The Pinhay Partnership

Pinhay House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Pinhay House is a residential care home registered to provided 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

Although people said they felt safe, people's care and treatment needs were not always managed safely. We identified concerns about out of date risk assessments, prevention of pressure ulcers, nutritional risks and poor moving and handling practice. Further improvements were also needed in medicines management and in accident and incident reporting systems.

Following a period of sickness absence by the registered manager, the provider's quality monitoring systems had lapsed. This meant they had not been used to monitor the quality and safety of the service people received or identify improvements needed. Safety and quality issues identified had not been recognised or responded to in a timely way. This caused harm to some people and increased the risk of harm for others.

People were not protected from abuse and improper treatment because systems and processes designed to monitor people's safe care and treatment were not effective. This exposed people to harm and increased risk of harm from neglectful care. Three safeguarding concerns were identified during the period of inspection. These related to concerns about circumstances of a person's fall, delays in recognising and report skin deterioration to professionals leading to a person developing a pressure ulcer. Also, neglectful care by staff failing to complete people's weekly/monthly weights since June/July 2019 resulting in delays in recognising and responding to significant weight loss.

There was a high turnover of staff. Staff vacancies and short-term sickness were affecting recommended staffing levels and there was high use of agency staff. Improvements in staff training and practice were needed to ensure all staff adhered to best practice guidelines published by the National Institute for Health and Care Excellence (NICE).

People and families praised a number of staff who had developed positive and friendly relationships with people. However, we also identified issues about attitude and approach of some staff in treating people with dignity and respect.

The implementation of person-centred electronic records started nine months ago had not been completed successfully. Paper care records were out of date about people's care and treatment needs and any risks. This meant care records lacked up to date information to guide staff about how to meet people's individual

needs.

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 lacked capacity, improvements were needed in consistently assessing people's mental capacity and in documenting best interest decisions, and capturing involvement of representatives, families and professionals in those decisions.

People did not always receive person centred care that met their individual needs or preferences. People, relatives and staff all identified activities as an area for improvement. People were not consistently offered opportunities to take part in regular activities and there wasn't enough to occupy them. Activities were dependent on staffing levels and the availability of an activity co-ordinator. Some people were bored and wanted to go outside more but couldn't as they needed staff support to do so. Where they were provided, activities did not always take into account the individual needs of people living with dementia.

Systems were in place to ensure equipment was safe and in good working order. The premises were clean and free from odours. Some parts of the environment required redecoration and refreshment to ensure it was homely. We have made a recommendation that improvements were needed in providing people with disabled access to shower, bath and toilet facilities.

People and families were concerned about staff turnover but were happy with the care and the leadership of the service. Families were made welcome and could visit anytime. They praised the quality and variety of the meals provided.

Following our feedback, the provider voluntarily agreed not to admit people until further improvements are made. District nurses and other social care professionals and the local authority quality team were supporting the service to make the required improvements.

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

Rating at last inspection: Good (Report published March 2016). At this inspection the rating has deteriorated to Inadequate.

Why we inspected
This was a planned inspection based on the previous rating.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

Enforcement
We identified eight breaches of regulations in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding, good governance, staffing and a failure to notify CQC of the absence of the registered manager. Please see the action we have told the provider to take at the end of this report.

Following the inspection, the Care Quality Commission (CQC) took enforcement action by imposing a condition on the providers registration. This required the provider to provide CQC with a monthly report outlining actions and progress towards making the required improvements.

Follow up
We met with the provider on 23 October 2019 to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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
The inspection team included an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care 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 Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the CQC. This means that they 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 unannounced.

What we did before the inspection
We used the information the provider sent us in the Provider Information Return (PIR.) This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. 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 used all of this information to plan our inspection.

During the inspection
We met all 21 people who lived at the home and spoke with five relatives to ask about their experience of the care provided. We looked at five people's care records and at medicine records. 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 spoke with the provider, registered manager, deputy manager and with nine other staff which included care staff, housekeeping and maintenance staff, the chef and an activity co-ordinator. We looked at five staff files in relation to recruitment and at records of their staff training and supervision. We reviewed quality monitoring records, such as checklists, audits, policies and procedures and servicing and maintenance records.

After the inspection
We also spoke with seven health and social care professionals who regularly visited the service to get their feedback.

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

●People were at increased risk because of staff shortages. A number of staff had left, new staff were undergoing induction and there was short-term and long-term sickness absence. The registered manager was actively trying to recruit care staff for day and night shifts, as well as a cleaner and kitchen assistant. They said recruitment in the local area was difficult and two further staff gave notice of their intention to leave during the inspection.

● Wherever possible, vacancies were being covered by staff working additional hours and by agency staff. The deputy manager was frequently undertaking duties to fill staff gaps and they and the registered manager spent a lot of time trying to cover the rota. Care staff were also having to cover the kitchen assistant role at times.

● Some people and relatives expressed concern about the loss of staff they had got to know and trust and the impact on their care. People's comments included; "This last month or two they have been a bit short staffed and we don't get the same carers. I find that a bit disturbing and it takes time to get used to new staff," "Mainly it does [have enough staff], but sometimes you come in and it's slightly tenuous." A relative said, "It's been a rocky time, they have struggled with staff. On the whole, they kept it going." A professional said, "There never seems to be enough staff."

● Rotas and staff feedback showed the providers' preferred staffing levels of four care staff in the morning and three in the afternoon were not being consistently maintained. A dependency tool in people's care records used to determine the number and skills of staff needed was not accurate about their staffing support needs, as these had not been updated since July 2019.

● Staff said although people's essential care was completed, they felt standards of care and support had dropped. Staff said; "Disappointed at the moment, staffing has been difficult," "Some staff have left and there is too much staff sickness," and "Staffing is getting better, but it has been a struggle." Other staff said, "It's hard to monitor people," "We have to keep an eye on [names of three people] who tend to wander in and out of bedrooms. No one is hurt but people get frightened."

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we contacted the registered manager and the provider to ask them to take further steps to stabilise the staffing situation. The registered manager contacted us on 11 September 2019 to say the provider had decided not to admit any more people until staffing levels were adequate. This meant staff could prioritise meeting the needs of people who already lived at the home. On 25 September 2019 the registered manager said they had received some applications and were hopeful of recruiting additional staff.

● Staff had been safely recruited. All staff pre-employment checks to check suitability had been carried out before staff started working with people. For example, criminal record checks, and obtaining references from previous employers.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People's care and treatment needs were not always managed safely. We identified concerns about risk assessments, prevention of pressure ulcers, nutritional risks, moving and handling and about accident and incident reporting systems.
● People's risk assessments had not been updated since July 2019 about changes in people's health needs or increased levels of risk. For example, related to the prevention of pressure ulcers, falls and nutritional risks. Absent or out of date risk assessments put people at high risk of avoidable harm because staff did not have up to date information to minimise risks for them. For example, staff told us about two people they identified as at risk of malnutrition as they had a poor appetite. Those people's risk assessment and care records were not up to date about these risks, so staff did not have up to date information to guide their practice.
● People were at increased risk of malnutrition because systems in place to monitor their weight weekly had lapsed. When we looked at people's weekly weights records, on the second day of the inspection, we found they had not been weighed weekly since 10 June 2019. This increased the risk of malnutrition for those people, because staff were unaware of any significant weight losses, which may require further actions to reduce risks.
● We immediately made the registered manager aware and asked them, as a matter of urgency, to arrange for those people to be weighed. On 12 September 2019, they sent us the list of weights which showed two people had lost a significant amount of weight, one of which needed urgent further action. The registered manager contacted the person's GP for advice who prescribed nutritional supplements for them.
● On the first day of the inspection we witnessed some poor moving and handling practice in the lounge by three staff. For example, footplates were not being used, which meant people's feet were dragged along the floor which exposed them to the risk of injury.
● Two health professionals also told us about poor moving and handling they had witnessed during their visits, which they had intervened to correct. For example, staff using arm under arm support when helping people to stand up, which increases risk of harm to people's shoulder joints and increases risk of staff injury. A health professional said they had to keep reminding staff about the correct techniques, which meant moving and handling remained a concern.
● The accident/incident systems were disorganised. Although accidents were reported, neither the registered manager nor the deputy manager were signing off reports to confirm they had checked staff were taking all appropriate actions to reduce risk of recurrence. Supporting documents such as post fall injury assessments were difficult to find. Some people's daily records suggested behaviours that challenged the service were not being reported or recognised as areas of risk.
● Pressure relieving equipment was used to reduce risks, however, there was no guidance in care records about the appropriate setting for each mattress according to person's weight. Also, there was no system in place to ensure mattress settings were regularly checked to make sure they were maintained at the appropriate settings for each person's weight.
● A week after the inspection district nurses raised a safeguarding alert relating to concerns that staff failed to report concerns about a person's deteriorating skin. Entries in the person's daily records between 11 and 15 September 2019 showed their skin health had deteriorated from redness, to a bleeding wound. When district nurses visited they found the person sustained a pressure ulcer (bedsore) which may have been preventable, or minimised, had professional advice been sought earlier. This meant staff did not recognise, report or adequately manager early signs of skin damage.

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

● We made the registered manager aware of our concerns about moving and handling. On the second day of the inspection the registered manager was monitoring moving and handling in the lounge and intervening to correct any poor practice.
● People who could speak with us said they felt safe living at the service, as did relatives we spoke with. A relative said, "No concerns about safety. They keep an eye on [person] and know their ways."
● Regular checks of the environment were undertaken to make sure it was safe and to minimise risks to people. For example, checking the fire panel, fire exits, security and hot water temperatures.
● There was an ongoing programme of repairs and maintenance. For example, a number of carpets had been replaced, roof repairs and further improvements to fire safety systems were planned. Paintwork was chipped and peeling in some corridor areas.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from abuse and improper treatment because systems and processes designed to monitor people's safe care and treatment were not effective. This exposed people to harm and increased risk of harm from neglectful care.
● Three safeguarding alerts were raised during the inspection. One related to concerns about a person having a fall and actions taken by staff in response. The registered managers' investigation highlighted the person needed half hourly checks on their wellbeing, but these had not been carried out for a number of hours prior to their fall.
● On 12 September 2019, CQC raised a second alert to the local authority about neglectful care by failing to complete people's weekly or monthly weights since June 2019. On 19 September 2019, a health professional raised a third alert about a delay by staff in recognising and reporting signs of skin breakdown resulting in a person developing a pressure ulcer (bedsore). Both these incidents were being investigated by the local authority safeguarding team.

This is a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We followed up these concerns with the registered manager and received assurances the service was working with local health professionals to manage and minimise these risks. The registered manager said action had been taken to improve those people's care and address the issues with staff to learn lessons and improve practice.
● Staff had received safeguarding training and knew about the different types of abuse. They knew what to do if they had concerns about a person's welfare and felt confident to raise these with senior staff, deputy or registered manager. Two staff said they had reported concerns to the registered manager who had taken action to protect people. One said, "I reported a concern, it was investigated. I was completely put at ease and it was dealt with appropriately."

Using medicines safely
● Some improvements in medicines management had been made but more were needed. In the provider information return, the registered manager reported high numbers of medicine administration and recording errors over the past 12 months. We followed up what action had been taken in response to these frequent errors.
● The registered manager said all staff administering medicines had been retrained in medicines management. Staff wore 'do not disturb tabards' when doing medicines to help them focus and to try and

prevent interruptions. A local nurse prescriber undertook regular reviews of people's medicines at the home to ensure prescribed medicines remain appropriate.

● The deputy manager was the lead for medicines management and monitored staff skills, although the competencies checks were not documented. Monthly audits last completed until August 2019 identified continuing medicines errors. These were followed up with individual staff, through supervision and were discussed at team meetings.

● In June 2019 the service moved from medicines in 'blister packs' to each person having their own boxed medicines. Staff were still getting used to the new system which they said took longer.

● When we looked at Medicine Administration Records, we found similar issues to those reported by registered manager were still occurring, so further improvements were still needed. For example, recording gaps which meant there was a lack of clarity about whether or not medicines had been administered or if staff forgot to sign to confirm their administration. Also, as staff failed to consistently record remaining tablets, it was difficult to account for accuracy of remaining medicines.

Preventing and controlling infection

● People were protected from cross infection. Staff had received training to ensure they worked safely, and had access to appropriate protective clothing, such as gloves and aprons.

● Cleaning staff followed a cleaning schedule and responded to any urgent needs. Most areas of the service such as bathroom, bedroom and toilet areas were clean. We highlighted some stains in the lounge area which the registered manager has since had steam cleaned. A relative commented; "The cleaning staff are fantastic. The bedroom is always clean and tidy, no matter what time I visit."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA/DoLS and found instances where they were not.

● People living with dementia were subject to restrictions without the proper authorisations in place. Although records of mental capacity assessments and best interest decisions had been well completed at Pinhay House in the past, these had lapsed.
● Over the past few months decisions had been made to use sensor mats to monitor some people's movements or use bed rails meant for their safety. Also, decisions were made for two people to move to shared rooms. There were no records of mental capacity assessments or best interest records about any of those decisions. There was no record whether or not legal representatives, family members and appropriate professionals were consulted and involved in those decisions. This meant consent for decisions about those restrictions were not properly obtained.

This is a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered manager acknowledged mental capacity assessments and best interest decisions paperwork had not been kept up to date. They undertook to update these as soon as possible.
● Relatives and legal representatives we spoke with said they were consulted and involved in decision making. For example, a relative said, "When the home wanted to move [person] to a downstairs shared room [staff member] phoned on the Saturday and I said 'no' and then [registered manager] phoned on the Monday. [Person] needed a hoist, but the room would not have been big enough, so I agreed to the move." Another relative said, "It's mainly good. Things sometimes fall through."
● People said staff sought people's consent before supporting them. For example, about

personal care and any staff support needed. One person said, "They say 'do you want any help?'," another said, "I would rather do it myself. They come in and see when you are in the bath, they are ever so good that way. The carer stays with you and will help if you need it."

● Staff had received training in the MCA/DoLS and demonstrated good understanding of the principles of consent. A relative said, "[Person] is not forced …. Staff will try to do [personal care] as kindly as they can if [person] is agitated."

● A number of DoLS applications for people subject to restrictions for their safety and wellbeing had been submitted to the local authority DoLS team, which were awaiting their assessment.

Staff support: induction, training, skills and experience

● Improvements in staff training and in monitoring staff practice were needed to ensure all staff adhered to best practice guidelines such as those published by the National Institute for Health and Care Excellence (NICE).

● Two staff told us they hadn't completed any practical moving and handling training since coming to work at the home. Although several staff said they had undertaken training on dementia, further improvements in skills of some staff were needed to ensure they understood the needs of people living with dementia and interacted appropriately with them.

● When we tried to follow up what exact training each member of staff had received, we were unable to as the training matrix used to monitor staff training was out of date.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager explained previously the service had a training lead who worked closely with the deputy manager to ensure all new staff completed induction, required training and that other staff did their update training. They said they were aware some staff were behind on training and had started to book them on training.

● Other staff reported positively about staff training and some staff were undertaking further qualifications in care. The provider had an in-house training programme, which used workbooks for staff to follow. Training included first aid, fire safety, health and safety, communication and person-centred care.

● Recently the registered manager had arranged for staff wellness training, to raise awareness and promote positive mental health amongst staff.

● Staff had opportunities to discuss their work, receive feedback, and identify further training and development needs through six monthly supervision meetings.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;

● People's needs were assessed before they began to use the service, with one exception. A person admitted to the home three months ago had a number of complex care needs. No initial assessment had been undertaken and the person had no risk assessments or care plans to guide staff about their individual needs. This meant staff were relying on an out of date local authority assessment information about this person's care needs.

● However, where people's needs had changed, monthly reviews were cursory, did not involve people or relatives and had not been completed since July 2019. The review consisted of a date and an entry stating, 'no change.' For example, one person's care plan showed they could eat and drink independently, when in fact the person now needed full staff support to eat and drink. This meant reviews did not accurately reflect significant changes in some people's care and treatment needs.

● Two relatives we spoke with who were legal representatives for people had not been involved in their reviews. They said, "I have not been invited to any reviews," and "We've not had a review. It would be very

useful."

This is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We highlighted to the registered manager and the deputy manager the person whose needs had not been assessed. By the second day of the inspection the deputy manager had completed an assessment and care plan for the person. Older assessment records we looked at had essential information about people's health, personal care, emotional, social and cultural, needs.
Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People did not always receive best practice care, this was because care and treatment concerns were not identified about effective prevention of pressure ulcers, weight loss, medicines management and in relation to safe moving and handling techniques.
● People and relatives were happy with the healthcare support they received. Relatives said, "They always inform me and get medical assistance if needed, They seem very concerned and aware," and "The paramedics have checked [person], the doctor came in the night" One relative was impressed that staff had supported a person to improve their mobility, and said, "Staff got him standing. That's amazing."
● Staff worked in partnership with to a variety of health professionals to meet people's health and care needs. Records showed people where needed saw GP's, district nurses, speech and language therapy, podiatry and opticians regularly. However, recently their advice was not always captured or communicated accurately, which had led to some care and treatment difficulties.
● With one exception due to a communication failure, staff checked on people regularly, repositioned people and offered them regular personal and skin care. However, a person's relative mentioned a person had a sore bottom, although the registered manager was not aware of this. So, we asked professionals to check and follow this up.
● Relatives speaking about people unable to reposition themselves said, "The staff turn [person] over every two hours and change them," and "Person spends more time in bed now. Really good skin integrity."

Supporting people to eat and drink enough to maintain a balanced diet
● People were at increased risk because staff support for people's nutrition and hydration was inconsistent. At lunchtime we identified concerns about the support four people received to eat and drink. For example, a person eating in their room was asleep with their meal untouched in front of them when we checked before lunch and were still asleep when we checked again after lunch. Eventually, a staff member arrived and tried to encourage the person to eat. At 3.15pm when we checked again the person was still wearing their clothes protector and had their half-eaten dessert in front of them.
● People's nutrition and hydration care plans were not up to date about their current needs. Their weekly or monthly weight monitoring was not being carried out and records of people's food and drink intake were inconsistently recorded. This meant staff may not be alerted to new concerns about people's nutrition/hydration. A relative was concerned the person had lost a great deal of weight and did not know if the person was taking food supplements. We asked the registered manager to follow up their concerns, which they did.
● Staff were aware of the importance of good hydration and people were offered regular drinks. However, there were recording gaps in some people's food and fluid charts for some mealtimes, which meant we couldn't be sure they were offered food and drink at those times.
● People and relatives all praised the food. People said, "The food is good. We can choose," "The chef checks to see everyone has a balanced meal," "You couldn't wish for anything better." Others said, "If you don't like something they will get you something else, they are very good like that," and "If anybody suggests

anything we have it." Relatives said, "The food is marvellous and [person] eats so well," "[Name of chef] is brilliant with [persons] food."
● People's meals were well presented, with lots of fresh vegetables including for people who needed a softer consistency diet, due to swallowing or choking risks.

Adapting service, design, decoration to meet people's needs
● In the provider information return, the registered manager explained that the colour red had been incorporated into the décor of the home. They explained this was because red is a colour easily distinguished by people living with dementia.
● Changes had been made to make the garden more accessible by installing ramps across gravelled areas. Some adaptations in bathroom/toilet areas had been made to meet people's needs, for example, raised toilet seats and a chairlift bath seat. However, service had no showers, only baths, which some people couldn't access due to their mobility needs and restricted space. Plans to develop a wet room facility on the ground floor, to offer a 'wet room' accessible to all had not gone ahead due to financial constraints.

We recommend further improvements in disabled access to baths and showers are made to ensure everyone who lives at the home can access bathing and showering facilities.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always treated as individuals or with dignity and respect. On the first day of the inspection we observed several people not being treated with dignity and respect. Poor interactions seen included a member staff shouting loudly at and shaking a person sleeping at the table in their nightwear. This happened twice more over a short period of time before staff left the person to sleep. Other staff spoke loudly and indiscreetly about people's needs in communal areas, with a complete disregard for their privacy and dignity.
- Prior to lunch, a member of staff spoke to three people in a very loud and intimidating way to try and get them to stand up and move to the dining table. Other staff transported people to the table by wheelchair backwards with undue haste. Staff didn't interact or communicate with those people about what to expect, which must have been disorientating for them. A health professional also remarked on witnessing a member of staff shouting at a person with poor mobility to try and get the person to stand up, on a previous occasion when they visited.
- People who required support with mealtime they needed did not receive the personalised support of supervision they needed. The dining area was arranged as a long table down the middle of the lounge/diner. We observed a staff member supporting two people simultaneously, one with a visual impairment, to eat their lunch. They offered each person a spoon of food, in turn. Then every so often they stood up, left both people, and walked up along the table to offer a third person a spoon of food, before returning to the two people they were assisting. Other staff too were approaching people from behind unexpectedly which was confusing and upsetting for those people.
- For example, a staff member gave a person their tablets and a drink, whilst they were chewing a mouthful of food. Their instructions to take a drink and swallow their tablets was confusing for the person and clearly interrupted their enjoyment of the meal. When the staff member approached a second person in a similar way, they became upset and refused to take their tablets.
- A person who lived at the home was assisting another person with their meal, by spooning food into their mouth. Throughout the meal the person was hugging and kissing this person, who didn't appear to enjoy their attention. However, staff didn't notice or intervene for about 30 minutes, until eventually a member of staff took over supporting this person to eat and drink.

This is a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We fed back our observations of people's lunchtime experience to the registered manager. On the second day, they had made changes. They had arranged two separate sittings for lunch half an hour apart and had reconfigured the dining room tables so four people could share a table. This helped people move to table more easily and meant there was more staff support available. They also arranged for people to be offered their medicines with before or after lunch, not whilst they were eating. Although early days, the dining experience on the second day seemed calmer and everyone was better supported. The manager oversaw lunchtime and intervened to improve staff practice, wherever they identified a staff member needed improve their approach.

● People who were able told us they were well cared for and were treated with dignity and their privacy was respected. People's comments included; "They [staff] are very good," "It's lovely, everyone has been very nice." Relatives said; "Staff are very caring, friendly and helpful. I have been very impressed," "I think [person] has settled. It's as good as it could be. They [staff] were incredibly open and welcoming."

● When person starting to pull up their top, a staff member quickly noticed and intervened to protect the person's dignity. However, another person spoke about occasions where staff weren't immediately available to protect a person's dignity when they walked into another person's room uninvited.

● One person praised help they received to maintain their independence. They said, "I found it embarrassing to eat. Now I have a plate with a lip on it and I always have a spoon. I can feel what I have on my plate. I sit right up to the table. I have a full apron if it is food that's going to make a mess, but I sit with everybody [in dining room] now." Another person appreciated the help and support staff gave them to care for their cat, when they moved to the home. This meant they were no longer anxious about their pets' welfare.

● We also observed good communication and interactions between staff and people, addressing people by name in a courteous and friendly way. Staff asked, "Have you finished your tea?" "You seem to be struggling with that, can I help you?," and "would you like a bit more?", and praised a person when they said, "You have done well".

● People were supported to maintain contact with friends and family members. Visitors were made welcome and could visit anytime. A relative appreciated that staff provided a lift for them once a week, so they could visit their loved one.

● People's faith was maintained because local church representatives from two different churches visited. One person derived great comfort when they were visited by their local priest, who visited and prayed with them. Regular communion services took place at the service.

Supporting people to express their views and be involved in making decisions about their care;

● People were offered day to day choices about the time they wanted to get up and go to bed, and about what they wanted to wear and eat.

● Where people lacked capacity, legal representatives and families reported being involved in decisions about people's care. Relatives said, "They do telephone me. [Name] keeps me informed. I have seen [person's] care plan today," and "If I thought anything is wrong I tell them. I tell [registered manager] and she responds."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's care plans were not up to date so did not provide clear, consistent information about their current needs and risks. This meant people were at increased risk because staff did not have accurate information about their current care and treatment needs. For example, people with physical and mental health needs had no individual care plans to guide staff about how to support people with those needs.

● A planned implementation of person-centred electronic records started nine months ago had not been successfully implemented. The registered manager said they and their deputy had not been able to complete putting people's existing information onto the new system due to sickness and staff shortages. The reliability of the electronic record had been affected by incomplete coverage around the home and local issues with broadband reliability. Another area which had led to the ineffective use of the system was the loss of staff trained to use the system.

● When we visited, staff had stopped using the electronic records. However, the paper care records had not been reviewed since July 2019. They were out of date about many people's current health needs and their risks, so staff could not rely on these for information on how to support people effectively.

● Other records were also out of date such as weekly/monthly weight checks, mental capacity assessments and best interest documentation. There were also gaps in records of people's food and drink intake. This meant we could not determine whether the gaps related to poor record keeping or that required care was not provided.

● Poor standards of record keeping meant staff were relying on verbal handover and on entries in people's daily records and a communication book to be aware of new risks or care needs for people. This increased the risk that staff, particularly new and agency staff did not have all the up to date information they needed to meet people's individual needs.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed our findings about record keeping with the registered manager and the provider and urged them to make a decision about which care record system to use, so they could prioritise getting those records up to date. Following the inspection, the registered manager informed the Care Quality Commission (CQC) they have agreed with the provider the service will use paper records for now.

● Daily care checklists and daily records were well completed and captured all aspects of personal care provided including oral hygiene. However, they were variable about people's emotional wellbeing, choices offered and how they spent their day.

● People did not always receive person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences. For example, one person we met had very limited vision and was struggling to find their things because many of their possessions were still in bags and boxes.
● People's social, emotional and wellbeing needs were not always being met. We observed people's care was often provided around the routines of the home, or the availability of staff, rather than in response to people's preferences. People spent a lot of time sitting around in the lounge and there wasn't enough to occupy them.
● People's comments included; "There don't seem to be many activities going on," "Some days it seems boring," "We don't go out much," and "I would like to go to a garden centre." One person said they were keen to resume cross stitch but said they hadn't yet managed to do so, as they needed staff help with this due to their failing eyesight.
● On the first day of the inspection, we observed that a few people joined in and enjoyed a quiz activity. However, others with more advanced dementia were unable to participate or say what they would like to do. People's activities records were no longer being completed, so it was difficult to confirm what activities they were offered or enjoyed.
● An experienced activity co-ordinator was currently on sick leave, although another activity co-ordinator had recently been recruited. There appeared to be little structure to activities to take account of people's particular interests. When we asked the co-ordinator about the activities programme, they explained they were having to prioritise people's care needs over planned activities a lot of the time. They said, "I do what I can, but I don't plan ahead as it has been so short."

This is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The activity co-ordinator knew about people's interests, and said they spent one to one time with people who struggled to engage with group activities. For example, doing manicures, and chatting with people about their interests. Other people enjoyed reading books, the daily paper, watching the TV and listening to music, and knitting.
● The service also had some external entertainment, for example a visiting harpist and a person who played the guitar and sang. A relative said, "[Carer] takes [person] to the laundry, for a walk. They like to fold the clothes." Another relative said, "[Person] tends to stay in their room for a few days. Staff pop in to keep them company and check on them regularly." A professional praised how staff had engaged a person who was restless and agitated, by providing them with access to tools and equipment they were familiar with from their previous job.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans provided information about people's sensory or hearing impairment. For example, whether they needed a hearing aid or glasses.
● The registered manager gave us examples of other ways they made information accessible for people. For example, that a person with memory loss liked a written note to refer to as a reminder of where they lived now. Notes were also used to help communicate with people who were hard of hearing and chose not to wear their hearing aids.

Improving care quality in response to complaints or concerns

● People said they had no complaints but would speak with the staff or management if they had a concern. Information about how to raise a complaint was provided to each person and was on display. One person said, "I feel comfortable with all of the staff. I have no complaints about this place at all." A relative said, "If I think anything is wrong I tell them. I tell [the registered manager] and she responds."
● A relative who had previously raised a concern about an individual member of staff said they were satisfied with how it was dealt with.

End of life care and support
● One person was receiving end of life care during the inspection. Although the person did not have a care plan in place about this need, staff had worked with person's GP and local nursing staff to make sure the person was kept comfortable and pain free.
● Each person had a Treatment Escalation Plan (TEP) in place. This recorded important decisions about whether or not the person wanted life-prolonging treatment or admission to hospital if their health deteriorated.
● Some people had advanced care plans which captured personalised information about people's end of life wishes, such as any preferred funeral arrangements.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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;

● The registered manager had been absent from the service earlier this year and more recently in June/July due to a planned sickness absence. During this period the deputy manager took responsibility for the running of the home. The registered manager had undertaken a phased return to work and was now back full time. The provider had failed to notify the Care Quality Commission (CQC) about the interim arrangements for managing the service during their absence.

This is a breach of Regulation 14 of the of the registration regulations 2009.

● 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.

● During the inspection, we identified eight breaches of regulations in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding good governance, staffing and a failure to notify CQC of the absence of the registered manager.

● Monthly monitoring of trends had lapsed, so opportunities to identify people at increased risk, or pinpoint areas in the home or times of day when more accidents occur were being missed.

● Where responsibilities such as weekly/monthly weights had been delegated to care staff, there was poor oversight. For example, until the inspector made them aware, neither the deputy manager nor registered manager were aware people were at high risk of harm because people's weekly/monthly weights had not been completed since June/July 2019.

● Some poor practice amongst some members of the staff had not been identified and addressed. For example, dignity and respect issues and unsafe moving and handling practice. The registered manager said, "Staff are obviously not taking things on board."

● Several professionals also spoke about the need for improved communication within the staff team about passing on information. Two professionals also identified concerns about approaches of some staff towards people, moving and handling concerns and staff not following their advice. Other commented on frequent staff changes but said staff were caring and did a good job.

● Communication failures within the staff team meant there was a delay in reporting concerns to health professionals about a person's deteriorating skin wound, and that 30-minute checks needed for another person were not carried out.

● Staff identified the deputy manager as in day to day charge of the home. One said, "The deputy is on the

floor most and the registered manager tends to be upstairs."
● The registered manager said staff shortages meant they had to prioritise people's care over quality monitoring and record keeping.
●The provider's quality monitoring had also lapsed, as the partner who monitored standards of care and paperwork had been off sick.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We asked the registered manager if they felt they would benefit from support from the local authority quality monitoring team to re-establish their quality monitoring systems, which they said they would. The day after the inspection we contacted the team, who were planning to visit the service on 15 October 2019. Since the inspection, the partner who monitored standards of care has returned to work, so should also be able to help with this aspect.
●The ethos of the service was for staff to treat people in the same way they would wish for their relatives to be treated.
● Where mistakes were made, the registered manager was open and honest with people and families. For example, when accidents or incidents occurred, families were informed. Where concerns about staff had been identified, they were dealt with through retraining, supervision and where necessary, through formal disciplinary procedures.
● Most staff feedback about working at the home was positive. Staff praised teamwork and most felt well supported by management. They identified staffing, improved bathroom facilities, activities and getting people out and about more as key areas for improvement. Staff comments included, "People are happy here, but they don't know what they are missing out on," and referring to activities and opportunities to go out, staff said, "That would improve life so much."
● People and relatives praised management of the service. People's comments included; "I know who she [manager] is, she listens," "Management here are very approachable." Relatives said, "I feel I have built up a good relationship with all of them," "They are very responsive to phone calls, they always have time, nothing is too much trouble," and "They make sure the residents come first." Two people said they would like staff to wear names badges which they would find helpful to know names of staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and families were consulted and involved in day to day care decisions. In the provider information return, the registered manager had planned to devise a survey to seek feedback from families and health professionals about the quality of care provided. They planned to use the findings to identify areas for improvement.
● Regular staff meetings were held. Minutes of staff meetings in June and August 2019 showed discussions about gaps in record keeping, difficulties being experienced with electronic records and about improvements needed in medicines management. Also, about protecting vulnerable people by reporting any concerns.

Continuous learning and improving care
● The registered manager and deputy manager had undertaken a management development course and had ideas for improvement. They said the need to prioritise people's immediate care needs meant they hadn't been able to progress these.
● The registered manager and deputy are members of the Devon Care Kite Mark group and attend local workshops and information days. They kept up to date with regulatory changes through monthly newsletter

and accessing the CQC website.
● Staff had opportunities to progress to senior roles and were encouraged to obtain further qualifications.

Working in partnership with others
● Staff worked in partnership with health and social care professionals such district nurses, GPs, a nurse practitioner, mental health services and social workers. The service had well established links with local churches.
● In the provider information return the registered manager said the service held coffee mornings and garden parties and a firework display with food afterwards on Bonfire Night and invited staff, families and local people.
●The local Brownies troupe visited the service twice a year to entertain people and the registered manager planned for local primary school and pre-school children to come and visit on a more regular basis. The service also provided student work experience placements for students to gain experience in care and to do voluntary work as part of pursuing their Duke of Edinburgh award.

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 14 Registration Regulations 2009 Notifications – notices of absence 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always personalised to their needs and preferences. Care was often focused on daily routines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Concerns were identified about staff attitude, moving and handling and support for people at mealtimes

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care and treatment was not always sought in line with legislation and guidance. This was because consent for

decisions about restrictions on people meant for their safety and well being were not properly obtained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at increased risk because of staffing and skill shortages. A number of staff had left or were on long term sickness absence. Recommended staffing levels were not being consistently maintained. Improvements in staff training and practice were needed particularly in moving and handling, pressure area care and in caring for people living with dementia.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and well-being were not effectively managed. Risks were identified about pressure area care, moving and handling and unexplained weight loss. People's risk assessments lacked detail for staff about the care they needed to reduce risks.

The enforcement action we took:

Notice of proposal to impose a condition on the providers registration.

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 People were not protected from abuse and improper treatment because systems and processes designed to monitor people's safe care and treatment were not effective. This exposed people to harm from neglectful care.

The enforcement action we took:

Notice of proposal to impose a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance People's care records and risk assessments lacked detail to instruct staff about their care and treatment needs. Quality monitoring systems had lapsed. This meant the provider had not mitigated risks relating to the health, welfare and safety of people using the service.

The enforcement action we took:

Notice of proposal to impose a condition on the providers registration.