The Pinhay Partnership

Pinhay House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Pinhay House is a residential care home registered to provide personal care to up to 25 people aged 65 and over. There were 21 people living there, when we visited, most of whom were living with dementia. The home is a grade II listed Victorian building, overlooking the sea, just outside Lyme Regis. Accommodation is over two floors with stair lift access to most, but not all rooms on the upper floor. Three bedrooms are double rooms for shared occupancy, with the rest single room accommodation.

People's experience of using this service and what we found
People, relatives and staff all reported improvements since the last inspection. Comments included, "Things had gone downhill, now they are on the up, definitely improved", "We all feel that we can approach them (management) with our concerns which are usually sorted quickly." Staff said, "We are moving in the right direction, but care still needs to be more person centred."

People's risk assessments and care plans provided more detailed and up to date information for staff about how to safely care for each person. However, we identified a new risk in relation to a person with a swallowing difficulty/choking risk, which we asked the provider to take further steps to address.

Improvements had been made in quality monitoring systems. Further improvements were still needed, as provider audits had not identified nor fully addressed known risks. For example, related to increased risks of dehydration due to inconsistent record keeping for people reluctant to drink.

People were better protected from potential abuse and avoidable harm through neglectful care. Staff had undergone additional training to meet their needs. We found improvements in people's skin care, in moving and handling practice and in managing people at risk of poor nutrition. Staff had a good understanding of signs of abuse and felt confident any safeguarding concerns reported were listened and responded to.

Staffing levels had improved and staff sickness levels had fallen. A long term vacancy on the night shift had been filled. Staff were working extra hours and the service no longer needed agency staff, so people received care from staff who knew them.

The provider was more proactive in identifying and tackling risks relating to people's health, welfare and safety. Previously lapsed quality monitoring systems such as weekly weights, care audits and monitoring of accidents/incidents had been reinstated. Areas for improvement highlighted by audits led to further staff training.

People's care plans and risk assessments were more detailed, personalised and up to date about their care needs and any risks. We have made a recommendation about improving monthly care plan reviews to evaluate what was working well and to capture any recent changes.

Staff felt better supported and reported improved communication, team working and improved staff morale. Where mistakes were made, staff were supported to learn lessons and improve practice through further training and support.

The service was clean and free from odours. Staff were wearing face masks and following Covid 19 government guidance to minimise risks to people. Systems were in place to ensure equipment was safe and in good working order.

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

Rating at last inspection
The last rating for this service was Inadequate. (report published January 2020). This service has been in Special Measures since September 2019. The provider completed an action plan after the last inspection to show what they would do and by when to improve . Since then the provider has sent monthly reports on their progress.

During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
At the end of May, a visiting health professional made us aware of some concerns about moving and handling practice, support for people with eating and drinking and about some poor staff interactions with people. Shortly afterwards, The Care Quality Commission (CQC) received two anonymous concerns which included similar themes and reflected areas of concern we highlighted at the previous inspection .

A decision was made for us to inspect and examine those risks and follow up what improvements had been made since we last visited the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only. Our report is only based on the findings in those areas at this inspection. The ratings from the previous comprehensive inspection for the Effective, caring and Responsive e Key Questions were not looked at on this occasion.

We found evidence the provider has made a number of improvements. Two ongoing breaches in relation to people's safe care and treatment and quality monitoring systems were identified. These related to a safety risk relating to a person with swallowing difficulties. Where areas for improvement had been identified, for example, in relation to dehydration risks, further improvements were still needed to minimise the risk of harm and improve people's quality of care people receive. Please see the Safe and Well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Follow up: We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety.

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

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Pinhay House Residential Care Home

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 Care Act 2014.

Inspection team
Two inspectors visited the service.

Service and service type
Pinhay House is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the CQC. The previous registered manager left at end of March and the deputy manager has been acting as 'the manager' since then. They now plan to apply to register. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We announced the inspection the day before we visited to discuss the safety of people, staff and inspectors with reference to the Covid 19 pandemic.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We had not requested the provider

send us a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We had been receiving monthly progress reports from the provider since the last inspection, in accordance with a condition placed on their registration following the last inspection. We looked at notifications received from the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We attended a safeguarding meeting on 17 June 2020 where health and social care professionals who work regularly with the service provided feedback about care at the home. We looked at all the feedback information we received from people who contacted CQC about the service since our last inspection. We used all of this information to plan our inspection.

During the inspection
We saw all 21 of the people the service supported in communal areas. We spoke in depth with two people who could tell us about their experiences of care. We looked in detail at the care and treatment of five people and reviewed six people's medicine records.

We spent time in communal areas observing staff supporting and interacting with people. We 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 sought feedback from relatives and advocates of everyone who lived at the home by asking the provider to send them our contact details. We received feedback form five relatives and looked at records of providers' contact with families.

We spoke with the acting manager, both providers and with 10 members of staff which included a care supervisor, care workers, maintenance and housekeeping staff. Following the inspection, two further members of staff contacted CQC to provide additional feedback. We looked at five staff files in relation to recruitment and at records of staff training and supervision relevant to the areas of concern. We reviewed quality monitoring records, such as records of daily, weekly and monthly checks, audits, servicing and maintenance records. We also looked at staff meeting minutes and spoke with a visiting community nurse to get their feedback.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. This meant people were not safe and were at risk of avoidable harm. At this inspection, we found some improvements in people's care and treatment with further improvements still needed to reduce the risk of harm.

At this inspection this key question has improved to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● At this inspection, we identified a new risk in relation to a person with a swallowing difficulty/choking risk. The person's care plan showed the texture of their food needed to be a modified diet to make it easier to eat and a thickening agent added to all drinks. At lunchtime, we observed a staff member offered the person a drink without thickener. This caused the person to cough, which increased their risk of inhaling fluid or choking. When the staff member continued to offer the drink, the inspector asked more senior staff to intervene. The incident highlighted the service had run out of thickener.
● The incident also highlighted confusion about this person's dietary requirements. This was because their care plan showed they needed a pureed diet, whereas information in the lounge for staff to follow showed they needed a soft diet. We asked the provider to take immediate steps to further minimise risks, for this person, which they have done.
● The person's care plan was reviewed and updated to reflect the advice given by a speech and language therapist, and further updated advice has been sought. The provider took steps to secure a regular supply of thickening agent. Following the inspection, the provider decided only senior experienced staff were allowed to support this person with eating and drinking.
● We also followed up previous concerns raised about people's nutrition/ hydration. Staff were aware of the importance of good hydration and offered people regular drinks. Records of people's food and drink had improved, although there were still gaps, particularly at night.
● Where people's records showed they had not drunk much over several days, and were at increased risk of dehydration, care records did not show what action had been taken in response, so risks remained.

The above demonstrates an ongoing breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We followed up previous concerns raised about staff moving and handling practice as well as recent concerns about hoisting, which are still being investigated. People's care records had been updated with

details of their moving and handling and any equipment needs. Staff followed people's moving and handling plans. For example, they safely helped people to transfer from their chair to a wheelchair to go to the table for lunch. Staff used clear instructions and worked at an unhurried pace.

● The acting manager said an occupational therapist visited the service the week before the inspection to review three people's moving and handling needs. The therapist watched staff using the hoist and did not have any concerns. However, they recommended use of a specialist chair for a person, which had been implemented. This meant the person no longer needed hoisting when they went into the lounge, which was better for them.

● We followed up previous concerns raised about people's skin care. People at high risk of developing pressure ulcers had more detailed care plans about their skin care, pressure relieving equipment and frequency of repositioning. Staff followed this guidance, and records showed people were regularly repositioned in accordance with their care plan. Where any concerns about skin health were identified, health professionals confirmed they were contacted in a timely way, and staff followed their advice.

● We followed up a recent concern about the support people received to use the toilet which is still being investigated. We found people were offered support to use the toilet at regular intervals and systems showed staff prompted people frequently throughout the day.

● Regular checks of the environment were undertaken to make sure it was safe and to minimise risks to people. For example, fire safety and wheelchair checks, as well as monitoring hot water temperatures in bathroom areas to ensure these were kept within health and safety recommended limits. There was an ongoing programme of repairs and maintenance.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider failed to protect people from abuse related to neglectful care. This was because systems to monitor people's safe care and treatment were not effective, and exposed people to increased risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People appeared safe, relaxed and comfortable at the home. One person said, "I feel safe here, absolutely." A relative said, "I'm very confident [name of person] is safe."

● People were protected from potential abuse and avoidable harm. Staff had undertaken safeguarding training and demonstrated a good understanding of how to protect people from abuse. They felt confident safeguarding concerns reported were listened and responded to.

● The Care Quality Commission (CQC) attended a multiagency safeguarding meeting on 16 June 2020 where concerns raised by a professional and two anonymous whistle-blowers were discussed. Specific concerns about four people were still being investigated and a further follow up meeting is planned for 23 July 2020.

● Where concerns about suspected abuse were identified, they were appropriately reported to the local authority safeguarding team and CQC. The provider worked in partnership with other agencies to protect people.

Staffing and recruitment

At our last inspection people were at increased risk because recommended staffing levels were not being maintained and because staff needed further training in moving and handling, pressure area care and in caring for people living with dementia. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● There were enough staff to keep people safe and meet their needs. Some staff had increased their hours and a long term vacancy on nights had been filled. Staff worked flexibly so that people received care in a timely way and at a pace that met their needs. The service was no longer using agency staff. Two experienced staff had recently been recruited and were due to start work in the next few weeks.
● The service had focused on training staff in areas of greatest risk to improve staff skills and confidence. For example, all staff completed moving and handling training in February 2020. A new care supervisor was appointed in November 2019 who worked alongside staff to improve practice.
● The provider had a robust recruitment process. Background checks were made on all staff before they began work and new staff completed a probation period. This was to make sure they had the right skills and attitudes to work safely with people.

Learning lessons when things go wrong
● Accident and incident reporting had improved. The acting manager reviewed all reports to ensure appropriate actions were taken to reduce the risk of recurrence. They had an overview of individual risks and any trends and took preventative action. For example, by referring people at increased risk of falls to an occupational therapist for further advice.
● Staff supported a person after they had fallen. Staff were all alerted by the emergency bell and all attended. Staff reassured the person and checked them for injuries and supported them back to their chair.
● Where mistakes were made, staff were supported to learn lessons and improve practice through further training and support.

Using medicines safely
● Medicines were safely managed but some areas for further improvement were highlighted. Since the last inspection, better systems for receiving, storing and disposal of medicines, staff competency assessments and regular audits had been introduced. This meant action was taken to follow up areas for improvement.
● We identified a thickening agent needed to reduce a person's risk of choking had run out. The acting manager contacted the GP practice, which arrived at the home that afternoon.
● Improvements in completing Medicine Administration Records (MAR) were seen, although there were still a few missed signatures to confirm whether or not prescribed medicines had been given. Also, we found some gaps in monitoring of fridge temperatures used to check refrigerated medicines were stored at recommended temperatures.
● Where people were prescribed 'as required' medicines, there were no individual protocols in place to guide staff in their use. Following the inspection, the acting manager outlined steps underway to develop these.
● Staff administering medicines wore a red tabard to advise others not to disturb them, which reduced the risk of a potential medicine error. Two staff administered morning medicines to ensure people received their medicines in a timely manner. They interacted well with people when they were administering medicines. They explained what the medicines were for and stayed with each person until they had been taken.

Preventing and controlling infection
● People lived in a home which was clean and free from odours. Housekeeping staff followed cleaning procedures to help ensure standards of hygiene were maintained.
● Because of the increased infection risk to people during the Covid 19 pandemic, CQC undertook an Emergency Support Framework (ESF) assessment with the provider on 26 May 2020 to assess their infection control measures. This showed the provider had good infection control practices in place to minimise the

risks to people and staff.

● When we visited, we saw staff washed their hands regularly and wore face masks at all times, in line with government guidance. They used gloves and aprons when providing people with personal care, measures which helped to protect people from the risks of infection.

Requires Improvement

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 the last inspection this key question was rated as 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.

At this inspection this key question has improved to Requires improvement. This meant the service management and leadership needed further time to improve and demonstrate the improvements in culture and more person centred care could be sustained over time.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection people were at risk because quality monitoring systems had lapsed. This meant the provider had not taken effective action to mitigate risks to people's health, welfare and safety. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found no evidence that people had been harmed, this inspection identified some gaps in quality monitoring systems. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

● Quality monitoring systems had improved, with regular checks and audits reinstated. This meant the service was more proactive in identifying and managing risks relating to people's health, welfare and safety. However, provider audits had not identified some risks highlighted at the inspection. For example, relating to swallowing difficulties/choking risks.
● Care record audits highlighted the need for staff to improve completeness and accuracy of daily food and drink records. Staff meeting minutes on 25 June 2020 showed these findings were discussed with staff. However, sufficient improvements had not yet been made to demonstrate all staff understood the importance of maintaining accurate records and the importance of taking further action to minimise risks.

The above represents an ongoing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care records had been updated and were more accurate and personalised about their care needs. Care plans were reviewed monthly, but reviews were mostly cursory. For example, most entries we looked at recorded 'no change', when there had been changes.

We recommend monthly care plan reviews evaluate what was working well and capture any recent changes.

● People's care had improved because weekly/monthly weights were checked, and any concerns were followed up. Mattress settings for people needed pressure relieving equipment, were checked regularly to ensure they were correctly set for each person's weight. A training matrix had been developed which showed proactive steps were taken to keep staff training up to date and identify new training and development needs.

At our last inspection the provider had failed to notify the Care Quality Commission (CQC) about absence of the registered manager or about the interim arrangements for managing the service during their absence. This was a breach of Regulation 14 Registration Regulations 2009. When the registered manager left in March 2020, the provider notified CQC and outlined interim management arrangements.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People, relatives, staff and professional all praised improvements in care at the home. One relative wrote, 'The home has improved greatly over the last few months, the management team have been very supportive.' Staff said, "Things had gone downhill, now they are on the up" and "people's care has improved a lot, staff are more caring, spend that bit more time with people, with more attention to detail." A professional said, "Staff are helpful, knowledgeable about people's care needs and follow advice."

● Staff feedback showed staff felt better supported, communication between staff, morale and team working had improved. However, we were aware of tensions between some staff, so not everyone was fully on board with the changes. One staff said, "Some days there is an atmosphere, an awkward vibe. I'm not sure staff feel safe to say. It is nothing to do with management and it doesn't affect people's care."

● During the inspection we saw changes in culture were having a positive impact on people's care. The atmosphere was calmer and more relaxed. Care was more person centred, staff were more engaged with people as individuals and there was a reduced focus on tasks.

● We saw lots of good practice. For example, staff knew about people as individuals and chatted with them about their families and interests. They noticed when a person became agitated or anxious and immediately went to reassure and calm them.

● Staff were being given opportunities to improve through a 'no blame' culture. Where mistakes were made, areas for improvement were identified with additional training and support provided. Staff supervision records showed individual staff development needs were identified and any poor practice/attitudinal issues were followed up. Individual staff performance was being managed and monitored, so formal capability procedures could be pursued if staff did not meet expected standards.

Continuous learning and improving care

● Staff identified two new staff had joined the service since the last inspection, who were having a positive impact on practice. They were also freeing up the acting manager to focus on their new management role. A care supervisor worked alongside staff and focused on promoting person centred care and improving staff skills. They had developed competency tools to set standards and assess individual staff skills. For example, in relation to moving and handling practice.

● Improved systems for monitoring staff training had been introduced. A new training matrix meant proactive action was being taken to ensure required staff training was up to date. Training materials had improved and staff understanding of training was checked through discussion, competency checks and assessment questionnaires. Recently, staff had undertaken innovative in house training to better understand people's experiences of moving and handling, being supported with eating and drinking and the

impact of living with dementia on their day to day lives.
● The local authority quality improvement team had supported the provider to make improvements in quality monitoring systems. The acting manager identified further development needs in undertaking incident investigations and report writing, which they are seeking further support with.
● The provider and acting manager kept up to date with changes in care through membership of a care management forum, attendance at local authority forums and through membership of the Devon Care Kite Mark group. They also used information and tools from the National Skills for care website.

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 service had been open and honest with relatives about past failures in care highlighted following the last inspection. They held individual and group 'Duty of Candour' meetings with relatives and kept them informed about improvements underway.
● Relatives said staff at the home kept in regular touch and would always contact them about any concerns, such as falls or changes in health. This was confirmed in regular notifications sent to CQC about safeguarding concerns and falls resulting in injury.
● Following the recent safeguarding concerns and ongoing investigations, the provider had written a letter to relatives to inform them about actions being taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives were consulted and involved in day to day care decisions about people's care and treatment. Families and legal representatives confirmed they were consulted in any best interest decisions
● The provider had kept in touch with families throughout the last few months, when visitors were not allowed to prevent transmission of Covid 19. Regular e mails calls, and web based calls were arranged, so relatives were kept up to date about their progress. A Facebook page was also developed with the appropriate consents, so relatives could see photographs of people enjoying the garden and other leisure activities
● The management team kept in regular contact with staff through daily handover, individual supervision and regular staff meetings. Records of discussions with staff showed ongoing efforts to consult and involve staff in the changes and in making further improvements.
● For example, staff were asked to identify additional training needs. In response, the provider had arranged for local professionals to provide further training on managing people with diabetes, pressure ulcer prevention and use of blood thinning medicines in the next few weeks.

Working in partnership with others
● Staff worked in partnership with health and social care professionals such as community nurses, GPs, a nurse practitioner, mental health services and social workers. A pharmacist visited the home fortnightly to support the service with medicines management. Feedback from local professionals at a recent safeguarding meeting on 17 June 2020 showed staff at Pinhay worked well with them, sought advice appropriately and followed that advice.
● During the pandemic, a local GP practice had set up regular fortnightly calls with local care homes, where staff could access support and advice from GP's, community and specialist nurses and members of the Frailty team.
● The provider increasingly used web calls and photographs to seek individual medical and nursing advice for people, so the need for professional visits was minimised, where possible.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some risks to people's health and safety were not effectively managed. We identified an ongoing risk in relation to managing a persons swallowing/choking risk. Also, in relation to people at high risk of dehydration. This was because records were not consistently maintained of how much fluid people drank. They did not demonstrate further actions had been taken where records showed people were at increased risk of dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Improvements had been made in quality monitoring systems, which meant the service was more proactive in identifying and taking risks relating to the health, welfare and safety of people using the service. However, further improvements in were needed to ensure risks relating to dehydration, minimising swallowing/choking risks were minimised and to embed improvements in medicines management and quality monitoring systems.