The Pinhay Partnership

Pinhay House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced and took place on 7 and 14 February 2017. Pinhay House is a grade II listed Victorian mansion, overlooking the sea, just outside Lyme Regis. It is registered to provide accommodation with personal care for up to 25 older people, most of whom are living with dementia. 22 people lived there when we visited.

On 5 May 2016 two breaches of regulations were found in relation to serious concerns about people's safety and more minor concerns in relation to consent. Following this inspection the service made safety improvements to the environment and worked closely with local health and social care professionals and with the local authority quality monitoring team. We last inspected the service on 29 June 2016 to check if the required improvements had been made, which they had been with evidence of further improvements being made.

The service has a registered manager. 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.

Staff demonstrated a high awareness of each person's safety and how to minimise risks for people. Personalised risk assessments balanced risks with minimising restrictions to people's freedom. Accidents and incidents were reported and included measures to continually improve practice and reduce the risks of recurrence.

Staff developed positive, kind, and compassionate relationships with people. People appeared happy and content in their surroundings and were relaxed and comfortable with staff that were attuned to their needs. There were lots of smiles, good humour, fun and gestures of affection. People's care was individualised, staff knew people well, treated them with dignity and respect, and were discreet when supporting people with personal care. The service had enough staff to support people's care flexibly around their wishes and preferences

Staff understood the signs of abuse and knew how to report concerns, including to external agencies. They completed safeguarding training and had regular updates.

People experienced effective care and support that promoted their health and wellbeing. Staff had the knowledge and skills needed to carry out their role. Each person had a comprehensive assessment of their health and care needs and care plans had instructions for staff about how to meet those needs. Staff worked closely with local healthcare professionals such as the GP, community nurses and mental health team to improve people's health. People had access to healthcare services for ongoing healthcare support. Staff recognised when a person's health deteriorated and sought medical advice promptly when they were feeling unwell. Health professionals said staff were proactive, sought their advice and implemented it.

People received their medicines safely and on time from staff who were trained and assessed to manage medicines safely.

People praised the quality of food and were supported to improve their health through good nutrition. Staff encouraged people to eat a well-balanced diet, make healthy eating choices and to exercise and maintain their mobility.

People and relatives were happy with the service provided at Pinhay House. The culture of the home was open, friendly and welcoming. Care was holistic and person centred, staff knew about each person, their lives before they came to live at the home. They understood people's needs well and cared for them as individuals.

People's rights and choices were promoted and respected. Staff understood the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and involved person, family members and other professionals in 'best interest' decision making.

People pursued a range of hobbies, activities and individual interests. For example, reading, arts and crafts and organised quizzes and games such as Bingo and Scrabble. Where people chose to remain in their rooms, volunteers and staff spent time with them to chat and keep them company.

People received a good standard of care because the staff team were led by the provider and registered manager who set high expectations of standards of care expected. There was a clear management structure in place, staff understood their roles and responsibilities, and felt valued for their contribution. Staff were motivated and committed to ensuring each person had a good quality of life. The provider used a range of quality monitoring systems such as audits of care records, health and safety and medicines management and made continuous improvements in response to their findings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected because staff understood signs of abuse, and knew how to report any concerns.

People's individual risks were assessed and actions identified for staff to reduce them as much as possible.

People were supported by sufficient staff who could provide care at a time and pace suitable for each person.

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

People received their medicines on time and in a safe way.

Is the service effective?

Good

The service was effective.

People were well cared for by staff that were trained and had the knowledge and skills to carry out their roles.

People were offered choices and their preferences respected. Staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and acted in accordance with them.

People were supported to access healthcare services. Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

People were supported to lead a healthy lifestyle and to improve their health through good nutrition, hydration and exercise.

Is the service caring?

Good

The service was caring.

People and relatives said staff were caring and compassionate and treated them with dignity and respect.

People were able to express their views and were actively involved in decisions about their care.

People were supported by staff they knew and had developed good relationships with.

Staff protected people's privacy and supported them sensitively with their personal care needs.

Is the service responsive?

Good

The service was responsive.

People received individualised care and support that met their needs and promoted their independence.

People's needs were assessed and care records accurately reflected their care and support needs.

People were engaged in activities that were meaningful to them.

People knew how to raise concerns and complaints, and were provided with information about how to do so. No complaints were received since we last visited.

Is the service well-led?

Good

The service was well led.

People received a consistently high standard of care because the provider and registered manager led by example. They set high expectations for staff about standards of care expected.

The culture was open, friendly and welcoming.

Staff worked well together as a team and care was organised around the needs of people.

People, relatives' and staff views were sought and taken into account in how the service was run.

The provider had a variety of systems in place to monitor the quality of care and made changes and improvements in response to findings.

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.

This inspection took place on 7 and 14 of February and was announced. The inspection team comprised of an inspection manager and an inspector. We reviewed the information included in the information we held about the home, such as the provider's action plan, notifications and feedback we received from health and social care professionals.

We met with all 22 people using the service, and spoke with four relatives. We looked at four people's care records and at people's daily records in their room. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with 14 staff which included the registered manager, both owners, care staff, a staff trainer, activity co-ordinators, a chef and housekeeping staff. We looked at systems for assessing staffing levels, for monitoring staff training and supervision, staff rotas, and at five staff files, which included two recruitment records for new staff. We also looked at quality monitoring systems the provider used such as audits, provider visit reports. We sought feedback from commissioners, and health and social care professionals who regularly visited the home and received a response from eight of them.

Good

Is the service safe?

Our findings

People were safer because safety improvements reported previously had been maintained and embedded in practice. Staff demonstrated a high awareness of each person's safety and how to minimise risks for people. Staff comments about safety included; "People are well looked after, always keep an eye on everyone;" "Staff are risk aware;" "Concerns are taken seriously"; "It's safer" and "Good control of risks." A professional said, "Staff look after people well and another said, "People's movement is not restricted, there are lots of places to wander freely."

People had individual risk assessments which were well completed and were reviewed monthly or more frequently in response to need. Care plans were completed to instruct staff how to minimise risks identified. For example, people at risk of falling, with choking/swallowing risks or of developing pressure ulcers. Staff knew which 13 people needed more close supervision and had systems in place to monitor those people regularly. For example, checking on some people every half hour during the day and hourly at night. Where a person experienced behaviours that challenged the service, staff noticed and intervened to distract them and kept the person and others safe.

Where people were assessed as at high risk of falling measures were taken to reduce those risks as much as possible. For example, by seeking the advice of the community 'Falls team' and ensuring a person had good fitting footwear and their room was kept clutter free. Staff reminded people to use their mobility aids when they were moving around the home and to concentrate when going downstairs to increase their safety and independence. At night, where people were at high risk of falling when getting out of bed, staff used pressure mats or passive infra-red sensors to alert them to people getting up, so they could go and assist them. Regular falls audits were undertaken to monitor any changes or trends and identify if any person's risk of falling had increased so further actions could be considered.

Accidents and incidents were reported and reviewed to identify ways to further reduce risks. For example, the registered manager had recently notified us of an incident where two people were found on their pressure mats, which hadn't alarmed. The investigation highlighted the pressure mats hadn't been properly plugged in. That meant they hadn't alerted staff when those people got out of bed, although records showed both had recently been checked by staff. Since then additional evening checks have been introduced to ensure this didnot happen again. Where incidents had occurred, staff at the home were open and honest with people and relatives about practice concerns identified and steps taken to address them.

Environmental risk assessments were completed and showed measures taken to reduce risks. For example, fitting a key pad to the kitchen and cellar doors, so people couldn't wander into those areas unaccompanied. An external company had completed an audit of risks at the home, and additional work to improve fire safety at the home was nearly completed. The remaining two fire doors were due to be replaced. Then an external company was due to undertake a further visit to update the health and safety risk assessment.

The service employed a handyman who did day to day repairs and maintenance but the maintenance

manager had recently left. Discussions were ongoing about replacing their health and safety roles, for example, as fire warden. In the interim, staff in charge of the shift acted as person responsible in the event of a fire. An up to date fire risk assessment was in place, staff received fire training, and did regular fire drills, most recently in November 2016. Since we last visited, the registered manager notified us of a minor fire which occurred in the kitchen, and fire staff praised how staff managed this incident. However, an analysis of the incident had identified additional learning in similar circumstances. Each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of an emergency.

There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the home. Hot water was temperature controlled in areas people accessed independently and records showed bath temperatures were checked before the person was immersed. We identified one hot water tap that was 51 degrees, (hotter that the health and safety recommended limit of 44 degrees) which we raised with the provider. They disabled this tap and were arranging to have it checked and repaired. Gas and electrical appliances and equipment was regularly serviced and tested as was all equipment used at the home such as hoists, slings and pressure relieving equipment. Contingency plans were in place to support staff out of hours with any emergencies related to people's care or related to services at the home such as electricity, gas and water supplies.

People's safety and wellbeing was promoted because there was sufficient staff to keep people safe and meet their needs at a time and pace convenient for them. The atmosphere in the home was calm and organised; staff worked in an unhurried way and were able to spend time with people. People were offered support with personal care regularly throughout the day. The registered manager used a dependency tool to assess and monitor the support each person's needs and amended staffing levels accordingly.

For example, the registered manager identified that more staff were needed early in the morning and in the evening when people were getting up and going to bed. So they had changed staffing rotas to have extra staff available at those times. They had also employed additional activity co-ordinator staff to support people with activities seven days a week, which meant people were occupied with things of interest to them. There was always a staff member on duty in the lounge to help support people safely. When we visited there were care staff four on duty during the day and two waking night staff. There was also a cook and two housekeeping staff, who also did the laundry. Weekly rotas were prepared in advance, so staff knew which shifts they were working and any gaps in staffing could be filled by existing staff working extra shifts. This meant people were always cared for by staff who knew them and agency staff were never used.

People were protected from potential abuse and avoidable harm. Staff had received safeguarding adults training and the provider had safeguarding and whistle blowing policies in place. This meant staff knew who to contact and what to do if they suspected or witnessed abuse or poor practice. The registered manager had reported concerns about suspected abuse since we last visited, and outlined actions to address those concerns. For example, in relation to a person who lacked capacity and was vulnerable in relation to their finances. Staff worked closely with the person, relatives and a local authority appointed advocate to ensure all financial decisions were made in their 'best interest'

All appropriate recruitment checks were completed to ensure fit and proper staff were employed, including robust checks for volunteers working in the home. Staff had police and disclosure and barring checks (DBS), checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

People received their medicines safely and on time and could administer their own medicines, where it was assessed as safe for them to do so. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicines administered were well documented in people's Medicine Administration Records (MAR). Clear prescriptions for prescribed creams used body maps to communicate which part of body to apply the cream. Where people had medicines prescribed 'as required', for example for pain relief, staff checked with the person whether they felt they needed the pain relief.

A whiteboard in the medicines room highlighted any recent prescription changes for people. For example, people prescribed antibiotics. Staff checked temperature of medicine refrigerator daily to check it was storing medicines which needed refrigeration at the correct temperature. MAR sheets were audited weekly with actions taken to follow up any discrepancies or gaps in documentation. A pharmacist audit reported positively about medicines management at the home.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Housekeeping staff used suitable cleaning materials and followed cleaning and infection control procedures. Staff used hand washing, and protective equipment such as gloves and aprons to reduce cross infection risks. Regular infection control audits were carried out with steps taken to address any concerns identified. For example, replacing a carpet when it remained odorous after steam cleaning. The most recent environmental health food hygiene inspection had rated the home with a score of three out of five. Since then ducting has been deep cleaned, and a refrigerator repositioned. Worked was planned imminently to replace worn worktops in the kitchen with plans to replace the kitchen, when funds allow.

Good

Is the service effective?

Our findings

People and relatives thought the staff who worked at the home had the right skills and knowledge to support them. Staff had a range of training opportunities which enabled them to feel confident in meeting people's needs and in recognising changes in their health. A visiting professional said staff at Pinhay House were good at managing people's skin care and avoiding pressure ulcers. A mental health professional praised staff skills in managing a person whose behaviours sometimes challenged the service. They said, "Staff did a lovely job with him, and created good environment."

People received effective care, based on best practice, from staff that had the knowledge and skills they needed to carry out their roles and responsibilities. Most staff had completed health and social care diplomas at level two or above, so had the knowledge, skills and competencies they needed to meet people's needs. When staff first came to work at the home, they undertook a period of induction, and worked alongside more experienced staff and the registered manager to get to know people. A new staff member was undertaking the national care certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life. A new staff member said, "It's really nice, staff are helpful and supportive."

The staff team received a combination of formal training, practical training and working one to one with training staff to monitor their practice. These methods helped ensure the staff team were competent and demonstrated the values and attitudes needed for their role. Staff undertook regular update training such as fire safety, health and safety, and infection control. They also completed training relevant to people's individual needs, for example, understanding dementia.

During the inspection we received some anonymous concerns about moving and handling practice at the home. This related to a staff member being asked to lift a person upstairs in April 2016, when the stair lift failed. The registered manager had notified us of this incident at the time, and impressed on staff that people should never be lifted manually due to risks of injury to person and staff. Staff had received practical moving and handling training. We observed moving and handling practice in communal areas of the home throughout both days of the inspections, and found staff practice was in accordance with the regulations.

People had detailed moving and handling plans which showed how staff needed to assist a person to mobilise, and any equipment such as a wheelchair or walking frame. All equipment people needed such as electric beds, pressure relieving mattresses, stand aid, handling belts, hoists, slings and slide sheets for repositioning people in bed. We received feedback from an occupational therapist confirmed staff had requested seating assessments appropriately for two people and with moving and handling. They confirmed the home had appropriate moving and handling equipment and loaned them specialist equipment when needed. They said, "I have no concerns, only positive things to say."

People had access to healthcare services through regular visits from their local GP and district nurses. They had regular dental appointments, eye tests and visits from a chiropodist. Health professionals said staff were proactive, contacted them appropriately about people and carried out their instructions. A

professional said the home communicated well with them and said, "I'm always asked to write in people notes about my visit so staff know what's been done and have instructions for any follow up." Two mental health professionals said staff worked well with them to support people with mental health needs, one of whom did a regular memory clinic at the service. They said staff contacted them for advice and support, and praised how well they had managed a person who lived there, who was quite agitated. They said staff coped well with distracting people but might benefit from some further training on managing challenging behaviour to fine tune their skills.

People were involved in decision making about their care and were offered day to day choices. Staff sought people's agreement before carrying out any care and treatment and ensured they were supported to make as many day to day decisions as possible. For example, about the time they wished to get up or go to bed, what they wanted to wear and about food choices.

People's legal rights were protected because staff understood the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Staff had undertaken relevant training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Mental capacity assessments were undertaken and where people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who knew the person well and other professionals, where relevant. For example, in relation to a decision to use bedrails to keep a person safe in bed. This showed people's legal and human rights were upheld.

DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's best interests. The registered manager had made 21 deprivation of liberty applications to the local authority DoLS assessment team for people living at the home. This was because they identified some people may be deprived of their liberty due to their frailty and inability to leave the home without supervision for their safety and wellbeing. One authorisation had been granted and they were awaiting assessment of the remaining applications.

People enjoyed lunch in the dining room and adapted crockery and cutlery was provided to those who needed it, so they could eat independently. The second day we visited was Valentine's day and people enjoyed having their potatoes served in a heart shape. One person had a meal placed in front of them but didn't attempt to eat it. Staff explained the person would sometimes eat their food and they discreetly helped the person after a while. They sat with the person and waited patiently for them to swallow each mouthful before moving onto the next.

People praised the quality of food and were supported to improve their health through good nutrition. Since we last visited, the service had employed a new chef and many people and relatives commented on the improved quality of food. The chef said he was really enjoying his new job.There were also two part time chefs and the care staff did not need to prepare any meals. The chef went round the home each day asking people what they would like for supper. Lunchtime meals consisted of one main choice and a vegetarian alternative. They were passionate about the importance of good food and nutrition for people's health and all meals were home made using fresh ingredients. Staff reminded people of the choices available and where a person didn't fancy either cooked lunch options, they were offered an alternative instead. Menus were updated regularly in consultation with people and included vegetarian options. People were offered a range of breakfasts each day such as melon, eggs, grilled tomatoes on toast. Suppers consisted of a hot choice or sandwiches. On the first day of our inspection people could have jacket potoatoes with prawns and a Marie Rose sauce.

Staff knew people's likes/dislikes and any food restrictions due to medical conditions. For example, the chef prepared low fat/reduced sugar alternatives for people with diabetes. Where people needed soft or pureed food, due to chewing or swallowing difficulties, each ingredient was presented separately to make the meal more appetising. A relative of a person on a soft diet said they appreciated the home-made soups, which their mother really enjoyed and often ate when they refused their meal. This was in accordance with the instructions in their care plan. One person told us " The food is very good, they said what would be your favourite dish? I said Chinese and Matron said she'd put it on the menu!". Another person ate better when they were in a quieter environment, so were offered their meal in a quieter place away from the dining room. The chef served the desserts to people in the dining room and asked everyone what they would like.

Staff encouraged people to eat a well-balanced diet and make healthy eating choices and offered people drinks regularly to maintain their hydration. For example, milkshakes and 'build up' drinks' , regular snacks and 'finger food' was provided for people who preferred to eat whilst moving around. People were offered regular hot and cold drinks, and jugs of water and squash were provided. Where people were at increased risk of dehydration, staff kept individual records of what they drank each day, although there were some gaps, which we fed back to the registered manager. People identified at risk of malnutrition had their weight monitored weekly, and any record of weight gains or losses were managed proactively. One person said "The food is excellent. I put on weight , I did need to!"

Adaptations were made to the home to meet the individual needs of people with disabilities, for example, grab rails were fitted in corridors, bedrooms and bathrooms to help people move around independently. For example, on the staircase there was individual signage for one person to remind them where to go at the top of the stairs to find their room. A stair lift provided people with access to all but six rooms on the upper floor. This meant people in those rooms needed to be mobile enough to navigate the remaining six steps to their rooms. At handover, staff discussed a person whose health and mobility had deteriorated following a recent spell in hospital, whose room wasn't accessible via a stair lift. We followed this up with the registered manager and provider who had contingency plans in place to relocate the person down stairs, if needed. The provider outlined future plans to improve disabled access for people, such as plans to install a 'wet room' downstairs next year.

Good

Is the service caring?

Our findings

There was a family atmosphere at the home; people looked relaxed and comfortable with staff who were kind and compassionate towards them. There was a strong ethos of caring by staff who developed positive, caring and compassionate relationships with people. There was lots of spontaneous laughter, singing, dancing, chatting and good humour. Staff knew each person well and treated them as an individual. People's comments included; "They always pop in and see me, so I'm not alone"and "This is very good; "They are so kind. Its quite unique here, I'd give it full marks."

Relatives said they felt welcome at the home and said staff were polite and friendly. Comments included; "This is a lovely home, they understand her so well; " "She chose to come her and has been happy here." One relative particularly appreciated that a staff member stayed with the person to support them when they were admitted to hospital. Professional feedback included: " Staff always attentive;" "All staff good natured, they genuinely do care about the residents" and "Staff treat people with dignity and respect, they are lovely with the residents, they know them so well, it's really good." We saw one person trying to stand up and wanting to go to the toilet. The care worker immediately came to her side and said " Will you come with me. I won't leave you at all".

Staff were visible round the home, spent time with people and were interested in what people had to say. They treated each person as an individual and demonstrated empathy in their conversations with us about people. Staff spoke about people with respect and affection and organised their time flexibly around people's needs and wishes. People could spend quiet time on their own, whenever they wished. When a person spilt their drink over themselves, a staff member immediately came to their assistance and helped them back to their room to change their clothes.

Staff treated people with dignity and respected their privacy when helping them with daily living tasks. They noticed when people needed help, helping a person to stand up from the table and to reposition another person more comfortably in their chair. Staff complimented people on their appearance, one said, "You look very pretty in that blue today." At lunchtime staff protected some people's clothes from spillages. Staff were discreet, and respectful in their manner and approach when supporting people with personal care. For example, seeking the person's permission before providing any personal care and providing privacy for a person when they used the bathroom.

All staff were very kind with people.We observed some lovely practice at lunchtime. Care staff spotted when people weren't eating their lunch and gently encouraged them to eat more. Where people were distressed they reassured them. One person was anxious asking where her mother was. The care worker said "Not today, she's busy, but I'm here today with you" and sat with her. One person told a care worker " I love you" and the care worker replied " I love you too".

Two people at the home shared a bedroom which had been discussed and agreed with those people and their families. Each person had a commode by their bed for use during the night. As there was no screen in the room, we asked staff how they ensured each person's privacy. Staff explained they used to use a privacy

screen but this posed a risk as one person was inclined to pull it, which put them in danger. We followed this up with the registered manager and provider, who said both people were likely to be moving downstairs in the near future. They have since confirmed both people have moved downstairs and further steps have been taken to ensure their privacy.

People were supported to express their views and be actively involved in making decisions about their care. They were involved in developing their care plans. Care plans also included details about how to support people with decision making, for example, a person's care plan said 'Can answer questions after being given a little time to think.' Where appropriate, relatives were also invited to participate in regular reviews of people's care. One relative said, "They encourage family participation."

People's care records included details of their communication needs, for example, when people needed glasses for reading or used hearing aids. Another person with speech difficulties used simple signs such as a 'thumbs up' sign to indicate they were happy. They used a whiteboard for more detailed instructions, such as which book they wanted staff to get from their bookshelf.

One person previously had their dog living with them until they were no longer able to look after it with staff support. Instead a staff member had taken the dog to live with them but brought the dog to visit the person each time they were on duty in the home. When the dog arrived it ran happily to the person, who was delighted to see it and sat happily near them during their visit. This meant the person, and others at the home could continue to enjoy the dog, without having the ongoing responsibility of looking after it. One person told us they really liked the cat who lived at the home.

Visitors were made welcome and could visit at any time. Staff supported people to keep in touch with family and friends, including by phone and e mail. One person was heading out to enjoy lunch with a friend. Staff organised family celebrations for people's birthdays. Each person was encouraged to personalise their room with things that were meaningful for them. For example, photographs of family members, treasured pictures or favourite ornaments and pieces of furniture.

People's spiritual and religious needs were known to staff, for example, some people liked to attend local services and others received holy communion when the local vicar visited. People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, such as the person's views about resuscitation in the event of unexpected collapse.

Good

Is the service responsive?

Our findings

People received personalised care that responded to their individual needs. One person said, "They are all marvellous." Staff knew people well, understood their needs and cared for them as individuals. Relatives feedback included, "Overall the home is good. Some staff are fantastic and one in particular is amazing." They also praised the chef, the housekeeping and the activities staff.

Before each person came to live at the home, a thorough assessment of their needs was undertaken. This was to make sure staff could meet their care needs alongside the existing needs of people living at the home. The service used evidence based tools to assess people's risks and developed detailed care plans which provided staff with detailed instructions about the care. For example, for a person confined to bed, their care plan included information about moving and handling aids and pressure relieving equipment.. The person received regular skin care, and staff helped them to change their position every few hours and applied cream to their skin to prevent it becoming dry or sore, in accordance with their care plan.

Staff involved people and those close to them in developing individualised care plans. They reviewed and updating them as people's needs changed. The service had worked with the local authority quality monitoring team to improve people's care records. Each person had a care record folder, which was organised, easy to navigate and old records were removed and archived regularly. Care plans were more detailed and accurate about people's care needs. A useful summary care plan provided a quick overview of all aspects of their care. A 'This is me' record provided a detailed history about the person and their life before they came to live in the home, so staff could engage I conversations of interest to them. Care records were audited regularly and audits had identified further improvements needed in daily records, for example, to ensure there were no gaps in people's food and fluid charts. Fluid charts also needed to be added up each day so staff were aware of how much each person had drunk.

People were busy around the home and there was lots going on. Several people enjoyed a daily paper. The service employed five part time activity co-ordinators and other care staff were encouraged to involved people in activities individually and in groups. A weekly programme of activities provided interest and stimulation for people. This included arts and crafts, a 'Flexercise' class, a movie club and singing and dancing, quizzes and scrabble. When the weather was warmer people enjoyed trips out to visit the beach and other local attractions. There had been trips to the Otter Nurseries for lunch in November . On the second day we visited people had made valentine cards and presented one to the chef, who was very touched. A relative said " The activities are working well, they are funded properly". There were regular activity meetings to look at what was happening and future plans. They were currently thinking of trips to the Silver Screen (a cinema putting on a special screnning for those people living with dementia) and swimming in a hydrotherapy pool.

Where people chose to spend most of their time in their room, or didn't have many visitors, staff popped in regularly and chatted with them and the activity co-ordinators did one to one sessions. For example, playing a game of Dominoes with a person confined to bed. Several people had made friends with others living at the home which offered them mutual support and companionship.

Staff responded to people's individual needs. For example, a person who liked to watch TV in the lounge became upset if people walked in front of them and obscured their view. The registered manager arranged for the TV in the lounge to be mounted on the wall, which meant it was visible to them at all times. Where another person had continence needs, staff recognised when the person needed to use the toilet and offered them the opportunity to visit the toilet at regular intervals. For another person's relatives, staff had arranged a notebook in their room so they could write messages to one another about the person's day to day progress and any needs such as toiletries.

People and relatives said they had no concerns or complaints about the home. They said if they had any issues, they felt happy to raise them with the registered manager, deputy or the provider and they were dealt with straightaway. The provider had a written complaints policy and procedure. Written information was given to people and relatives and was on display in the home about how to raise a complaint. People, relatives, staff and visiting professionals said they would be happy to raise concerns with the registered manager or provider and were confident any concerns would be addressed. We looked at the complaints log which showed no complaints had been raised since we last visited.

Good

Is the service well-led?

Our findings

People and relatives said they very satisfied with the quality of care and many said they would recommend the home to others. One relative said, "On the whole it's very good and we are regularly involved in discussions about mums care." Another relative wrote, 'Staff currently working at Pinhay are almost without exception very hard working, all compassionate and go the extra mile to ensure Mum's needs are met.'

Professional comments included: "Staff have tried very hard to improve standards and I can see improvements;" "Lots of improvements seen under the new manager, who is very focused " and "Since the registered manager came to work there, they are very responsive and proactive." When we asked staff what the best aspects of their home included their comments included; "Residents care needs are first priority before tasks;" "well run;" "I feel able to have my say and contribute ideas."

There was a clear management structure in place, the registered manager was in day to day charge, supported by a deputy manager. They organised, supported and led the staff team and acted as a role model for staff about the standards of care and attitudes they expected. Staff were monitored and supported staff in their practice and senior staff were being developed to take on more responsibilities and to be accountable. People, relatives the provider and staff expressed high levels of confidence in the registered manager and deputy manager.

Staff worked well together as a team, and there was good communication and support. Staff felt valued and appreciated for their work and there were opportunities to progress. The chef told us he had been invited to a staff meeting and everyone had applauded him , this showed how staff valued each others contribution . Regular staff meetings were held with all staff, people's individual care needs were discussed, as were care records, dignity and respect issues and 'best interest' discussions. Also discussions about people's individual care, the role of keyworkers and about risks and how to minimise them.

The service had a whistleblowing policy which encouraged staff to raise concerns in good faith. Where staff had raised concerns these were taken seriously and thoroughly investigated by an external person appointed by the provider. Although the concerns raised were not upheld by the investigation, this was used as an opportunity to improve and learn lessons. For example, increasing awareness about the need to adjust management style to meet individual staff needs.

The provider spoke about how the home were promoting the home's values amongst the staff team. They reiterating expectations that staff about working in 'The Pinhay Way.' This related to staff working in a well organised, efficient , caring way. Where issues about practice or capability were identified they were dealt with through supervision, training and through formal capability procedures, if expected improvements were not achieved. Most staff feedback was that relationships had improved at the home and the current team was working really well together.

Staff were made aware of any recent changes to people's health and care needs when they came on duty through a staff handover meeting. This ensured that important information was shared, and acted upon. A

communication book was used to follow up important messages about people care and treatment. For example, blood test results and prescription changes.

People's and relatives views were sought day to day, and through regular care reviews. Staff kept in regular contact with families by phone and e mail. For example, one relative sent feedback to CQC during the inspection which included, 'The home is responsive to any contact we have made to discuss Mum's care and we feel as if we are working in partnership with the home.

The provider used a range of quality monitoring systems to continually review and improve the service. The registered manager did a range of checks and audits to monitor and identify areas for improvement. For example, by checking people's care records, medicine records, health and safety checks of the environment and checks of cleanliness, equipment, of kitchen, laundry and waste management. They took action to address areas where improvements were needed. For example, in relation to improving care records and improvements to the environment. Senior staff were increasingly taking on responsibility for quality monitoring as part of their development, for example, undertaking audits of medicines management and infection control.

The registered manager kept up to date with evidence based practice through regular attendance and participation in the local provider engagement network. They worked closely with the local quality monitoring team and with local professionals to implement evidence based practice tools to improve the quality of care and record keeping.

The service had evidence based policies and procedures were provided to guide staff in their practice. These included policies on safeguarding, Mental Capacity Act, health and safety and infection control.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. The registered manager had notified the Care Quality Commission (CQC) about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.