The Pinhay Partnership

Pinhay House Residential Care Home

Inspection report

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Date of inspection visit:
05 May 2016

Date of publication:
10 June 2016

Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

Pinhay House is registered to provide accommodation with personal care for up to 25 older people, most of whom are living with dementia. The home is a grade two listed Victorian mansion, near the edge of a cliff overlooking the sea, just outside Lyme Regis.

On 7 and 12 May 2015 we carried out an unannounced comprehensive inspection, where we judged the service to be overall good, but which required improvement in the safe domain. This was because we identified a number of risks related to the premises, in relation to a leaking boiler flue and because the home did not meet current fire regulations. Also, because we witnessed some unsafe moving and handling practices and a lack of detailed moving and handling care plans to instruct staff about how to move people safely. The provider sent us an action plan outlining work planned to meet the people's safety needs and to comply with statutory requirements, which they said would be completed by the end of August 2015.

On 5 May 2016 we carried out a focused inspection to check on the safety and welfare of people living at the home. This was in response to notifications we received about two serious incidents which occurred at the home over the early May bank holiday weekend. In separate incidents, two people left the home unaccompanied and wandered onto a nearby cliff path, one of whom fell and was seriously injured. The other person was found unhurt and was returned to the home. Over the previous two months, the registered manager had also notified us about two other serious incidents, in which two people had fallen at the home and sustained broken bones.

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

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

When we arrived at the home on 5 May 2016, a further two people had fallen in their bedrooms overnight. One person had been taken to hospital and the second person had sustained facial bruising.

Staff were aware of signs of abuse and knew how to report concerns about suspected abuse, and any concerns reported were investigated. However, people were at increased risk of avoidable harm at Pinhay House because of the lack of clear risk management procedures. There were a high number of unwitnessed falls, with insufficient actions being taken in response to further reduce risks for people. People's individual risk assessments and care records lacked detail about the level of supervision they needed. Risks for individuals were not effectively communicated within the staff team which led to inconsistent care and

safety practices. Some environmental risks had not been identified and others had not been reduced to an acceptable level in a timely way.

Staff offered people choices and supported them with their day to day preferences. However, where people lacked capacity, their legal rights were not fully protected because staff were not acting in accordance with the requirements of the Mental Capacity Act (MCA) 2005. Where people lacked capacity, relatives and health and social care professionals were not consulted and involved in decision making in people's 'best interest'. This meant people's legal and human rights were not fully protected.

On 6 May 2016, the day after the inspection, we contacted the provider to request them to take further urgent steps that day to address some of the ongoing safety risks we identified for people at the home. Later that day they contacted us to advise us of additional measures they were taking to improve safety at the home. This included a temporary increase in staffing levels at the home day and night to protect people and the introduction of regular documented checks of the whereabouts of people. The provider also brought forward urgent works needed to protect people such as arranging for a gate to be installed to prevent people being able to access the cliff path.

We also raised a safeguarding alert to the local authority safeguarding team about the care of eight people we identified were most at risk at the home. We are working in partnership with the provider, registered manager and other agencies to protect people from further avoidable harm.

People were supported by enough staff so they could receive care at a time convenient for them. Although there were some vacancies at the home, existing staff worked extra shifts to cover any gaps in the rota. This meant people had continuity of care from staff they were familiar with who knew about their needs. A robust recruitment process was in place to make sure people were cared for by suitable staff. We followed up the safety concerns we had raised previously about risks at the home and found these had been addressed.

We identified two breaches of regulation at this inspection. We identified two breaches of regulations at this inspection. You can see what action we told the provider
to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Some aspects of the service were not safe.

People were not adequately protected from avoidable harm. There were a high number of falls, with insufficient actions being taken in response to further reduce risks for people.

People's risk assessments and care plans lacked detailed instructions for staff about how to manage and reduce risks and staff were not consistently following instructions about people's care.

Some environmental risks had not been identified and others had not been reduced to an acceptable level.

New security equipment installed at the home had not been properly introduced, which had increased risks for people.

Staff understood their responsibilities to safeguard vulnerable people and to report abuse. However, people were at increased risk of avoidable harm because risks were not being adequately managed.

People were supported by enough staff so they could receive care at a time convenient for them.

A robust recruitment process was in place to make sure people were cared for by suitable staff.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff offered people choices and supported them with their day to day preferences. However, where people lacked capacity, their legal rights were not fully protected because staff were not acting in accordance with the requirements of the Mental Capacity Act (MCA) 2005.

Pinhay House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Pinhay House on 5 May 2016. This was in response to concerns about the safety of people living at the home. An inspector visited the service to check on the safety and welfare of people following four recent accidents notified to CQC during which people sustained serious injuries. The inspector looked in detail at one of the five key questions we ask about services: is the service safe? They also reported on one issue identified in the key question; is the service effective?

Prior to the inspection we gathered and reviewed all the information we held about the home. This included looking at the previous inspection report, action plan, notifications and all previous contact we had about the home, including all documents sent to us.

Most people living at the service were unable to comment directly on their care and experience of living at the home as they were living with dementia. We observed the care of people and staff practice in communal areas of the home and visited some people in their rooms. We spoke with nine staff including two provider representatives, care staff as well as catering, housekeeping and maintenance staff. The registered manager was on sick leave on the day we visited, but we spoke and corresponded with them before and after the inspection.

We looked in detail at three people's care records. We followed up all serious accidents/incidents which had happened to people at the home in the previous three months. We looked at environmental risk assessments, at accident/incident reports, at fire safety checks and at relevant policies and procedures. We spoke with a health professional and a therapist who visited the service during the inspection. We contacted

the GP surgery and district nurses who regularly visited the home to get their feedback.

Inadequate

Is the service safe?

Our findings

When we arrived at the home, staff told us two people had fallen in their bedrooms overnight, one of whom had to be admitted to hospital for assessment. We looked in detail at the circumstances of those accidents and of the four previous serious accidents which had recently occurred at the home.

An incident form showed on 30 April 2016, a person walking unaccompanied in the grounds of the home, got lost and wandered onto a nearby steep, slippery cliff path. Staff noticed they were missing after about 20 minutes and started searching for them. After an hour, the person hadn't been found, so staff called the police to help in the search, in accordance with the home's missing person's policy. A member of the public found the person near the home, and returned them to the home unhurt.

The person's care records showed they were admitted to Pinhay House earlier in the year. They had Alzheimer's, (a form of dementia), and were fairly independent and mobile. The person's support plan said, '[Service user's] short term memory is not very good, sometimes they will go out and not be able to find their way home.'

When the person first came to live at the home, their risk assessment showed they could walk independently in the grounds of the home. Their risk assessment had been updated when they needed more supervision . This instructed staff to accompany them whenever they went outside. However, on 30 April 2016 the person was allowed outside unaccompanied, although a staff member said they intended to follow them a short while later. By the time the member of staff went outside, the person had disappeared.

We asked several other staff about their understanding of the arrangements for supporting this person to go outside. Some staff said the person frequently went out in the grounds unaccompanied, and they kept an eye from inside on their whereabouts through the windows. Other staff said they thought the decision that staff needed to accompany the person outside had only been made after they got lost. This showed the changes in the person's risk assessment had not been effectively communicated within the staff team. This meant there was confusion among staff about the measures needed to keep this person safe.

On the evening of 2 May 2016, another person left the home unnoticed sometime between seven thirty and eight o' clock in the evening. This occurred when a person accidentally tampered with a reset button on an electronic keypad, which set off the alarm and unlocked an outside door. A new key pad system had recently been fitted at the home. However, the reset button on that door was installed at a height accessible to people at the home, which meant it was easy for them to activate it inadvertently.

The provider said staff had been taught how to enter and exit via the keypad system, and how to change the codes. However, they had not had any other instruction on the new system, such as how to silence the alarm or reset the system, if it was accidentally triggered. The provider said they planned to do more staff training on the system over the next few weeks. In the event, the alarm was triggered at the weekend, and rang for over 30 minutes, because staff didn't know how to reset it and in the confusion, a person left the home unnoticed.

Staff did not check whether everyone was accounted for when the alarm was activated. They continued giving people their evening drinks and helping them to bed. A staff member realised the person was missing and raised the alarm just before nine when the search began. This meant the person was out of the home for over an hour in the dark before staff noticed their absence. The police were called to help in the search and the person was found on the cliff path, lying on the ground by a staff member at around nine thirty pm. Staff stayed with the person, wrapped them in blankets, until the ambulance crew arrived. They were transferred to hospital for treatment. They have since returned to the home.

This person's care records showed they had recently been admitted to the home from another home. Details from their previous home showed the person had made several attempts to leave that home. Their Pinhay House risk assessment said, '[Person] is at low risk due to the spacious environment. Has an alarm mat so staff are aware when [person] is out of bed. This showed the service had failed to identify this person was at increased risk of trying to leaving the home, given their history. This meant their risk assessment and care plan had not prompted staff about the need to be vigilant and monitor the person's whereabouts at regular intervals.

Following both people's disappearance from the home, staff completed accident/incident forms and wrote detailed statements about the circumstances of both incidents. However, the investigation had not been completed so there was a delay in identifying lessons learnt and highlighting further safety measures needed for people's protection. We followed this up with the provider, who explained the investigation would be completed by the registered manager when they returned from sick leave.

The provider said they reminded staff to be vigilant about people's whereabouts and had decided to install a secure gate to prevent people accessing the cliff path. The contractor was also due to visit the following week to relocate the reset button. This meant there was an ongoing risk that people at the home could tamper with the security system again, and unlock the door. Staff had been instructed to check people's whereabouts if the alarm went off again. However, there was no protocol or procedure in place about how staff should manage this risk, although the provider developed one in response to our questions about this.

We also looked the care of the two people who had fallen overnight. One person was admitted to hospital as they had sustained an injury. We accompanied the deputy manager to look at the person's room. They had a pressure mat which had failed to alarm to attract staff attention when this person got out of bed. The deputy manager checked the pressure mat which was working, although they wondered whether it had been plugged in properly. The second person who fell had got out of the end of their bed, which meant their pressure wasn't activated. This person fell again later that night, and had a bruised face. Staff had sought the advice of the emergency 111 service and instigated more regular checks for 24 hours after their fall, to monitor the person for any further ill effects from their fall.

This person had previously fallen down the cellar stairs on 29 March 2016 and fractured their shoulder. They were partially blind, and followed a member of staff into cellar, an area they should not have been able to access. When the registered manager notified us about this injury, we followed up with them what further steps were being taken to reduce the risk of recurrence. The registered manager said a keypad was going to be fitted to the door. When we visited, the keypad had not yet been fitted, but a temporary lock ad been put on the door to prevent people accessing this area. Staff also told us, a member of staff stood at the top of the cellar stairs, each time another staff member went into the cellar, to help make sure people were kept away from this area.

This person's risk assessment, last updated on 9 April 2016 showed they were at high risk of falling. It said, '[Person] can become confused and their failing eyesight makes it difficult for them to move around in an

unfamiliar environment. [Person] is to be supervised while walking around the home.' We asked staff how they checked the whereabouts of people around the home. Staff said there was always a member of staff on duty in the lounge supervising people, which we confirmed during our visit.

Staff also had a list of people who lived at the home which they checked at mealtimes to ensure each person was given their meals. They also identified tea/coffee rounds and working around the home as other opportunities to check on people's whereabouts. However, these had failed to alert staff on the evening a person went missing. Staff said they couldn't realistically monitor people's whereabouts at all times, particularly in corridor areas. At night, staff said they checked people in their rooms one to two hourly. However no records of these checks or records of repositioning people in bed were kept, so the frequency of checks could not be verified.

We saw one person leave the lounge on several occasions and wander around the ground floor and adjacent corridors. They were not followed or supervised by staff, as required by their risk assessment. Accident forms showed this person had experienced seven falls over the past two months, many of which were unwitnessed. This meant this person remained at high risk of falling because they were not being adequately supervised by staff.

Accident/incidents were reported, with details about any steps taken to reduce individual risks for people. However, the accident/incident records showed a high number of accidents had occurred at the home over the past three months. There were 20 accidents reported in February 2016, 13 in March and 17 during April, many of which were falls that were not witnessed by staff. Although the deputy manager reviewed the March accidents/incidents, they had not yet reviewed the accident/incidents for April. This meant there were delays in identifying increasing risks for individuals, and in highlighting any themes or trends.

For example, the reports showed there were particular times of the day and night when there was a high number of falls around the home. This meant people remained at risk of further accidents/incidents at these times, because sufficient measures were not being taken to reduce those risks to an acceptable level. We asked the provider to look further at these risks to identify further actions to reduce them.

At the previous inspection, we found environmental risk assessments at the home were not suitable or sufficient because they didn't highlight all known risks or identify measures to reduce them. In response, the registered manager had compiled more detailed internal and external risks environmental risk assessments. These were more comprehensive and showed how risks were being managed. However, some external risks had still not been identified, such of the home's proximity to a steep and slippery cliff path. Where outdoor risks had also been identified, some risk reduction measures needed had not yet been implemented.

For example, the gardens/grounds of the home were not secure, and there were slips, trips, and falls risks related to concrete steps and unsecured storage arrangements for gas cylinders. The risk assessment showed plans to look at installing handrails and gates in these areas over the next 12 months. This meant the provider had not taken all reasonably practicable steps to mitigate all identified health and safety risks for people.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of signs of abuse and knew how to report concerns, which were robustly investigated. However, there was a lack of awareness that some practices at the home such as the lack of clear risk management and supervision for individuals and the lack of documented checks was putting some people

at increased risk of avoidable harm.

We asked the provider and the registered manager how satisfied they were about safety measures for service users at the home, given the level of accidents/incidents and people's injuries over the past few months. They acknowledged mistakes had been made and they were concerned about recent events. The provider said, "We are searching our hearts to see what we can do better. We are going to be doing a lot of work on this to make sure people are safe."

On 6 May 2016, the day after the inspection, we contacted the provider and requested they immediately take more urgent steps to increase the supervision of people at the home and to further reduce health and safety risks for people. We also raised a safeguarding alert to the local authority safeguarding team about the care of eight people, who we thought were most at risk at the home. We are working in partnership with the provider, registered manager and other agencies to protect people at Pinhay House from further avoidable harm.

Later that day, the provider contacted CQC to advise us of a series of additional measures being taken to improve people's safety at the home. They included increasing staffing levels at the home day and night over the weekend, so staff could better monitor and protect people. They had reviewed people's individual risks and identified a list of people to staff who they considered were at increased risk. They had instigated regular documented checks of those people's welfare and whereabouts. The provider had relocated the reset button, which meant people could no longer access it, so were unable to activate the alarm or unlock the door. The provider also brought forward planned works to get them done urgently the following week. For example, to install a gate the following Monday to prevent people being able to access the cliff path. They also made a voluntary undertaking not to admit any more people to the home, until they were confident their improved systems were adequately protecting people's safety and welfare. We have been in regular contact with the registered manager and the provider to monitor how the additional measures they have introduced are reducing risks for people.

We followed up what action had been taken in response to the environmental risks identified at our previous inspection. The provider confirmed the leaking flue had been replaced. Burn risks for people had been significantly reduced. This was because the provider had fitted thermostatic controlled valves to all areas of the home, which meant water temperatures accessible to people were within the 44 degrees maximum recommended by the health and safety executive. A phased programme of work to replace fire doors to meet the current fire regulations was ongoing, and 80% of fire doors had been replaced, with the remaining planned over the next few months. Fire safety precautions were in place, regular checks were made of the fire alarm system and fire prevention equipment. People's personal evacuation plans had recently been updated following a simulated fire drill.

All staff had received moving and handling training, and each person had a detailed moving and handling plan. The provider had purchased additional equipment such as hoist slings and electric adjustable beds. Staff undertook a number of moving and handling procedures in the communal lounge throughout the day, which were in accordance with current moving and handling regulations.

People were supported by enough staff so they could receive care at a time convenient for them. Throughout the day, staff were available to support people's care needs, at a time and pace convenient for them. People were occupied enjoying activities, and other leisure pursuits. The service had five care staff on duty during the day, which including the registered manager, deputy manager or a care supervisor. They were two waking night staff and the rotas showed these recommended staffing levels were maintained. The provider also employed three activity co-ordinators, who were also trained to support people with personal

care and with eating and drinking. They also employed cooks, housekeeping and maintenance staff.

Although there were a couple of vacancies for care staff, as two staff had recently left, existing staff worked extra shifts to cover any gaps in the rota. This meant people had continuity of care from staff they were familiar with who knew about their needs. A robust recruitment process was in place to make sure people were cared for by suitable staff.

Staff reported the workload demands at the home had increased over the previous few months. This was related to the admission of several people to the home who were very mobile, but were confused and did not have the cognitive ability to manage their own safety needs. Staff also spoke about the increasing demands of people who had become frailer and more dependent. For example, four people needed two staff to provide all their personal care. Staff thought the combination of these issues had significantly increased risks for people and demands on their time.

Staff and visiting professionals reported high levels of confidence in the registered manager, deputy manager and the provider. One staff said, "Communication is better, if you have something to say you can say it." However, three staff felt more needed to be done to reduce risks for people at the home. Two staff said they thought the needs of some people were too high for them to be safely cared for at Pinhay House.

In the two months prior to the inspection, CQC contacted the registered manager on several occasions to ask for their response to anonymous e mails we received about alleged bullying by various named members of staff. They investigated each allegation and found no evidence to support these claims. When we visited the home, we followed these concerns up again, and found no evidence the concerns raised with CQC were valid.

Since the inspection, the registered manager has reviewed staffing levels at different times of the day and has put additional staff on duty in the evenings. This was because they identified this period as a time when people needed more staff support because they were at higher risk of falling. They also plan to have a member of staff to start earlier in the morning, to provide additional support to people. We will visit the home again in the near future to carry out a further check on people's safety and welfare.

Requires Improvement

Is the service effective?

Our findings

We only looked at one aspect of this domain at this inspection.

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 Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) safeguards.

Staff sought people's consent for day to day care decisions such as whether a person wanted a bath, shower or a wash. However, where people lacked capacity to make an informed decision, or give consent, staff were not acting in accordance with the requirements of the MCA. There were no MCA assessments in place for the three people whose records we looked at. Although staff said families were consulted about people's care and treatment, there was no evidence of them being consulted in any 'best interest' decisions made. For example, in relation to the widespread use of pressure mats to alert staff when people got out of bed. This meant people's legal rights were not protected.

The provider had an MCA policy and procedure, although it was unclear from people's care records, which people lacked capacity, about which decisions and when. Staff used vague terms to describe people's level of cognition such as, 'Short term memory is not very good,' has 'Alzheimer's' or 'dementia.' There was no information to guide staff about how they could support people to make as many decisions for themselves as possible, although several staff could describe how they did this in practice. Only one person had mental capacity assessment documentation in their care records, but this hadn't been completed, other than to document details of a relative with lasting power of attorney for the person. When we asked the deputy manager and the provider about this, they were unable to explain why the mental capacity policy and procedures at the home weren't being implemented.

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

The registered manager had submitted deprivation of liberty applications to the local authority deprivation of liberty team for most of the people who lived at the home, and were awaiting their assessment. This was because they recognised most people were under the constant supervision and control of staff and were not free to leave.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who use services, who lacked capacity, did not have their legal rights fully protected because staff were not acting in accordance with the requirements of the Mental Capacity Act (MCA) 2005. This is a breach of regulation 11 (3).

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 People who use services and others were not fully protected against the risks associated with unsafe or unsuitable premises. Further improvements were needed to ensure health and safety risks for people were identified, risk assessed, and reduced as much as possible. This is a breach of regulation 12 (1) (2) (a) (b) (d) and (e).

The enforcement action we took:

Warning notice