# New Boundaries Community Services Limited

# Pinetops

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Pinetops is a residential care home providing personal care to up to six people with a learning disability and/or autistic people. The service had three people living there at the time of the inspection visit. Pinetops has communal living areas and each person has their own bedroom, two of which are upstairs.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
The model of care and setting did not maximise people's choice, control and independence.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Where people's freedoms to make choices had been restricted, these decisions were not appropriately reviewed and alternatives considered.

People were not fully involved in deciding how they wanted to be supported. The provider identified people's interests, goals and aspirations but their choices were not always respected. Staff were not always aware of people's goals and aspirations and the assessed risks associated with these. Staff did not receive the training and support they needed to make sure they could meet people's complex needs. This meant people were not supported to increase their independence and ensure a good quality of life, in line with their stated goals.

The management of risks, including those posed by the environment, was not robust and had been raised at our previous inspection in October 2021. Recording and monitoring of known risks was not always accurate and staff knowledge of risk was not comprehensive.

Right Care:
Care needed to be more person-centred to promote people's dignity, privacy and human rights. Staff did not always use age appropriate language. Care routines did not always ensure people's dignity was promoted.

There were usually enough staff but often these were agency staff or inexperienced staff who did not know people well. This limited people's opportunities to access the community and follow their own interests.

Staff had been trained in safeguarding people from abuse but the provider had not ensured safeguarding concerns were always reported and fully investigated.

Right Culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives. The provider did not have systems in place to support people to lead their best lives. Audits of care delivery and the monitoring of safety were poor. This placed people at risk of receiving unsafe care and treatment. Care did not meet people's complex needs and the provider did not have oversight of the failings of the service.

The values of the service, as set out in its policies and procedures, were not evident in practice. People led restricted lives and were not supported to develop and grow their skills and independence.

The provider did not ensure staff had the training, skills and experience they needed to deliver the care people needed. Staff were demotivated and the culture of the service was not inclusive and progressive. Action plans and monthly updates shared with the Care Quality Commission (CQC) did not drive improvement and did not demonstrate a cohesive culture.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection and update – The last rating for this service was inadequate (published 21 January 2022.) Conditions were imposed on the provider's registration and they submitted monthly improvement plans documenting how they were bringing about improvements. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 19 and 26 October 2021. Breaches of legal requirements were found. We imposed additional conditions on the provider's registration and required them to send us a monthly action plan documenting actions taken to improve safe care and treatment and good governance at the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pinetops on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to consent, safe care and treatment, safeguarding, good governance and ensuring there were enough skilled and experienced staff.

Full information about CQC's regulatory response to the serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well-led. | **Inadequate** |

# Pinetops

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors on the first day and one inspector on the following day.

Service and service type
Pinetops is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Pinetops is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was no registered manager in post.

Notice of inspection
This inspection was unannounced on the first day and we told the provider we would be returning the following day. Inspection activity started on 15 September 2022 and ended with a feedback session on 10 October 2022.

What we did before the inspection
We reviewed the provider's monthly action plan updates which had been shared with us. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
People who used the service were not able to speak with us about their care and so we observed care and support being provided. We spoke with two relatives, the provider, the regional operations manager and the manager. We also spoke with seven care staff including two night staff and three agency staff . We received feedback from the local authority quality monitoring team and the fire officer reported their findings to us.

We reviewed a range of records. This included three people's care plans, three sets of medication records, one staff recruitment file and other records relating to the quality and safety of the service.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to operate an effective system to identify, monitor and report safeguarding concerns.This was a breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 13.

- One relative told us several personal items of value belonging to their family member had gone missing. These missing items had not been reported to the police, or to the local authority and CQC as a safeguarding incident. The provider had failed to fully investigate these missing items or put actions in place to reduce future risk.
- People who used the service were not always treated with respect. Staff sometimes used language which belittled people. We observed staff treating people like children. One person was not 'allowed' to have a biscuit with staff explaining, " [Person was] a bit naughty so no biscuits for [them] today." The same person was also not allowed to have access to all areas of their own room, with some parts being locked.
- Staff had received safeguarding training, although there were no records of the training bank staff had received. Staff were not all confident in spotting the signs which might indicate a person was at risk of abuse or which incidents needed to be reported.

The provider did not operate an effective system to identify, monitor and report safeguarding concerns and did not ensure care was provided in a way that ensured people were not controlled. This was a continued breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess and manage risks relating to the safety of the environment. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 12.

- The provider did not take prompt action to reduce risks posed by the environment.

●Fire doors throughout the service were not fit for purpose with large holes in and gaps at the base. This risk had been identified in January 2022 but no action had been taken to remedy this.
● People had individual fire evacuation plans. Staff told us those people who regularly refused to leave the building when the alarms sounded, would be placed behind these fire doors to wait for the fire service. Failure to act promptly on a known risk placed people at risk of harm.
● We asked the fire service to review the fire safety measures at the service and they attended after our inspection visit. The provider took remedial action to replace the fire doors after this.
● The laundry door was not locked. Staff were aware it should be locked and told us people who used the service were known to enter the laundry and potentially access the chemicals stored in there. Staff had not acted to protect people from this known risk.
● There was a padlock on the gate from the garden to the front of the property and the main road. The padlock was in place but not done up and people could have left the service and placed themselves at risk. This issue was also noted at our previous inspection in October 2021.

The provider had failed to ensure they assessed and managed risks from the environment. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was not working within the principles of the MCA. Appropriate legal authorisations were not in place to deprive a person of their liberty. Two people living at the service were unable to leave the service due to padlocked gates and locked doors put in place for their own safety. However, this had not been formally agreed and they had no DoLS in place.
● A recent decision for one person to undergo a medical procedure had not been taken in accordance with the MCA as no Best Interests meeting was documented. The medical procedure had not been discussed and agreed by a family member who had the legal authority to make decisions on behalf of the person. The service had not worked with other medical professionals to advocate for the person and ensure their best interests were upheld.
● Where the provider had assessed people's capacity to make decisions and then held Best Interests meetings, these meetings had not always been carried out in accordance with the MCA.
● Decisions relating to one person's access to areas of the service, including areas within their own room, had been taken by a former manager and deputy manager in 2019 and not reviewed since. Agreed actions were not the least restrictive option and it was not evident other actions had been considered or tried first.

The provider failed to ensure people, or their legal representatives, consented to care and treatment. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were enough staff and they were appropriately supported and trained. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 18.

● The service relied heavily on agency staff due to a significant number of vacant staff posts. On the day of our second inspection site visit two agency staff were on duty together.
● Agency staff did not receive a structured induction and did not have the skills and experience to support people safely and meet their complex needs. Feedback from relatives and permanent staff was negative. One typical comment from a relative was, "There are lots of agency staff, no consistency and not enough guidance….I worry about agency staff working together."
● Although permanent staff were safely recruited, there were no checks in place for new agency staff. The regional operations manager was not able to assure us agency staff,including all those we met during our inspection, had received the appropriate training, had the right to work in the UK and had a completed check from the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff were demotivated and did not feel valued or supported by the provider. Staff retention was poor and there were very few permanent staff in post. Night staff, who lone worked, told us they could not safely evacuate the building in the event of a fire. This issue had been raised at our last inspection of this service in October 2021.
● Due to a lack off medicines trained staff sometimes staff were required to administer medicines at the sister service nextdoor. This meant the staffing levels at the service were reduced for a period of approximately 30 minutes each time this happened. There were not enough staff who were able to drive the service's vehicle which was shared with nextdoor. This meant people were not able to go out as often as they would have liked.
● The manager, who had been in post since January 2022, was responsible for three services, one of which was a 20 minute drive away. All staff and all relatives stated they thought the manager was spread too thinly. One staff member commented, "The manager is doing ok but can't physically manage so many units – [it's] too difficult." Another said, "[The manager] is doing [their] best but they have too many units to cover [and] they are not getting the teaching or support. There are issues in every unit."

There were not enough trained, skilled and experienced staff to meet people's needs. Staff did not receive the support they needed to carry out their roles. This was a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Staff who administered medicines had received training and had their competence to administer them safely checked.
● Medicines were stored securely and mostly administered safely.
● Records for topical creams were not complete and did not demonstrate people had had all of their creams as prescribed.
● There were no pain protocols in place and people who used the service would not easily be able to let staff know they were in pain. This was an issue raised at the last inspection also.

Preventing and controlling infection

At our last inspection the provider had failed to ensure measures were in place to reduce the risk and spread of infection. This was a breach of regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been enough improvement at this inspection and the provider was no longer in breach of this section of regulation 12.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection. People had received their COVID-19 boosters on the day of our inspection.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Relatives told us they had been able to visit the service in line with government guidance throughout the COVID-19 pandemic and now were free to visit their relatives as and when they wished.

Learning lessons when things go wrong
- Lessons had not been learned following our previous inspection. Issues raised at the previous inspection remained a concern at this inspection.

Inadequate

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure there were governance arrangements in place to drive improvement at the service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 17.

●There was no registered manager in post. The previous manager, who left after the last inspection, was also not registered at this location. The last registered manager left the service in October 2020.
● The current manager had been moved from another of the provider's services where they were the deputy manager, having had only a few months experience in a care role. The provider had engaged them to manage three registered services and had not ensured they had a structured induction or effective ongoing support. The provider demonstrated a poor understanding of the demands of the role of registered manager.
● The provider's auditing systems were not robust and did not identify and address the safety and quality concerns we found at this inspection, some of which were longstanding.
● There were no checks, training and induction for agency staff. The provider failed to put a system in place to ensure agency staff were safe to work at the service and had the required skills and experience. This placed people at risk of unsafe care.
● Information systems were not robust. Pen pictures containing key details about people's care needs and preferences, were not routinely used. Care plans were not always updated with the latest information and staff were not aware of some key information. Agency staff told us they relied on care plans to inform them about people's needs. This meant there was a risk of people's needs not being met.
● People's wishes, aspirations and preferences about their care were captured in their care records but were not demonstrated in the care delivered. Keyworker meetings were not regular and people were not empowered to take control of their own lives. Records showed people's activities were limited and they spent the majority of their time in the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong
● The provider failed to understand their legal responsibilities and accountability as a registered provider. This was a finding at the previous inspection.
● Relatives told us they had not always been informed or updated on issues where something had gone wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Information was not always available for people in a format they could understand. Staff were not trained in Makaton which is a specific sign language for people with learning disabilities. One of the people who used the service used Makaton and some of their own signs. We only observed one member of staff using signs and there was no information to guide others.
● Staff meetings were not held regularly. Staff had limited opportunity to raise issues or make suggestions to improve the service. Staff felt the manager was supportive and received supervision sessions from them. All staff stated the manager had too much responsibility and was not able to be at the service as much as was needed. Staff felt unappreciated by the provider and morale was very low.
● Relatives commented they would like to be more involved in care decisions about their family member.

Continuous learning and improving care; Working in partnership with others
●The provider has not taken on board the findings of the last inspection and use them to build on. Care has not improved significantly since we last inspected and the process of improving the service has not been consistent. Following the last inspection the provider had engaged a consultant. However, new systems were only partially implemented and those which were in place were not fully embedded.
● Following our last inspection the local authority quality monitoring team had paid regular visits to the service and given the provider considerable advice and guidance. These visits had reduced in recent months but the provider had not reached out for further assistance and guidance when needed.
●The provider had not reviewed the service as a whole and considered its wider failings. They have concentrated at times on addressing some very individual elements of the service in isolation, for example, how the manager should manage their in-tray or pronounce the names of medicines. Given the widespread concerns we identified this represented poor oversight and a lack of effective monitoring.

The provider failed to operate an effective system to assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure people, or their legal representatives, consented to care and treatment. Regulation 11 (1). |

**The enforcement action we took:**

We issued a notice of decision to remove this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure risks relating to the environment were assessed and managed. Regulation 12 (1) (2) (a) and (b). |

**The enforcement action we took:**

We issued a notice of decision to remove this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to operate a system to identify, monitor and report safeguarding concerns and ensure people were not subject to disproportionate control. Regulation 13 (1) (2) (3) (4) (b). |

**The enforcement action we took:**

We issued a notice of decision to remove this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to operate an effective system to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a). |

**The enforcement action we took:**

We issued a notice of decision to remove this location.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure there were sufficient numbers of competent, skilled and experienced staff to meet people's needs. Regulation 18 (1) (2) (a). |

**The enforcement action we took:**

We issued a notice of decision to remove this location.