The Pinhay Partnership

Pinhay House Residential Care Home

Inspection report

Rousdon
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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**

Summary of findings

Overall summary

The inspection took place on 29 June 2016 and was unannounced. Pinhay House is registered to provide accommodation with personal care for up to 25 older people, most of whom are living with dementia. The home is a grade II listed Victorian mansion, overlooking the sea, just outside Lyme Regis.

This inspection was to follow up if the required improvements had been made following our last inspection on 5 May 2016. At that inspection we found two breaches of regulations related to people's safety and to consent. People were at increased risk due to a lack of detail in care records about risks, staff not following instructions. Also related to environmental risks relating to a new keypad system staff were unfamiliar with and hazards for people within the grounds.

At our previous inspection in 2015, we had also identified a breach of regulations relating to people's safety, although these risks have since been addressed. Following the most recent inspection, the Care Quality Commission (CQC) took enforcement action by serving a warning notice, which required the provider to take further urgent actions to comply with the regulations by 20 June 2016.

Since then, the provider and registered manager contacted relatives to make them aware of the accidents which had occurred at the home, in accordance with the Duty of Candour regulations. They also made people and relatives aware of the findings of the CQC inspection and displayed a copy of the inspection report in the main entrance and on their website. A relative we spoke with confirmed senior staff had been "very open" about the problems found at the home during the last inspection. At this visit, we concluded risks for people had significantly reduced because safety improvements had been made, and the provider has complied with the regulations.

This report only covers our findings in relation to these topics. You can read the report from the last comprehensive inspection by selecting the 'all reports' link for Pinhay House on our website at www.cqc.org.uk

The service had a registered manager who registered with the Care Quality Commission on 25 May 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safer because risks were being managed to reduce the risk of avoidable harm. People's individual assessments had been reviewed and updated, staff had more detailed instructions about how to minimise risks for each person as much as possible. Staff knew about people's individual risks, and were consistently following the staff guidance in people's care records. Environmental risks had been reduced because a programme of works had been undertaken which had improved safety with the home and the grounds. Staff had been trained to use new security equipment installed at the home.

In response to the safeguarding alert we raised with the local authority safeguarding team about increased risks for some people living at the home, two local authority representatives visited the home on 12 June 2016. This was to monitor progress and review people's safety, and they reported positively on improvements underway at the home.

Since our last inspection, all staff had completed update training on safeguarding vulnerable adults and on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood their responsibilities to safeguard vulnerable people from abuse. The provider had arranged for individual supervision meetings with each member of staff. They reiterated to staff their expectations of their role and emphasised the need for increased vigilance of people's safety around the home.

A trainer had also undertaken practice observation to check staff were consistently implementing the improvements in practice and to identify any further measures needed to improve people's safety at the home. The provider and registered manager carried out several unannounced visits during the night and at the weekend. This was to monitor that safety improvements were being maintained, and to provide support and encouragement to staff to raise any concerns or difficulties experienced, so they could be resolved.

People were supported by enough staff so they received more support and supervision around the home. Staffing levels had been reviewed and staffing levels increased, with rotas changed to provide people with more support during busy periods. The provider had introduced regular documented welfare checks for people, during the day and at night, to monitor people's safety and their whereabouts at regular intervals. Accidents and incidents were proactively monitored to identify and address any themes or trends, and the number of accidents and incidents had significantly reduced.

People's personal evacuation plans had been updated to show how staff could best assist each person to evacuate the building in the event of a fire. A programme of upgrading and replacing fire doors to meet the latest fire regulations was ongoing. A recent fire drill, undertaken by a designated fire warden at the home, showed a slow staff response time in implementing the fire procedures. They recommended the drill was repeated within a month, however, this had not yet been carried out. We followed this up with the provider who said they would arrange another fire drill in the near future.

Environmental risk assessments had been updated and a programme of work undertaken at the home to improve the environment of care for people and further reduce risks. All staff had been trained on how to use the new security key pad system fitted and knew what immediate steps they needed to take if the alarm was triggered. A key pad had been fitted to the cellar door to prevent any unauthorised access to the cellar, and another fitted to the staff office, which had a rear door to the outside. Three gates and fencing had been fitted around the outside of the property. This included a gate where a path in the grounds led to the cliff path, which prevented people being able to access the cliff path if they wandered in that direction whilst out in the garden.

Staff understood the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. Improvements had also been made to consent procedures to protect people's legal rights where they lacked capacity.

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 is safe.

People's risk assessments and care plans had been reviewed and updated. They included detailed instructions for staff about how to manage and reduce risks for people.

People were safer because environmental risks were being managed to reduce the risk of avoidable harm. A programme of work had been undertaken to increase safety within the home and in the outside grounds. A programme of work had been undertaken to increase safety within the home and in the outside grounds, some fire safety improvements still needed to be completed.

Staff understood their responsibilities to safeguard vulnerable people from abuse.

New welfare checks had been introduced during the day and at night to monitor people's their safety at regular intervals. .

People were supported by enough staff so they received more support and supervision around the home.

Accidents and incidents were proactively monitored to identify and address any themes or trends. Reports had significantly reduced, which demonstrated safety at the home had improved.

Is the service effective?

Good

The service is effective.

Staff understood the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice.

Pinhay House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 29 June 2016 and was unannounced. One inspector completed this inspection. Prior to the inspection we reviewed the provider's improvement action plan, and notifications received since the last inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern. We reviewed the previous two inspection reports and the warning notice served.

A number of people living at the service were unable to comment directly on their care and experience of living at the home as they were living with dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 14 staff including the registered manager, the provider's representative, care, administrative, housekeeping and maintenance staff.

We looked in detail at four people's care records which included people's individual risk assessments. We looked at environmental risk assessments, at all accidents/incidents reported since our previous visit and at fire safety checks. We contacted health professionals and commissioners who regularly visited the service for feedback and received a response from three of them.

Requires Improvement

Is the service safe?

Our findings

Risks for people had reduced because the provider had significantly improved safety at the home. Staff demonstrated a high awareness of each person's safety and were consistently following guidance about how to minimise risks for people. They knew which people needed to be more closely supervised and why. For example, one person was at an increased risk of falls because of their poor eyesight and another person's behaviours sometimes prompted others to become aggressive towards them. Staff had increased their support and supervision of people around the home. A relative who visited most days said they were very confident their mother was receiving safe care. They said, "She can get very anxious, and when she does, staff sing to her which calms and reassures her."

Staff said they felt well supported in making the required improvements. They confirmed the provider and registered manager were listening to their concerns and addressing them, and was seeking regular feedback. One staff member said, "The home is much safer, the building is more secure", another said, "Safety and security for residents has definitely improved."

People risk assessments had been reviewed and updated and included more comprehensive information about individual risks for each person and how to minimise them. These considered people's physical and mental health needs and identified measures to manage those risks. Some people had positive behaviour support plans in place for staff to follow. A positive behaviour support plan is a document created to help understand and manage behaviour in adults who display behaviour that others find challenging. Where people were becoming anxious or aggressive, staff noticed and immediately took action to distract or reassure the person.

For example, One person's risk assessment showed the person sometimes got frustrated and hit out at staff and others. Their behaviour support plan said, 'Speak slowly and calmly …' Staff had increased the one to one time they spent with the person, who loved to chat and enjoyed music. They said the person became more agitated in the evenings, which increased their risk of falling and of altercations with other people. Staff requested the person's GP visit and review their medicines, which they did and some changes were made. They also identified the person was often tired in the afternoon, so they introduced an afternoon nap for the person. As a result of these changes, staff said the person was much brighter and happier in the evening.

The registered manager had reviewed accidents and incident reports and identified key themes. These included times when people were at an increased risk of falls, and highlighted people most likely to be involved in incidents, related to behaviours that challenged the service. For example, they identified some people were more restless and agitated between four and eight in the evening. The staff duty rota was changed to increase staffing levels at times of highest demand. This was by a member of day staff coming on duty early in the morning and having an extra member of staff on duty between four and eight in the evening. This meant there were more staff support available for people at busy times of the day, such as when they were getting up and going to bed.

The registered manager had also reviewed and changed night staff routines in discussion with them. These changes maintained optimum staffing levels in communal areas of the home, so people received safe care and adequate supervision. The registered manager had also reviewed the management and administrative duties of senior care staff. This was so they had time to provide more support and supervision to the staff team and monitor staff practice, particularly at weekends. When we visited, staff were visible around the home and available to respond immediately to people's needs. There was a member of staff on duty at all times in the lounge area. Where the staff member needed to leave to assist a person back to their room, or to use the toilet, they used a call bell to summon another member of staff to stay with the remaining people.

The registered manager arranged for an occupational therapist (OT), who was a member of the 'Falls Team' in Lyme Regis to visit the home.. They provided advice about further reducing the risks of falls at the home. The OT said, "Staff are proactive when people are admitted to the home, and are making a lot of effort to reduce risks for people." They confirmed staff at the home already used a good falls risk assessment tool, which they suggested adding a few prompts to.

For example, to prompt staff to consider additional risks about people's medicines and about people at increased risk because of osteoporosis, (a medical condition that causes loss of bone density and an increased risk of broken bones). They also advised the registered manager about incorporating more physical exercise for people into their activity programme and about improving the lighting in some corridor areas. The OT confirmed they were satisfied that people had the equipment they had recommended. These included sliding sheets to make moving and handling a person much easier and a specialist chair for another person to keep them comfortable and prevent them sliding onto the floor.

The provider had introduced regular documented welfare checks for people, during the day and at night, to monitor people's safety and their whereabouts at regular intervals. For example, half hourly night checks for some people who were more restless and likely to get out of bed. Motion sensors had also been installed in some people's rooms. These alerted staff, when the person got out of bed, so they could go and offer to assist the person. Staff said if the person was awake they offered them a drink and offered the person help to use the toilet. Or, they assisted the person to get up and come downstairs to the lounge if the person was unable to sleep. These measures helped reduced people from the risk of falling.

People were safer because staff understood their responsibilities to safeguard vulnerable people and protect them from avoidable harm. Since our last inspection, all staff had completed update training on safeguarding and on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The provider had arranged for individual supervision meetings with each member of staff. They reiterated to staff their expectations of their role and emphasised the need for increased vigilance of people's safety around the home. They checked staff were up to date with the instructions in each person's care plan and risk assessments. In response to the safeguarding alert we raised with the local authority safeguarding team about increased risks for some people living at the home, two local authority representatives visited the home on 12 June 2016. This was to monitor progress and review people's safety, and they reported positively on improvements underway at the home.

Environmental risk assessments had been updated and a programme of work undertaken at the home to improve the environment for people and further reduce risks. As people could not always recognise risks to themselves, three gates and fencing had been fitted around the outside of the property. This was to minimise the risk of people accessing steep steps and other hazardous areas, such as the fuel storage tanks. This included fitting a locked gate where a path in the grounds led to a precarious, steep cliff path. When people sat outside on the veranda, there was always a member of staff nearby to offer any assistance needed.

Indoors, a key pad had been fitted to the cellar door to prevent any unauthorised access to the cellar. Another keypad was fitted to the staff office, which had a rear door to the outside, to prevent people going out unsupervised. All staff had been trained on how to use the new security key pad system fitted and knew what immediate steps they needed to take if the alarm was triggered. For example, to check the whereabouts of each person to ascertain if anyone was missing. Written instructions were located next to each keypad and a copy of these instructions had been distributed to each member of staff. A spare key for the keypad system was kept on site so staff could reset the alarms if it was activated.

People's personal evacuation plans (PEEPs) had been updated about how to support people to evacuate the building in the event of a fire, these were awaiting people's up to date photographs. A planned programme of upgrading the fire doors to comply with e recent fire regulations was ongoing. It showed 23 of 48 fire doors had been upgraded, with the remainder planned over the forthcoming months. A fire drill completed in April 2016 by a designated fire warden at the home highlighted a slow staff response time in implementing the fire procedures. This could put people at risk in a real fire situation, so the fire warden recommended a further drill be completed within a month, which had not yet taken place.

We followed up the fire safety improvements with the provider and registered manager. We found a lack of clarity about which one was responsible for leading and monitoring health and safety at the home and asked for this to be clarified. Following the inspection, the provider confirmed they will lead on health and safety issues for the foreseeable future and ensure any recommended actions from health and safety audits are carried out. They outlined plans to undertake a further fire evacuation drill in the near future to check the required improvements have been made. The provider had also arranged for a follow up audit of health and safety at the home for Autumn 2016, by a specialist who had previously visited the home, to help with the ongoing monitoring of health and safety at the home. .

Other environmental improvements planned included replacement of carpets in corridor areas and plans to install a wet room for people with mobility problems, who had difficulty getting into the bath.

The improvements introduced had significantly reduced risks for people, which was demonstrated by a significant decrease in accidents/incidents reported in the past month. Six were reported in June 2016, compared with 15-20 each month over the previous three months.

The provider has complied with the warning notice by meeting the requirements of the regulations. They will need to demonstrate the improvements are sustained over time, which we will check when we carry out our next inspection.

Good

Is the service effective?

Our findings

People's legal rights were protected because staff understood the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

Since the last inspection, the registered manager had arranged for local GP's and community psychiatric nurses (CPN's) to visit the home. They had helped staff at the home review people's capacity to make decisions about their care and treatment. Where people lacked capacity, staff had involved relatives, GP's, in making 'best interest' decisions. These included 'best interest' decisions about the use key pads on external doors, the use of alarm mats/sensors, bed rails, and covert medication (where a person's medicine is disguised in food or drink).

The registered manager planned to do monthly audits to monitor any cognitive changes in people's capacity to make decisions about their care and treatment. This was so they could proactively identify further changes in people's cognitive ability, which may need reassessment.

Where relatives or others had Power of Attorney for making decisions on behalf of people, the registered manager had contacted them to obtain copies of their authorisation. This was so they could confirm, whether they were authorised to make decisions about people's finances and/or about their care and treatment as well. This ensured people's legal rights were being upheld.

Staff identified five additional people that were subject to restrictions of their liberty in their 'best interest' for their safety and protection. Therefore, additional DoLS applications were submitted to the local authority DoLS team and staff were awaiting their assessment. Currently, none of the people living at the home was subject to a DoLS authorisation. Most people, with the exception of two, were unable to leave the home without staff or relative supervision, as it was unsafe for them to do so. A replacement door had been fitted to the entrance a person had previously left through, which made this corridor area more secure. One person had the door keypad code and could come and go as they wished, and another person was assessed as safe to walk unaccompanied within the grounds of the home. Staff opened the door to let this person in and out, and kept an eye on them through the window until they returned.