Mrs S J Nesarajah

The Pines

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 7 April 2016 and was unannounced.

The Pines is registered to provide care, support and accommodation for up to eleven people who are living with dementia and have a learning disability. At the time of our visit nine people were living at the service.

A registered manager was 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.

We found that decisions were made in people's best interest, however, we found evidence that the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not being fully adhered to in daily practice. Records were not clear about whether one identified person had the mental capacity to make a particular decision.

We made a recommendation that the registered provider follows the guidance and recommendations of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards when making specific decisions for people.

People were not always treated with dignity and respect. People and staff told us that some staff used a different language when they spoke with each other in front of people. This caused upset to some people at the service.

We made a recommendation that the registered manager monitors the communication to ensure staff can be understood by those they are caring for at all times.

People told us they felt safe living at the service. Staff had received training in relation to safeguarding and were able to describe the types of abuse and processes to be followed when reporting suspected or actual abuse.

Staff had received training and regular supervisions that helped them to perform their duties. New staff received a full induction to the service which included the mandatory training as required.

People and relatives we spoke with were positive about the care provided and their consent was sought. People were positive about the caring culture of the home and all the people we spoke to said that they liked the home.

People's care and health needs were assessed and they were able to access all healthcare professionals as and when required.

People's nutritional needs had been assessed and people were supported by staff to eat and drink as and when required. The menus provided a variety of meals and people were able to choose a meal that was different to the menu. People and their relatives were complimentary about the food provided.

Documentation that enabled staff to support people and to record the care and treatment they had received was up to date and regularly reviewed. People's preferences, likes and dislikes were recorded and staff were knowledgeable about the care needs of people.

Staff showed kindness and compassion and people's privacy was upheld. People were able to spend time on their own in their bedrooms and their personal care needs were attended to in private.

There were enough staff to ensure that people could undertake their activities and to meet the assessed needs of people. Staff encouraged people to be independent and to do things for themselves, such as cooking and cleaning their bedrooms.

People and relatives told us they thought the home was well run and they were able to have open discussions with staff. People told us they felt able to raise concerns and make complaints if they needed to.

Quality assurance processes were in place to help drive improvement at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of what abuse was and the processes to follow when abuse or suspected abuse had been identified.

There were enough staff to meet people's needs.

People's medicines were managed safely.

The provider employed staff to work in the home who had been appropriately checked to ensure staff were safe to work at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not followed the legal guidance as outlined in the Mental Capacity Act 2005 when submitting applications to deprive people of their liberty.

Staff received appropriate training and were given the opportunity to meet with their line manager regularly.

People had involvement from external healthcare professionals as well as staff to support them to remain healthy.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always respected. Staff did not always talk in English in front of people.

Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

People told us they felt they were looked after by caring staff.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care and support was planned and delivered in line with people's individual care plan.

People enjoyed a range of activities.

Information about how to make a complaint was available for people and their relatives.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place who was also the registered provider.

Audit checks for the service were effective to help to ensure that people were receiving safe care, treatment and support that met their needs.

Staff felt they were supported by the registered manager.

People, their representatives and staff were asked for their views about their care and treatment.

The Pines

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 7 April 2016 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and safeguarding concerns. A notification is information about important events which the service is required to send us by law. 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.

During our inspection we had discussions with five people who used the service, three relatives, three staff and the registered manager, who is also the registered provider. We observed how staff cared for people and worked together. We read care plans for three people, medicine administration records, mental capacity assessments for people, three staff recruitment files, supervision and training records, audits undertaken by the provider, minutes of resident and staff meetings, and a selection of policies and procedures.

At our previous inspection of the 11 July 2013 we did not identify any concerns at the home.

Good

Is the service safe?

Our findings

People told us they felt safe with staff who looked after them. One person told us, "I feel safe," another person told us, "People are always here to help." Relatives we spoke with told us they believed their family member was safe and any issues would be attended to.

The service had safeguarding policies in place that were clearly visible to staff. The registered manager informed us that all staff had completed safeguarding training. One staff member told us that they would recognise abuse in people who have difficulty communicating by, "Changes in behaviour, changes to their mood or facial expressions." Another member of staff told us they would report abuse, "To the most senior person on duty. I would also raise things to the manager. If I was still not happy I would follow whistleblowing policy and inform Care Quality Commission (CQC) or the safeguarding team." We looked at recent safeguarding incidents and it was clear that processes had been followed, the local authority had been informed quickly and CQC were notified in each instance. Staff records confirmed they had received training in relation to safeguarding people. This told us that staff were well informed about safeguarding and were able to take appropriate action when any concerns arose.

Assessments of potential risks of injury to people had been completed. We saw risk assessments were recorded in care plans and they had been regularly reviewed. Risks included falls, mobility, access to the community and medicines.

Accidents and incidents were recorded and appropriate measures were put in place to prevent them happening again. For example, one person living at the home had complex needs which caused two similar incidents to occur. The outcomes were recorded and meetings were held with healthcare professionals. The advice given was clearly recorded and we saw evidence of risk assessments being updated to reflect changes. During the inspection, we observed staff following the guidance of the updated risk assessment for this person. The person has had no incidents of a similar nature in the last six months. A healthcare professional had written to the Registered Manager to offer praise for the way in which this person's complex needs had been met. This told us that the home responded swiftly to incidents and had good communication with organisations involved in people's care, to ensure people were kept free from avoidable harm.

The interruption to people's care would be minimised in the event of an emergency. The service had an emergency and crisis procedure in place that provided guidance to staff of the actions to be taken in an emergency situation. For example, serious accidents fire and floods. It provided the details of a service where people could be evacuated to if required. People had individual personal emergency evacuation plans written.

There were sufficient number of staff deployed at the service to meet the needs of people. The registered manager told us that there were four members of staff on duty for the early shift, three for the late shift and two waking night staff. This was confirmed during discussions with staff and on the duty rota provided to us.

We observed these staffing levels during our visit. The registered manager told us that they were supernumerary to the duty rota and they were at the service every day. Extra staff were deployed when people required one to one support to attend external activities or healthcare appointments. People and relatives told us they thought there were always enough staff on duty. One relative told us, "There are always enough staff whenever I visit."

The provider carried out appropriate recruitment checks which helped to ensure they employed suitable staff to work at the service. The provider had obtained appropriate records as required to check prospective staff were of good character. These included two written references, proof of the person's identification, employment history and a check with the Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support service.

People's medicines were managed safely. People and their relatives told us there had not been any issues with medicines. One person told us, "I get my medicines when I should have them." Staff told us that they had been trained in relation to the safe administration of medicines; training records confirmed this training had taken place.

We looked at the Medicine Administration Records (MARs) held at the service. Each record included a colour photograph of the person so staff could clearly identify the person to help prevent errors. Other information recorded on the MARs included important information pertaining to the person. For example, diagnosis, prescribed medicines, and the GP and next of kin contact details. MAR sheets recorded the quantities of medicines received and the times each dose of medicine was to be administered. We observed a member of staff administering medicines. We saw they followed the correct procedures by administering to one person at a time. The member of staff checked the medicines against the MAR sheet to ensure they were administering the correct dose. We saw staff ask the person if they were ready for their medicines, explained to the person what the medicines were for and waited with the person until they had swallowed their medicines. After this procedure was completed the staff member signed the MAR sheet. This showed us that people could be assured they received their medicines as prescribed by their doctors.

PRN medicine protocols were in place. This is medicines to be given only 'when required.' For example, pain relief medicine such as paracetamol. It provided information about the medicine and the maximum dose to be administered over a 24 hour period.

The service had a medicines returns book. This was used to return unused medicines to the dispensing pharmacy so they could be safely destroyed. The pharmacist had signed the book for each return.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. People should be enabled to make decisions themselves and where this was not possible any decisions made on their behalf should be made in their best interests. We reviewed the provider's records and saw that staff had received training in the MCA and DoLS.

Although staff had an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS), we found evidence that the Mental Capacity Act (2005) was not being fully adhered to in daily practice. In one person's records we found a letter from the registered manager to the person's family stating that this person would not be able to engage in a particular activity with them due to this person lacking the mental capacity to decide to do so. The registered manager told us that a mental capacity assessment was carried out but was unable to show us a copy of one specific to this decision. On the day of the inspection, the registered manager told us, "(Person) does have the capacity to make decisions." The registered manager forwarded a MCA assessment dated 22 July 2015; however, this was in relation to the person's capacity to make an informed decision about their informal residence at 'The Pines Residential Home.' This assessment was not specific to the particular decision in question or evidenced that they had considered what the least restrictive option would be in relation to this decision. This showed us that this person was being deprived of their liberty without following the necessary process outlined in law and that the home were not seeking clarity on the person's mental capacity to make a decision that some may deem risky.

Applications were being made to the Local Authority seeking authorisation to deprive people of their liberty where they lacked the mental capacity to make the decision to leave the home. However, we found one instance where applications for deprivation of liberty had been made, despite the person concerned having already been assessed as having the mental capacity to make the decision to leave. A DoLS application was made following the assessment, despite the person being assessed as capable of making the decision.

We recommend that the registered provider follows the guidance and recommendations of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards when making specific decisions in people's best interest.

People told us they made choices. We observed people being offered choices throughout our inspection. For example, if they were ready for their lunch. One person had decided to go to their bedroom to spend time on their own. This person was supported by staff to go to their bedroom and then left alone. One relative told us, "Staff always ask X what they would like to do, the clothes they want to wear and the food they want to eat."

People were cared for by people who had the necessary skills. Relatives told us that they believed staff had been trained as they always seemed to know what they were doing. Staff told us they had received

induction training when they commenced working at the service and they had received up to date mandatory training. We saw evidence of this in the records provided by the registered manager. The registered manager told us, and this was confirmed by staff, that all staff employed at the service had just completed the Care Certificate training and were waiting for their certificates. The Care Certificate is an identified set of standards that health and social care workers adhered to in their daily working life. It covers the learning outcomes, competences and standards of behaviour that must be expected of support workers in health and care sectors and replaces previous common induction standards. Other training staff had received included epilepsy, understanding personality disorder and learning disabilities. Some staff had obtained the National Vocational Qualifications (NVQ) levels 2, 3 and 4.

Staff were provided with the opportunity to discuss their role and training needs through regular supervision and an annual appraisal. Staff told us that they had regular supervision where they could raise concerns. A staff member told us, "I have regular supervision where I can speak about my worries and we can sort them out." Another staff member told us, "I had good training and induction".

The registered manager told us when a new person who had particular needs came to live at the service, they arranged training for staff. Staff completed a test at the end of the training to ensure that they have understood it. For example, one person came to live at the home with a particular need that was new to the staff. Staff completed specialist training and we observed staff putting measures in place to look after this person safely. A staff member was also able to tell us about the condition and how it manifested itself. This showed that the training provided had given them the skills to support the person effectively.

People were supported to have sufficient to eat and drink. One person told us that the food was nice. Another person said, "I like pasta and they make it for me". Menus included meat, fish, pasta and vegetables. We observed people being given a choice of food to eat. A picture menu with key words was in the dining room. We observed staff pointing to this menu helping people to make choices. A staff member told us, "We offer people choices. Some people use sign language and key words and that's how we offer them choice. Other people use pictures." People's care records contained information on communication. Records were updated with dietary requirements and there was regular input from healthcare professionals where appropriate. Our observations showed that staff understood the individual needs of people. We observed people being offered drinks throughout our visit.

Staff identified risks to people in regard to their eating and drinking. Care plans we looked at included nutritional risk assessments. Referrals had been made to dietary and nutritional specialists when concerns had been identified.

People could be assured that their individual healthcare needs would be met by the required professionals when they needed them. We saw records that showed us people had access to all healthcare professionals. For example, GP, chiropody, speech and language therapist and dentist. During our visit we saw a physiotherapist had visited the service to attend to a person. Staff told us that all people had an annual health check with their GP. We saw that people had health action plans that provided information pertaining to the person about their healthcare needs.

Throughout our visit we observed staff interacting with people in a friendly and relaxed way. Staff supported people as and when required. For example, one to one support for people with mobility difficulties. Staff were aware of people's methods of communication as recorded in their care plans. For example, one person used Makaton sign language to enable communication. We saw staff waited for people to respond to them before progressing with conversations. This showed us that staff were able to communicate using people's preferred methods of communication.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. Some people told us that staff did not always communicate with each other using the English language. One person told us, "Staff speak to each other in their own language, this makes me feel uncomfortable not knowing what they are saying. I have asked them to talk in English." This was confirmed during discussions with staff who told us they expected all staff to communicate using English but not all staff adhered to this. Relatives told us that communication with staff was not always easy. One relative told us, "It is sometimes difficult to understand staff due to their spoken English." During our visit we observed staff on two occasions talking in a different language in front of people. The registered manager told us after the inspection that they reminded staff they must only speak in English in front of people and their relatives and to each other when in the home.

We recommend that the registered manager monitors the communication to ensure staff can be understood by those they are caring for at all times.

Staff promoted the privacy of people. Staff told us that they always knocked on people's bedroom doors and waited for a response before entering. Staff stated that all personal care needs were attended to in the privacy of people's bedrooms with the doors and curtains closed. We observed this practice during our visit. We saw people in their bedrooms with the doors either opened or closed, this was their choice.

People told us that the staff were very kind. One person told us that, "The staff and the manager are nice and kind." Another person told us, "They (staff) always asked permission before providing personal care." Relatives told us that staff were very caring and that they understood the care needs of their family members. Relatives told us that the service was very caring with a team of dedicated staff. They thought that the registered manager was approachable and listened to what they had to say.

We observed positive interactions between people and staff. It was clear that the people who lived at the service got on well with the staff who supported them. We observed staff sharing jokes with people and we could see that people were comfortable and happy.

Staff told us they knew people through working with them on a daily basis. Staff told us they regularly reviewed people's care plans and they involved people in this process as much as they wanted to be involved. We saw people had signed their care plans that indicated their involvement in the planning process.

Staff were knowledgeable about the needs of people. For example, one member of staff was able to give clear descriptions of people's past history, how their assessed needs were being met and people's individual likes and dislikes. We saw this information was recorded in the person's care plan.

During lunch people who were not able to communicate verbally were engaged with staff and we saw them anticipating their needs effectively. For example, one person could not communicate verbally and staff pointed at pictures that enabled them to make a choice. This showed us that staff knew this person well and

were able to pick up on non-verbal cues to meet their needs. Staff always offered choices to people and displayed patience in supporting people to make day to day decisions.

People were supported to be as independent as they were able to. Staff provided support to people as and when required but encouraged people to do things for themselves. For example, attending to their own personal care needs. People who were encouraged to go out independently to shop for their themselves. For example, buying food or personal items.

Relatives told us that staff were very caring and they knew their family member well. One relative told us, "They try to help X to be independent, but sometimes X will not do anything but staff are patient and try again."

People were supported to express their views and make decisions. Staff told us, "We offer as much choice as possible. We will ask people what they want to wear or whether they want a shower or a bath." Another member of staff told us, "If someone declines support we will wait and come back later to see if they have changed their mind."

We observed people moving freely between the communal parts of the service, including the kitchen. We observed one person discussing the meal they were about to prepare with a member of staff who was offering advice and support.

Good

Is the service responsive?

Our findings

People's needs had been assessed before they moved into the service to make sure their needs could be met. Care plans provided evidence that the care provided was responsive to people's assessed needs. One person had complex needs and we saw evidence in their care plan of support that was tailored to their needs. The registered manager told us how they supported this person and they were working towards this person's future. We saw evidence in this person's care plan of multiple professionals having input through frequent attendance at reviews and written correspondence.

Care plans were being reviewed regularly. All staff members had signed care plans to say they had read them. At the time of the inspection care plans were being updated using a new tool for developing person centred care plans.

We observed staff supporting people in the way in which it had been stated in their care plans. For example, one person required someone with them at all times and we observed staff providing this support. Another person required regular checks at night time and we saw a sheet that staff had signed to confirm this was happening regularly. Staff wrote up daily notes for each person that recorded the care given during the day. This showed that staff had provided care and support as outlined in individual care plans.

The registered manager told us that the bedrooms were due to be refurbished and they had involved people in choosing new colours and furniture to ensure the environment was suited to their individual tastes. We saw people's rooms and they had lots of photographs and decoration in line with the person's choices. For example, one person had lots of decoration in the colours of their favourite football team.

One person had an interest in sports and staff had arranged for them to have a television in their room so they could watch the sports channels. We observed staff talking to this person about their interests and also saw that their care plan reflected this as their main hobby. Daily notes showed that this person often enjoyed watching sports. This showed us that care plans were being written in a person centred way and staff were putting them into practice.

One person's care plan outlined details of future plans involving starting work. We saw evidence of links with local voluntary services which this person was able to engage with and start working. In all the care plans we reviewed, we saw evidence of links with other organisations, with detailed correspondence with healthcare professionals in files.

People had activity schedules in their rooms and people we spoke to said they enjoyed them. Activities included music, domestic chores, and visits to the local community, relaxation, gym and swimming. Some people undertook voluntary work in the local community.

People spent time in their bedrooms and in the communal areas taking part in activities. One person told us, "Staff help me get up early as this is when I like getting up" and another person told us "I like to go out

and they help take me out". Another person told us, "They let me lie in in the mornings."

People and their relatives knew how to raise concerns or make a complaint. There was a copy of the complaints procedure in the front entrance to the service. This included the timescale for responding to complainants and the contact details for the local ombudsman. Each person using the service had a copy of this document in their bedrooms that had been adjusted to their needs. For example, pictures, symbols and key words had been used. Relatives told us they had not needed to make a formal complaint but they would talk to the registered manager who they found to be approachable. One relative told us, "Staff listen to me and my family member and would address anything we were not happy with."

Staff told us they would report all complaints to the registered manager so they could be investigated appropriately. Staff told us some people could not tell them if they wanted to make a complaint. They stated that they could tell if people were unhappy through their body language, physical appearances and change in behaviours.

The service had received compliments. For example, one social care professional who had made a referral to the service sent a letter to the CQC stating," I was very impressed by the support of The Pines team from the initial stage of referral until the transfer and monitoring stages. They not only worked very closely with the family of the service user, making them involved at all levels and arranged regular meetings and visits, they also worked in close partnership with inpatient, local authorities, care managers, GP and commissioners to co-ordinate the transfer and ensured that the service user's change of environment did not have significant impact in their day to day life." Another social care professional informed us that staff and the registered manager had been really committed to a person they had referred to the service and had enabled the person to make many positive changes. They also stated that staff had "Bent over backwards" to help their client.

Good

Is the service well-led?

Our findings

People, relatives, staff and stakeholders were encouraged to give feedback about the service. We saw the results of the most recent survey undertaken. This included many positive comments. For example, people were complimentary about the standards of care provided at the service, the information their received from the service and the skills and abilities of staff and the registered manager. There were no negative comments about the service.

Staff told us there was an open culture and they were able to influence how the service was run and how to improve the quality of life for people. For example, there were regular staff meetings that also included people at the service. We saw minutes of these meetings that showed people were able to put their ideas forward and they had been actioned. Staff told us the registered manager listened to them and acted on what they say. One person had suggested getting a specific television network at the service and this was being arranged.

The registered manager was aware of and kept under review the day to day culture of the service. The registered manager is also the registered provider and told us they were at the service every day, the exception being when they were on annual leave. The registered manager told us they felt well supported by the deputy manager.

The service undertook quality monitoring to check that people received good quality care. Regular audits had been undertaken by the registered manager and a senior member of staff. These included daily and weekly audits that included the medicine records, care plans, cleaning, equipment used at the service and the environment. The service had also been inspected by the local pharmacist, environmental health and the local fire and rescue team. Where issues had been identified the registered manager had put an action plan in place to address them. The service also has an annual quality audit undertaken by an independent external consultant. This showed us that the registered manager was aware of their responsibilities to ensure people received good safe care.

The service regularly renewed safety certificates for fire and alarm systems. They kept a record of when these were to be renewed. The local fire service had visited the service and they told us they were satisfied with the fire safety procedures that were in place. Mobility equipment, such as hoists and stair lifts had up to date service plans from the manufacturers.

The Registered manager told us about the strong links with local services and showed us a letter from a local health service praising the support that they were able to provide to one person in order to achieve good outcomes for them. The letter states, "Staff worked in close partnership with Inpatient, Local Authorities, Care Managers, GP and commissioners to co-ordinate the transfer". The letter goes on to say, "I was very delighted and noticed significant improvement in the life of the two service users which they have achieved with the support of the team from The Pines."

Accidents and incidents were recorded and appropriate measures were put in place to prevent them

happening again. For example, one person living at the home had complex needs which caused two similar incidents to occur. The outcomes were recorded and meetings were held with healthcare professionals. The advice provided was clearly recorded and we saw evidence of risk assessments being updated to reflect changes. During the inspection, we observed staff following the guidance of the updated risk assessment for this person. The person has had no incidents of a similar nature in the last six months. A healthcare professional had written to the registered manager to offer praise for the way in which this person's complex needs had been met. This told us that the home responded swiftly to incidents and had good communication with organisations involved in people's care, to ensure people were kept free from avoidable harm.

The provider had a set of values that included the aims and objectives, principles, values of care and the expected outcomes for people. This was displayed at the service. We observed staff putting these into practice. For example, privacy and compassion.