Pinehurst Partners Limited

Pinehurst Residential Home

Inspection report

1-2 Haldon Terrace
Dawlish
Devon
EX7 9LN

Tel: 01626863500

Date of inspection visit:
24 May 2016
26 May 2016

Date of publication:
12 July 2016

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

Pinehurst is a residential home in the seaside town of Dawlish. It is registered to provide accommodation and care for up to 20 people of all ages who may have mental health needs. This inspection took place on 24 and 26 May 2016 and was unannounced. At the time of the inspection, 17 people were living at the home. People were all physically independent and able to engage in conversation. People living at the service were all over 40 years old.

The service had 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.

People expressed a high level of confidence in home. They told us they felt safe and happy living at Pinehurst. The atmosphere of the home was calm and relaxed throughout our inspection. There was laughter and appropriate banter between staff and people living at the service, as well as opportunities for quiet conversation.

People were supported by staff that knew them well. Staff were kind and caring and people spoke very highly of the care they received. One person said "The atmosphere is lovely, staff are nice, [name of registered manager] is great and you're treated like you are one of the family". There were enough staff available to meet people's care needs safely. Staff worked in a calm, unhurried way and had time for talking and supporting people with activities of their choice. People were encouraged to maintain their independence and to be part of the local community.

Staff ensured people's privacy and dignity was respected at all times. They worked closely with people to ensure they understood their needs and preferences. People were involved in planning and reviewing their care and felt listened to by staff. Staff demonstrated a shared commitment to the wellbeing and care of the people they supported and respected people's right to individuality and difference.

People were able to follow their interests and hobbies. There was also a range of activities available within the home which people enjoyed. Many people went out every day, either independently or supported by a member of staff. Staff had time to spend individually chatting with people. There were two holidays organised by the registered manager each year, where a group of people went away for a few days, supported by staff. These were greatly enjoyed.

Staff had received training in safeguarding adults and knew how to raise concerns if they were worried about anybody being harmed or neglected. They felt confident that if they had any concerns they could raise them with the registered manager and they would be acted upon quickly and effectively. One person said "If I was feeling nervous or unsafe I could go to anyone here, I feel perfectly safe".

We observed medicines being administered and this was done safely and unhurriedly. Medicines were stored safely and all stock entering and leaving the home was accounted for. Staff received regular training in medicines management and medicines audits were completed to ensure consistent safe practice.

There were robust recruitment processes in place to ensure that suitable staff were employed. Staff were well supported by the registered manager through supervision and appraisal. High standards of care were encouraged through staff training and development. Staff participated in a wide range of training courses in topics relating to people's care needs including medicines management, mental health, health and safety and safeguarding.

Staff had received training in, and understood the principles of the Mental Capacity Act 2005 (MCA) and the assumption that wherever possible people should make their own decisions about their care and treatment. We found that the registered manager had not fully understood how the MCA should be applied in a mental health setting. However, immediate actions were taken to remedy this, including seeking assistance from the community mental health team with a capacity assessment for one person and seeking MCA training provided by Devon County Council. We found there had been no detrimental effect on people living at the service.

We have made a recommendation about staff training on the subject of the Mental Capacity Act (2005).

Records showed each person had been assessed before they moved into the home and any potential risks to their health and welfare were identified. Where risks were identified there were measures in place to reduce these. We saw that staff were skilled at managing risks in relation to people's mental health. We were told by health and social care professionals that the service was very good at recognising signs of people becoming unwell and supporting people safely at times of crisis. A social worker told us staff were "quick to recognise and act if mental state becomes risky". The service's ability to respond proactively to signs of people's changing mental health meant that people achieved levels of mental stability that had not had in the past.

People were supported to eat and drink enough to ensure they maintained good health. We spoke with people about their meals and whether they enjoyed the food that was provided. Most people were positive. They said "Food is very nice and you just ask for an alternative if you don't like it. They are very flexible". However, some people said they would like more choice, particularly at teatime. We talked with the registered manager about this and they said that the menu choices were all generated by people themselves and people could always choose an alternative. However, they would encourage further discussion about this at the next house meeting and seek some new ideas.

People were supported to maintain good health from a number of visiting healthcare professionals. People told us they saw their GP or mental health worker when they needed to and we saw from records that there was close communication with health and social care professionals.

The culture of the home was person-centred, open and friendly. There was clear leadership from the registered manager. Quality monitoring systems were in place which were used to review and improve the service. There was ongoing investment in the home to ensure that the environment was well maintained and updated. The environment was safe, clean, homely and welcoming.
Not all notifications had been made to the Care Quality Commission in line with the provider's legal responsibilities. This had not had any detrimental impact on people. We have made a recommendation about the registered manager keeping in touch with current CQC guidance.

People's needs were met by the adaptation, design and decoration of the service. There was an ongoing programme of maintenance at the home. It was decorated and furnished in a comfortable, homely way. The space was big enough for people to find some personal space when they needed it.

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

People told us they felt safe and happy.

Staff were knowledgeable about their responsibilities to safeguard people.

Risks associated with people's changing mental health were recognised and responded to quickly and effectively.

People were supported in a safe and timely way because there were sufficient numbers of safely recruited and well trained staff.

There were systems in place to safely manage people's medicines.

Is the service effective?

Good

The service was effective:

Staff received training in a range of care topics and were knowledgeable about people's care needs. People spoke positively about the care they received.

The registered manager recognised their training in relation to the Mental Capacity Act (2005) needed updating, and took action to address this during the inspection.

People had prompt access to health and social care professionals, such as GPs and community psychiatric nurses.

People's needs were met by the adaptation, design and decoration of the service.

Is the service caring?

Good

The service was caring:

People spoke highly of staff. They said they were always kind and caring and listened to their views.

The atmosphere of the home was calm and welcoming.

People's privacy and dignity was respected.

People were supported to be involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive:

People received personalised care that was responsive to their needs.

People told us their choices were respected.

People were supported to take part in a wide range of activities and encouraged to develop as much independence as possible.

People and staff were confident the registered manager listen to their thoughts and deal with any concerns promptly and effectively.

Is the service well-led?

Good

The service was well led:

The culture was open, friendly and welcoming. People were at the heart of the service.

The registered manager was open and supportive and people and staff had confidence in their leadership.

There were effective quality assurance systems in place to monitor care and plan on-going improvements.

Pinehurst Residential 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 and 26 May 2016 and was unannounced. It was carried out by an adult social care 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.

Before the inspection we reviewed information we held about the service. This included feedback from health and social care professionals and notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We looked around the premises, spent time with people in the communal areas and observed how staff interacted with people throughout the day. We met with 10 people using the service. We observed the staff handover meeting between the night time and morning staff and spoke with five staff members, including the registered manager. We also looked in detail at three sets of records relating to people's individual care needs; two staff recruitment files; staff training, supervision and appraisal records and records relating to the management of the home, including quality audits. We looked at the way in which medicines were recorded, stored and administered to people. We spoke with two health and social care professionals who regularly visited the home (a community psychiatric nurse and a social worker).

Good

Is the service safe?

Our findings

People living were relaxed and comfortable with staff and each other. They said they felt safe and secure living at Pinehurst. One person said "Staff are nice here. Friendly and supportive. I feel safe now. Didn't feel safe at home before, but its better now". Another said "If I was feeling nervous or unsafe I could go to anyone here, I feel perfectly safe".

There was a calm atmosphere on both days of our inspection with no apparent tension between people. People's relatives told us they did not have any concerns about their relative's safety.
People were protected from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff said they were confident that if any concerns were raised with management they would be dealt with to make sure people were protected. Staff told us they had never had any reason to raise concerns about any of their colleagues. They were aware of whistle-blowing procedures, whereby they could report any concerns outside of the organisation without repercussions.

Some people needed support to manage their money and were assisted by the local authority Court of Protection team. We spoke with a representative of the team who said the registered manager worked closely with them to safely manage the finances of some people who lacked mental capacity to do so themselves.

Risks to people were reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references had been obtained.

We were told by health and social care professionals that the service was very good at recognising signs of people becoming unwell and supporting people safely at times of crisis. A social worker told us the service was "quick to recognise and act if mental state becomes risky". They gave an example of a person who had become unwell and was at risk of harming themselves. They told us staff had managed the risk "brilliantly" and this had prevented one of their clients from being admitted to hospital. They had done this through consistent risk management and close communication with the community mental health team. Also through the trusting relationship they had developed with this person which enabled staff to provide reassurance and relieve the person's anxiety and distress. They also removed items and medicines that may pose a risk and provided high levels of monitoring and support until they began to recover. This person told us "I trust staff one hundred percent". Their mental health case manager told us that the positive way the service responded had enabled the person to recover at home, without having to be admitted to hospital. Staff told us they had received mental health training. They knew how to support people positively and de-escalate situations and keep people and themselves safe.

There were close working relations between the community mental health team and the service and this was an important factor in supporting effective risk management. The care plans used at the service were generated by the local community mental health team and the registered manager had input into these.

Reviews were held every six months or more frequently if required. These plans gave an overview of people's mental health needs, but did not offer detailed written guidance for staff about how to provide care to each individual. We saw there was an additional document that supported the care plans. The registered manager told us this had been designed to help staff recognise indicators of an individual becoming mentally unwell. At the end of this document was a brief 'plan of action' which gave brief guidance to staff about how to respond. For example, one person's plan of action said "contact mental health team, be around people, PRN meds, music, remove any sharp items, support mental health and wellbeing". Staff were able to describe this person's care needs in great detail and how they supported them. This included spending time every day offering emotional support and talking through any worries and supporting them to maintain important relationships. However, guidance available in records would not necessarily have been sufficiently detailed to enable a new member of staff or agency worker to understand how to provide care. We spoke with the registered manager who acknowledged this potential risk. They told us they would expand care plans to provide more detailed guidance to support staff appropriately and reflect the care they were providing.

Some people smoked in their bedrooms and this was risk assessed on an individual basis to ensure they could manage safely and were aware of fire policy and procedures. People met with their keyworker every three months to complete a detailed review of their care needs and risk assessment. This included ensuring people who smoked remained familiar with the fire policy and could manage their smoking safely, including how to operate a fire extinguisher. Metal ashtrays and bins were available in people's rooms and fire extinguishers were situated outside bedrooms. Daily room checks were completed by staff. The fire system was tested weekly and there were regular fire drills. Fire training was provided by an ex fire-officer every six months. Staff told us they felt confident about the evacuation procedure. Personal emergency evacuation plans were in place for people. These gave staff directions on how to safely evacuate people from the building should the need arise, such as a fire.

Staff knew what to do in emergency situations. Staff told us if they had significant concerns about a person's health they would call the emergency ambulance service or speak with the person's GP. Staff were trained in first aid so that such help could be given if needed.
When we visited on 24th May, we identified an increased risk of scalds to people in the bathrooms. This was because of hot water from the basin taps exceeded the Health and Safety Executive (HSE) recommended temperatures (No hotter than 44 °C should be discharged from outlets that may be accessible to vulnerable people). This had not been identified through temperature monitoring. We discussed this with the registered manager who was confident that everyone currently living in the home had the ability to manage this risk. The registered manager commenced immediate individual meetings with people living at the service to make sure they did understand this risk and could manage it appropriately. We have since received copies of these risk assessments which show how people individually understand and manage the risk. For example, by mixing hot and cold water in the basin. It was noted that additional control measures, such as thermostatically controlled taps, may be needed should people's capacity to manage this change.

There were 17 people living at Pinehurst and on the day of our inspection there were four care staff and the registered manager on duty. The staff group worked as a team to meet people's personal care and support needs, as well as supporting them with activities, cooking and cleaning. At night time there was one awake member of staff and one sleeping. We asked staff and the registered manager if this system worked effectively and if they had time to complete all of their various tasks. They said they did and that a teamwork approach represented a more normal, family orientated lifestyle. The registered manager said that they had previously employed cleaners and less care staff, but this had given the home a more institutional feel that they had wanted to get away from.

We saw staff had plenty of time to support people and complete their shared tasks. In the afternoons they were able to take people out and engage in individual time and activities. The registered manager told us that at the time of the inspection people were mostly mentally well, but that staffing would be increased if people's needs changed. We spoke with a visiting social worker who said there were always enough staff to support their visits. This ensured good communication. Throughout the inspection we saw and heard staff attending to people's needs in a timely way. There was a relaxed and unhurried atmosphere in the home which indicated there were enough staff on duty.

People were supported to receive their medicines safely and on time. Medicines were stored safely. Everyone was able to consent to taking their medicines and no covert medicines (administered without people knowing) were given. Where PRN or "as required" medicine was prescribed to help manage people's anxiety there was detailed guidance within the medication records to guide staff about when it should be offered. One person became distressed during the inspection because of a delusional belief. We saw staff followed guidance by initially providing reassurance and trying to divert the thought process, before offering medication. We saw from records that PRN medicine was not a 'first resort' to help calm people; it was offered only when needed and when people also felt they would benefit from this. Staff told us they always tried talking and other ways of providing reassurance before offering medication. We saw that good practice was followed in that staff always recorded whether PRN medicine had been helpful or whether further actions were needed, such as seeking further review.

Staff were kind and patient when giving medicines and always sought people's consent. Clear notes were written on the medicines record sheet which explained the purpose of each medicine. Staff told us they believed it was important they understood this so that they could explain to people what they were taking each medicine for. We asked people about their medicines and they told us they understood what they were taking and what each medicine was for and that they were always involved in any changes.

Two people managed their own medicines. Staff checked daily how they were feeling. They met with them weekly for a more detailed conversation to discuss any issues, check the amount of medication left and ensure they still felt confident to self-medicate. There was also regular support from the district nursing service and their input and any advice was well recorded and passed on through handover meetings and records.

Medication audits were completed monthly by the registered manager and deputy and an annual audit was completed by the local pharmacy. People were encouraged to attend medical appointments and accompanied where necessary. There was close contact between the local surgery and the service where people took complicated medicines that needed careful oversight and regular blood tests.

All accidents and incidents were recorded, although these were infrequent. Information was analysed during managers meetings to look for any trends and make sure sufficient actions had been taken.

The home was in a good state of repair and decorative order and staff were able to highlight plans for further improvements. Renovation of the chimneys and veranda was taking place while we were inspecting. There was a small torn area of lino in the kitchen and the registered manager said they had already had a quote for the lino to be replaced and this had been ordered. Corridors, bathrooms and lounges were free from obvious hazards. Domestic chemical products were stored securely. The home was free from unpleasant odours. Records showed that equipment was serviced regularly to ensure it remained safe to use.

Good

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the MCA was not fully understood or being applied and this meant people's human rights may not be respected.

The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The registered manager told us that although staff received training in relation to the MCA, it was not something they thought they would use as people had full mental capacity, or came under the legal framework of the Mental Health Act. We discussed with the registered manager the need to protect people's best interests at times when they may lose mental capacity, for instance, if they became mentally unwell. The registered manager wanted people's rights to be protected and believed everyone should have a say in how their care was provided, at all times. They took immediate actions to arrange meetings between people and their keyworker's to discuss and record people's wishes about their future care and who they would like to be consulted, should a best interest decision need to be made about their care.

Whilst most people living at the service were able to make decisions about all aspects of their care, there were a small number whose capacity in particular areas needed assessment under the Mental Capacity Act. For instance, staff told us one person refused to attend GP appointments and was unlikely to understand the consequences of not receiving treatment should an emergency arise. We discussed this with the registered manager and deputy of the service who took immediate action to request assistance of this person's Community Psychiatric Nurse (CPN) with completing a mental capacity assessment. Since the inspection we have told this has been completed and plans are in place should a best interests decision making process be required. Although staff received training regarding the MCA, this was provided internally and was not up to date. The registered manager also told us they would seek external training opportunities to make sure their knowledge was refreshed. They later confirmed they had contacted the local authority mental capacity training team about accessing this.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that no one at the home was under any form of restraint or continuous supervision and control. However, this may change (for example, if someone needed continuous supervision due to risks to themselves or others) in the future and so it is important that the service fully understands how to apply this legal safeguard, should it become necessary.

We recommend that the service seeks training from a reputable source in relation to the Mental Capacity Act

(2005) and Deprivation of Liberty Safeguards to ensure knowledge and practice is up to date.

Staff were aware of the fundamental principle of the MCA that everyone should be assumed to have capacity unless they had been assessed otherwise and that decisions should be made in people's best interests if they lacked mental capacity. One said "it's about how you work out if people can make their own decisions and how to make decisions in people's best interests if they can't". They knew that other people needed to be involved in the best interest's process such as families and social workers or CPN's. Throughout the inspection we heard staff seeking people's consent and offer choices. People were asked what they wanted to do and what they wanted to eat or drink, whether they wanted to join an activity indoors or go out for a walk. Staff told us there was never any need to use restraint in the home.

Staff told us they felt trained to carry out their role effectively. The registered manager had systems in place to ensure all staff were trained in the areas identified by the provider as mandatory subjects. This included first aid; fire safety; manual handling; safeguarding vulnerable adults; infection control and food hygiene. Staff were also trained in areas to meet specific needs of people living at the service. For example, there was training about supporting people with mental health needs and about important medications and their side effects.

Staff were being supported to gain qualifications in health and social care and all staff held recognised national diplomas. New staff were completing the Skills for Care Certificate. This is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. Staff had regular supervision, appraisals and checks of their competency to ensure they continued to be effective in their role and had opportunities to discuss their development. All staff had an annual budget of £200 to do extra external training of their choice. Additional supervision was offered for any staff who required it and any staff performance concerns were reviewed by the registered manager. Did this include debriefing following any incidents or external support?

New staff undertook a detailed induction programme which followed the Skills for Care framework, including the Care Certificate. This is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support.
New staff shadowed other, more experienced staff. While they were completing this, they were extra to the staff on the rota. This meant they had time to learn their role fully and to develop relationships with people living at the service.

We spoke with people about their meals and whether they enjoyed the food that was provided. Most people were positive. They said "It is always very tasty" and "Food is very nice and you just ask for an alternative if you don't like it. They are very flexible". However, some people said they would like more choice, particularly at teatime. We talked with the registered manager about this and observed several mealtimes. A healthy home cooked meal was always available at lunchtimes. People were enjoying cheese and potato pie with vegetables on one day of our inspection and chilli con carne on the other. They were offered a variety of choices if they did not want this. One person decided they were not very hungry. They were offered several choices before deciding to have homemade tomato soup and crackers, which they enjoyed. Tea time meals were lighter and included ravioli, egg on toast, sandwiches, pancakes, soups and yoghurt. There was a menu that rotated every three weeks and a roast dinner was always available on Sundays. We asked the manager about how the menu was decided and they said everything on the menu was chosen by people themselves and discussed at the quarterly resident meetings. They said that there was a further meeting about to be held and they would be discussing the summer menu and so they would invite some new ideas from people and encourage further discussion.

Meals were a sociable experience. The dining room was connected to the kitchen and people and staff were chatting comfortably together while cooking and during the meal. People's food dislikes were clearly indicated on a white board in the kitchen and the main meal and an alternative was displayed on a chalk board. We observed staff asking people if they had had enough to eat and offering more if they were still hungry.

There was a barbeque in the courtyard which staff told us was used on sunny days during the summer. People told us they really enjoyed having a barbeque and sitting in the sun. Tea and coffee making facilities were available in people's rooms so they could make a drink whenever required. Hot drinks and biscuits and fruit were also available in the mornings and afternoons and people could ask if they wanted anything at other times. If people were going out for the day they would be provided with a packed lunch. A low sugar, healthy diet was offered to people who had diabetes and staff had attended a recent training course on diet and nutrition which had given them lots of ideas about how to keep meals healthy and tasty. For instance, by adding more fresh vegetables to stews and using fresh produce wherever possible.

Staff communicated effectively to ensure that any changes in people's needs were understood. There were handover meetings twice daily where key information such as medical appointments and any changes were discussed. If someone needed to go into hospital, the registered manager would attend ward rounds to make sure medical professionals understood background information about the person's care needs and preferences. If there were any changes to a person's medication following a psychiatric review, staff all needed sign to say they had read the summary letter, before it was filed. Any changes were also noted on the care plan and on a white board next to the medication cabinet. A relative told us that communication between them and the service had always been good. They felt confident they would be kept well informed.

People were supported to maintain good health by having access to visiting healthcare professionals and being supported to attend healthcare appointments. Records confirmed people received regular visits from district nurses, community psychiatric nurses and social workers. One person told us "if I need a doctor a visit is arranged for me and someone will come with me if I want". The registered manager said they took one person to their podiatry appointments. One person's needs had changed and they were waiting for a wheelchair. They had recently been assessed by an occupational therapist and were waiting for a new chair to arrive. A visiting social worker complimented the service about how good the service was at keeping in touch, seeking advice and communicating any changes.

People's needs were met by the adaptation, design and decoration of the service. The building was well maintained. It was decorated and furnished in a comfortable, homely way. The space was big enough to accommodate people and allowed them to find their own quiet space if they wanted to. There were two large lounge areas on the ground floor as well as a room used as a library and activities room. People who had bedrooms on the top floor of the house also had access to two additional small lounges. There was an outside courtyard area which was well used and also a communal garden area in front of the house. The amount of space meant that people could move away if they did not want to be involved with a particular activity or a particular person. One person told us if they felt at all uncomfortable with other people they could move to a different area and do something else. People could personalise their own space, for example, with furniture, pictures and ornaments.

Good

Is the service caring?

Our findings

People were exceptionally positive about the care they received at Pinehurst. They told us they were well cared for by staff who treated them kindly and with compassion and respect. The atmosphere in the service was relaxed. Staff were unhurried, with plenty of time to spend talking with people. People said "The atmosphere is lovely, staff are nice, [name of registered manager] is great and you're treated like you are one of the family" and "I like the carers sense of humour and how they treat me with respect for my independence. Its relaxed and friendly but they do a good job of looking after me". Another said "I like it here. Very nice". A visiting community nurse said "Staff here have hearts of gold".

We saw there was a collaborative, easy relationship between people and staff, with conversations flowing throughout the day about normal things; how their day had been, what they wanted to do, did they want any support with anything?

People received high levels of emotional support from staff. For example, when one person was becoming anxious we saw a member of staff put their arm gently around their shoulders, speak reassuringly and offer quiet time together. They went to the lounge and sat talking together for some time. Later we saw this person was calm and happy. One person told us "staff are very friendly and caring. It's always easy to talk to them. If you've got a problem, like you are having a stressful time, they will give their time to talk to you – it's a very caring situation"

People all had times when they felt extra special to staff for example, birthdays and if they had to go into hospital. One person who had lived at the service for many years had recently been admitted to hospital. Staff told us they had sent flowers and cards and taken friends from the home to visit. This person's health had deteriorated suddenly, but staff were determined to support their wish to return home. They were in the process of talking to hospital staff and district nursing staff about how to support this. They said "she's one of our family and we want her back with us".

People confirmed that they were supported to maintain contact with people that were important to them. Visitors were always welcome and were greeted warmly by staff and by name. One relative told us staff helped arrange visits so their sibling could come and stay when they wanted. This included preparing medicines that were needed and arranging train times. They said "staff have been delightful; supportive and friendly and very patient". Another person said their partner was always welcome to visit and that staff helped with making arrangements when they wanted to stay away for a night. One person was being supported by their keyworker to email their sister who lived in another part of the country.

All the staff talked about the people they were looking after with passion and caring. Staff described a strong ethos of care led by the registered manager. They aimed to provide people with as normal a home life as possible, and tried to function as a large family with an emphasis on teamwork. They recognised that some people had lost touch with their own families and wanted to provide them with a sense of security and care they may not have had previously. A member of staff said "It's a friendly, close knit home, like a family. I love it here. Residents and staff all get on well. I feel rewarded that people are stable and happy and joining

in and going out for days"

People were in control of their care and staff listened to them. People told us staff would take time to try and resolve any issues they had. People said staff would discuss options available and always included them in the decision making process.

One person was very happy to have been consulted before a new person came to live at the service. Their arrival had meant they would have to share some personal space (a private living area/lounge). They had now developed a good friendship and continued to be very comfortable with the space provided, which enabled them to have a private "living room" for reading, TV and personal visits.

Regular meetings were held for people to discuss any issues. The last one was in March 2016 and another was planned for June 2016. People could add whatever they wanted to be discussed to the agenda, but the themes always included food and activities and allowed people time to discuss if they were happy with their keyworker arrangements and their rooms. At the last meeting people had requested that pancakes went onto the tea time menu and this had happened. There had also been suggestions for group trips which were being followed up.

People felt they were encouraged to remain as independent as possible. One person had a care plan that included working towards moving back to living independently in the community. They were pleased to be able to do their own laundry and manage their own medicines with only a small amount of support. Where able, people were encouraged to take part in cleaning their own rooms and helping with laying the tables or putting their own washing away. Some liked to help with the washing up. One person said "carers here respect my independence and help me keep it". A member of staff commented "I think we support people to be as independent as they can; they do as much as possible, but get our support too".

We heard staff listening and communicating well with people, giving them their full attention and talking in a pleasant manner. When addressing people, staff used people's preferred names and appropriate language that was not patronising.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. Care records were written in a respectful and appropriate language. Throughout the inspection we saw and heard people being treated with respect and dignity. Everyone had a key to their own bedroom and could lock their door. Staff only entered with permission, unless there was an emergency situation .People's privacy was promoted. For example, people were discreetly assisted to their own rooms for any personal care. Staff always knocked on people's doors and waited for a reply and sought permission before entering. Staff told us some people were shy when receiving personal care and so they always made sure they had a cover-up available to minimise any discomfort.

Good

Is the service responsive?

Our findings

People had care plans in place which were personalised and reflected their current needs. People's needs were assessed before and while living at the home and care plans were developed following these assessments. Plans to meet people's needs were well maintained and reviewed regularly during keyworker meetings. All care records were personalised and showed how people liked to be cared for and their preferences about food, activities and people they wanted to maintain contact with. Daily records were updated by staff after handover and at the end of each shift. Anything that had a high priority, such as if someone had been ill or had a health appointment, was discussed at handover and written on a whiteboard in the locked office.

People's needs were carefully assessed before coming to live at the service and people were involved in this. New people were encouraged to visit the service and spend a few days to ensure it was the right place for them before they made a commitment to moving there. The registered manager advised they were careful to ensure any new arrivals would not upset the existing balance of people within the home. They made sure they had the right staff with the right training to meet people's needs before they accepted them into the service. They also sought as much information as possible from health and social care professional about people's needs, to ensure any initial care plan was able to respond to their needs. One person who was new to the service confirmed they had been visited by the registered manager before leaving hospital. They had also been part of their discharge planning meetings.

People were familiar with their care plans and confirmed their keyworker discussed them with them regularly to ensure "everything was up to date". We saw that quarterly reviews completed between people and their keyworker were comprehensive. They included discussion about whether risk assessments and care plans were up to date and correct, as well as discussion about emotional wellbeing and mental health from the person's perspective. There were also prompts to discuss other important aspects of people's life at Pinehurst such as relationships between people and staff, any changed interests and changes to medicines and physical health. People told us they valued these meetings and felt listened to and that any new information was explained to them.

People told us they also had more formal review meetings every six months organised by the community mental health team. These were attended by themselves and their CPN or social worker as well as the registered manager and anyone else they wanted there, such as a family member. People said they felt able to express their views and felt supported by the registered manager. Relatives said they were involved with the care planning process and review. Staff said they viewed the care plans often if they wanted guidance. We saw that care plans were updated to reflect any changes in needs, preferences or medicines. Staff could suggest if they felt the care plans needed amending to ensure the care plans reflected people's most current needs.

Not everyone was able or wished to be actively involved in formal meetings about planning their care. However, they had regular meetings with their keyworker where they shared their views. This meant staff

knew people well and when planning care, took into account what they knew about the person and their preferences. Relatives and advocates were involved in planning care when appropriate. One person told us they could ask whoever they wanted to their review meetings and that they could discuss their wishes with keyworkers or any member of staff at any time. They told us everyone had access to their care records if they wanted and said "the files are like our belongings; we can see them and read them whenever you like".

Staff displayed a good knowledge of people and their individual needs. One staff member told us how they supported an individual when they were distressed. This included offering reassurance and explanation of why they were feeling this way. They encouraged them to sit down and rest and used distraction to try to divert them into happier thought patterns, for instance, by talking about favourite family members or favourite activities or celebrities. If the person continued to be distressed another staff member would take over and spend time with them. Calming medicine was offered only if the period of distress became prolonged.

Staff told us about one person who had complex needs relating to their mental health. They told us that it was very important to be sensitive to this person's difficulty in dealing with change and keep routines in place. Also, to make sure they had involvement in all aspects of decision making. Care records supported this approach and also noted favourite activities such as shopping on Tuesdays, knitting and playing with favourite dolls. We saw from activity records and discussion with staff that they were being regularly supported to do these things and that a clear routine was in place.

One person had a preference for a female care worker to support them with personal care as they felt uncomfortable about having a man attend to them. This was recorded in their person centred value sheet and they told us their preference had always been respected.

Visiting health and social care professionals told us the keyworker system (where each member of staff worked closely with three people) was helpful in ensuring staff knew people's needs really well. Detailed knowledge of people's interests, their health and social histories as well current care needs, meant they could always respond appropriately to people's needs.

A highly person-centred and skilled approach to people's care meant that many people often achieved a newfound stability in their mental health. This was something that all staff were proud of. Staff told us that one person had recently arrived unsettled, angry and aggressive. They were much calmer now and joining in with life at the home as well as visiting relatives. This person told us "I am happier now. Less angry than I was and I am mixing in with the others".

There was a friendly atmosphere throughout the home and lots of activities going on. On the afternoon of the first day of inspection we saw a gentle exercise group taking place in one of the lounges. On the second day people were making colourful leaves and postcards to send or hang on a 'craft tree', which occupied one wall of the activities room. People were also spending time talking with each other, or with their keyworker. They told us there keyworker time was special and they could choose what they did "we go for a walk, go for a coffee or play a game or chat in the lounge. Whatever I want to do really".

People were using the activities room for craft activities and to play dominoes. Some people were part of a reading group and there was a library of books available in the activity room. Suggestions for new books for the club were made by people at quarterly 'resident meetings' and then purchased by the provider. The registered manager told us if they were going shopping or into town, they would always see if anyone wanted to come with them. They said that often people engaged better if activities were spontaneous, rather than arranged with too much notice. Recently it had been a nice sunny day and they had asked

people what they wanted to do. They had suggested a trip to Dartmoor for an ice cream and a walk. People told us they had really enjoyed this. One trip that had been planned was a day trip to the hometown of one of the people living at the service. They had not been there since their childhood and were very much looking forward to the visit.

The registered manager told us they felt it was important for people to have a break from their normal routines and experience different places. With this in mind, they organised small holidays twice a year, which were funded by the provider. Most recently they had stayed for three nights at an inn on Exmoor. People had enjoyed day trips to seaside towns in north Devon, as well as visiting national trust properties and antique centres, which several people were very interested in. We saw photos of this holiday. People were happy and smiling and appeared to be enjoying themselves. One person had not felt able to join in with a group holiday and so a member of staff took them on their own individual break.

People's interests were noted in their care records on their 'person centred value sheet' and staff knew everyone's interests well. People were supported and encouraged to maintain their specific interests. For example, one person enjoyed painting and went to an art class. The registered manager had also created a small studio space where they could paint and have space to enjoy this hobby. Another person enjoyed sewing and classical music and had access to both in their bedroom. Staff told us "Everyone's different here they have such different personalities and interests. That's how it should be".

There was positive involvement with the community. One person told us "I go out every day. I know loads of people!" We saw people coming and going throughout the day. One person had a routine of going to a local pub for lunch and a glass of wine once a week. They told us they enjoyed this very much and others could join them if they wanted. A group of people went out with a member of staff for a walk to the sea front and a cup of coffee. Others were heading off to visit friends. Staff said they encouraged people to get out and about as much as possible and have an active life. People regularly walked locally and went to nearby cafes and sometimes caught the train into Exeter.

People were supported to maintain and express their religious beliefs. One person who had recently moved to the home had a strong Christian faith. Staff had introduced them to the local church and they were now visiting regularly to worship as well as to join in with community activities such as fetes and coffee mornings.

People were supported to raise concerns. They told us they knew how to raise a complaint if they wanted to and would talk with the registered manager or their keyworker "I can always talk to my keyworker. She's great. And [registered manager's name] is nice and very open". The complaints policy was clearly displayed in the hallway. We looked at complaints records and saw one complaint had been raised where someone had requested a change of keyworker. This had been investigated thoroughly to understand and address the issues. A different keyworker had been introduced and the person was happy with the response.

Good

Is the service well-led?

Our findings

There was a strong person-centred culture at the service and this was underpinned by the passion and commitment of the registered manager. They recognised that many people living at the service had felt left out of society in the past due to mental ill health. They said "For me it's all about providing somewhere for people to live that really is their home. I want people to be as comfortable as possible and to lead as normal a life as possible. I don't want to restrict people's freedoms. I want to normalise people's environment as much as possible so that they feel part of society".

The registered manager was held in high regard by everyone we spoke with. This included people living in the service, relatives, health and social care professionals and staff. One person told us "It's a really good home. Well led. I wouldn't change anything about it". A visiting social worker told us "[Name] is great; when he contacts us, it is for the right reasons. He is very competent".
A member of staff said "he's always there if you need him and he really listens to staff". Another staff member told us the registered manager was sensitive to the needs of staff as well as people living at the service and this encouraged staff loyalty to the service. For example, one staff member was pregnant and told us her shift patterns had been shortened so that she could continue to work without becoming too tired.

The leadership style of the registered manager was positive and encouraging. They were open, calm and approachable throughout the inspection and gave people time to talk and listened to their responses. Staff received clear direction and advice to any concerns raised. For instance, at handover meetings the plans and focus for the day were discussed. We heard discussion about one person who was becoming low in mood. The registered manager took immediate steps to make the person's social worker aware and told staff to increase the amount of individual time they were spending with them. They said "I want to see everyone rally around and work as a team".

Staff told us they believed they worked well together and were an effective team. Teamwork was encouraged by the registered manager as part of maintaining a family-feel to the home: "I see us as a big team working together. People who live here are part of it. It's not them and us". The registered manager was involved in the day to day support of people in the home and staff said they would "muck in" in and help with anything. Staff felt supported by this. They also received regular supervision and appraisal where their personal development and any learning needs were discussed.

The registered manager told us they had a stable staff group and retained staff well. The stability of the staff group was seen as a key component in developing and maintaining relationships of trust between staff and people living at the service. This was an important aspect of people's mental wellbeing. When they did need to recruit, they did so carefully to employ people with the right skills and aptitudes who would work well with the existing team and person-centred culture of the home.

The registered manager was supported in their role by a deputy manager and senior carer. They had regular monthly meetings to discuss quality assurance at the service. All had a clear knowledge of their respective

roles and responsibilities. We observed a close working relationship and they told us they trusted in each other's skills.

There were systems in place to assess, monitor, and improve the quality and safety of care. A series of monthly audits were undertaken. These audits included looking at medicines, the environment and care plans. We saw that any issues identified were dealt with robustly. For example, we saw a medicines error identified where a medicine had been given twice. This had no detrimental effect on the person concerned. The incident had been investigated and understood in terms of staff member's tiredness at the end of their night shift when giving medicines. New arrangements had been made to ensure there were always two staff present when morning medicines were given. Staff had received additional training and support until they felt confident to return to the role. Staff told us they thought the systems for giving medicines were now really robust and people told us they always got their medicines when they wanted them.

People and their relatives or representatives were encouraged to give their views on the service either directly to the management and staff or through regular care plan review meetings. People completed quality surveys once a year and we saw that responses were analysed and changes made where necessary. The registered manager made sure they understood the root cause of any concerns raised and always kept people's welfare central. For instance, when someone had requested a change of keyworker, there was exploration of why this request had been made. The keyworker was changed as the person had requested.

The registered manager recognised the importance of close partnership working with key mental health professionals to support people's health and wellbeing. Mental health professionals responded quickly to requests for support from the service because they trusted that these would be made appropriately. The deputy manager told us they had also worked closely with district nurses in the past to support people to remain living at Pinehurst until the end of their life.

There had been few significant events that the registered manager needed to notify the Care Quality Commission of. One had been notified in line with their legal responsibilities, but the other had not been notified. This had no significant impact on people using the service. We discussed this with the registered manager, who noted an oversight and undertook to refresh their understanding of incidents they must notify. We discussed how the registered manager kept in touch with best practice and they told us they used to be involved in care managers forums for exchanging information and ideas, but had not attended for some time. We saw that the CQC guidance the registered manager was referring to was out of date. The registered manager took immediate steps to order up-to-date guidance.

We recommend that the service consider current guidance on their responsibilities regarding notifications to the Care Quality Commission and take action to update their practice accordingly.

Records were well maintained. They were accurate and regularly updated. All records we asked for were kept securely but were easily accessible.

People were supported to be involved in the local community. Staff encouraged and supported people to go out every day of the week. This ranged from attendance at clubs, to walking to the nearby seafront, visits to local cafes or the local church.