatives said that this meant that you could not go out unless it was in a vehicle. One said "It's a real shame as the country park is really close and it would be good to go out for a change of scenery". One person told us "I still go out in my wheelchair as it's my independence but I have had to agree that it is my risk". One person was not able to visit on the normal bus as the road to the service was too steep for them to walk down. This meant that there were limitations of people's autonomy and some restrictions on their freedom. The registered manager told us that this had been identified as an issue but could not be resolved due to planning restrictions.

We did observe aspects of good practice with staff knocking on people's doors before entering and ensuring that doors were closed whilst attending to personal care. There were times when staff were seen to speak kindly to people and were encouraging in their approach. People were encouraged to take drinks in the lounge and staff kept on checking they were not too hot as the temperature outside was rising. A relative told us that "The staff here are marvellous" and that "My [relative] cannot communicate but staff always speak to them like an adult and not a child: they always explain what they are going to do and when".

We observed that some staff explained to people what they needed to do in order to deliver the appropriate support. We saw staff be patient with a person when assisting them to stand and provided clear instruction so that the person was able to do this for themselves. Staff also were observed speaking to people appropriately where their level of cognition was unclear.

Many of the people who lived at the service had life limiting conditions. Staff told us that "It is essential to keep someone pain free and comfortable" and that "It is essential that we lesson any distress as far as possible". The service provided care for people up until the end of their lives if this was in line with their wishes. They worked in conjunction with the GP, community nurses and the hospice to ensure that a person was able to remain at the service.

Staff were aware of the responsibility they had to meet the diverse needs of people and this included taking into account a person's cultural and religious needs. We saw how staff had been involved in meeting the specific cultural and religious needs of one person. This included looking at support with prayer times and dietary requirements

Information was available for people who used the service, relatives and prospective new admissions. This included information about the service, its purpose as well as information about the registered provider.

Requires Improvement

Is the service responsive?

Our findings

People said that staff met their needs and that they had "All the help that's needed" and "Out of care homes, this one is as good as you can expect".

Staff carried out an assessment prior to a person coming to live at the service. This assessment was not always detailed and care plans not completed in a timely manner. This meant there was a risk that the support provided may not be correct or given in a way that did not meet their needs or preferences. We looked at the records of a person who had been in the service for a week and the information available was limited. This resulted in their care had not been provided in line with their preference and wishes.

Care Plans were completed and accessed via a computer system and a hard copy of the most up to date care summary in a file. Out of the nine paper files we reviewed, only four of those contained an up to date summary. Two of those had information dating back to 2014 and this was not an accurate reflection of a person's needs. This meant that, should the computer fail or staff be unable to access it, there was a risk that care delivery and clinical oversight may not be correct. The registered manger confirmed following the inspection that all up to date information has been placed in the persons file.

The care plans we reviewed were not of a consistent standard. Some lacked in detail about a person's wishes and preferences whilst others contained information that would allow staff to provide a more individualised level of support(such as getting up routines, likes and dislikes, gender preferences etc.) The registered provider had recognised that not all of the care plans were person centred and told us that staff were working to improve the information.

As well as care plans, staff completed a daily record of what care had been offered, delivered and how a person had been on that day. The registered provider had an expectation that a minimum of four entries per day should be recorded. Staff did not always do this and compliance was being monitored by the registered manager. The records that had been completed did give provide useful and constructive information as to what had occurred over a given time period.

Charts were in place to record specific care interventions at a glance and to enable staff to monitor people's well-being. We found that on the upper floor, these records were not completed in line with the registered provider's requirements. This had already been identified within the service by the registered provider and formal letters sent to all staff reminding them of their responsibilities and accountability.

Repositioning charts were in place for staff complete when a person received pressure relief. We looked at the charts of four people and saw that the records did not evidence that four hourly pressure relief had taken place as stated in the support plan. One person's record indicated they had been repositioned at 2 AM and 8 AM and another stated 2 AM and 11:30 AM: both of which were less than four hours required. There was a risk that people were not being repositioned and therefore more susceptible to developing a pressure ulcer. This also impacted on the overall comfort of individuals.

Records were kept, where applicable, to record a person's fluid and dietary intake. These were important to monitor and evidence that somebody's nutritional and hydration needs were met. At the last inspection in February 2015, we had brought it to the attention of the registered provider that records needed to be more accurate. In four of the charts that we looked at, these records had not been completed accurately throughout April and May 2016. This meant that staff could not know what somebody had eaten or drunk. For example; 9 May 2016, there was no record of a person's fluid intake since 2 AM. At 1.30 and 5.30 they were observed to have a cup of tea and two cups of Coke on their table which was out of reach. At 3.30 on 10 May 2016, we visited the person again to look at the records. We found that retrospective entries had been made for the 9 May 2016. Records for the 10 May 2016 indicated that they had been offered drinks but refused. They had a cup of coffee and two cups of Coke on the table. Another person had received a drink at 5 PM but there were no other entries until 9 AM the following morning .A lack of fluids places a person at risk of dehydration especially during the hot weather. These charts were not checked or monitored in order to analyse and utilise the information to make decision on care, support or medical assessment.

Support plans indicated some people suffered from constipation and as a result close and careful monitoring was required of their bowel movements. Charts kept for this purpose were incomplete. We found that records for one person suggested that they had not opened their bowels from 18 April to the 2 May and another person only had one entry in April. Daily records did not always record this information. This meant that staff could not easily monitor the risk of constipation and therefore take the appropriate action.

Care and support was not always delivered as indicated in the support plan which placed a person at potential risk. We saw that a person was finding it difficult to maintain sitting balance and this placed them at risk of falling out of their wheelchair. Staff told us that, at one time, they had been provided with a chest strap which helped secure the person in an upright position. They told us that this was no longer used as "You are not allowed to restrain a person" and "I think the family did not want it". The person's care plan indicated that they had been assessed by the OT as needing a lap strap attached to a handling belt in order to ensure they were upright and safe in the chair.

These are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered provider had failed to ensure that they had assessed, monitored and mitigated the risks to people from unsafe or inappropriate care. There was not a contemporaneous and accurate record held in respect of each person so that decisions could be taken in relation to care and treatment provided.

People said they "Rarely had to complain" but that if they did "The manager will sort it out". The registered provider had a complaints policy in place and the registered manager was aware of her responsibility to investigate informal and formal complaints. We reviewed the complaints log and saw issues reported has been investigated and dealt with appropriately.

There were staff employed specifically to provide social stimulation and activity. This was either done on a one to one basis or in a group activity. Activities included arts and crafts, reading, skittles and film afternoons. Some materials used like books needed to be reviewed in terms of age appropriateness. Staff had not fully considered the appropriateness of some activities for people with an acquired brain injury (ABI) or demonstrated that building social skills and independence for people with ABI is not the same as providing support for older people or those with a more physical disability. Staff should consider any current research and best practice guidelines. Staff also arranged fund raising activities to pay for trips out and excursions.

Requires Improvement

Is the service well-led?

Our findings

People felt that the service was well managed and that staff were "Kept in line". Relatives knew who the registered manager was as she had previously been a member of staff. They felt that she was "Stamping her mark" and "Making improvements".

There was a registered manager in place and they had been in this post since December 2015. Prior to this they had been the deputy manager at the service. The registered manager was aware of their responsibilities and legal obligation to inform CQC of key events within the service.

Registered manager organised meetings for staff at all levels to bring them up to date with policy and procedure, the outcomes of quality audits and any other information. Monthly managers meetings were attended to keep up to date with any changes within the company. The deputy manager attended quarterly meetings with the registered provider's clinical development manager.

A series of monthly audits are completed in line with a schedule set by the registered provider. Any actions highlighted were added to a service improvement plan so that actions from all audits were on one document. Progress was highlighted on the service improvement plan and actions are removed once they were completed. The service improvement plan was reviewed monthly by the regional director.

The concerns raised on this inspection, had been picked up on previous quality audits carried out with a registered provider. They were part of the Service Improvement Plan and progress was monitored and reviewed on a monthly basis. This demonstrated that the on-going actions and checks were not robust enough to monitor and achieve improvements.

Some of the concerns had been recognised by the registered provider in January 2016 but were still not rectified and the completion dates continually extended: this included care planning, compliance with the MCA and DOLS, the lack of monitoring of diet and fluids and awareness of poor practice. Risks to the health, safety and welfare of people were not being minimised or removed within a timescale that reflected the risk and impact on people. Progress against the action plan was not being achieved in a timely manner and additional actions were not being taken where progress was not achieved as expected.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems and processes in place were not effective in ensuring compliance and improvements were not made in a timely manner.

Bi-Monthly meetings were held with relatives and people who used the service to enable the service to cascade information to all involved in Pinetum. The minutes from the meeting were typed up and can easily be accessed. Relative and professional surveys were sent out quarterly. The registered provider carried out a service user survey but this was only to a small random sample [3 people on the last survey]. This meant that not everyone was offered the opportunity to respond.

The service had taken place in an independent survey carried out by "Your Care" and this was based on the response from 19 people. They scored 891 out of 1000 which was above average and an improvement on the 2014 rating.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times. A person's privacy was not always maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to ensure that where a person lacked in mental capacity to make an informed decision or to give consent, staff had acted in accordance with the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure that they had assessed, monitored and mitigated the risks to people from unsafe or inappropriate care. There was not a contemporaneous and accurate record held in respect of each person so that decisions could be taken in relation to care and treatment provided. The systems and processes in place to monitor quality and safety were not effective in ensuring compliance and improvements were not made in a timely manner.