Woodland Healthcare Limited

Pine Tree Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Pine Tree Court is a residential care home providing personal and nursing care to 18 older people living with dementia at the time of this inspection. The service can support up to 40 people.

People's experience of using this service and what we found
People's needs had been assessed. However, people were at risk of not always being protected from harm or inappropriate care as their care plans did not always provide current or clear guidance for staff to follow on how to mitigate their risks. Care plans had not always been updated where people's needs had changed or when lessons had been learnt from incidents or accidents.

The service was not always following all aspects of the governments COVID-19 guidance. Management took immediate action to ensure they were following current guidance.

Safe recruitment practices had not always been followed and pre-employment checks had not always been undertaken to gather assurances about staff's previous employment and conduct.

People and their relatives felt the service was safe and that there were enough staff to meet people's needs.

Staff, people and relatives spoke positively about the management and the support they received. While monitoring systems were in place to manage the services, the service records did not always show how risks were being mitigated while action was being undertaken.

People's medicines were managed and administered well. Management and staff worked with people's representatives and healthcare professionals to ensure people's needs were reviewed and care was carried out in their best interest.

Care staff used personal protective equipment (PPE) and supported people to reduce the risk of infection.

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

Rating at last inspection
The last rating for this service was good (published 18 May 2019)

Why we inspected
This inspection was prompted by a review of the information we held about this service. This included information about staffing and fire safety processes in the service.
As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pine Tree Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We made a recommendation to support the provider's oversight of the quality monitoring systems.

We have identified breaches in relation to safe care and treatment and safe recruitment practices at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Pine Tree Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors 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.

Pine Tree court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Pine Tree Court is a care home providing nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The provider was looking to recruit a manager for Pine Tree Court.

Notice of inspection
This inspection was unannounced

What we did before the inspection
The provider had completed a Provider Information Return (PIR) prior to this inspection in December 2021. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with six people living at Pine Tree Court. We also spoke with five people's relatives and one person's friend. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and medication records. We looked at four staff personnel files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We spoke with two representatives of the provider, the clinical lead, a nurse, four care staff (one who also works in the kitchen) and a housekeeping staff.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating for this key question has change to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People's care plans had not always been updated to provide staff with clear and current guidance on how to meet people's needs. One person presented behaviours which may challenge staff. There was no clear positive behaviour support plan or guidance on how staff should support this person. Staff, were maintaining a record of incidents where the person may be anxious, which enabled them to identify any potential triggers, however, these records had not informed the person's care and support plans. This meant staff didn't have current guidance to meet people's needs.
- Staff worked with healthcare professionals to support this person and ensure the care was effective. This included ensuring that any prescribed medicines were appropriately administered. Healthcare professionals reviewed incident charts, however, hadn't provided a support plan to the service which could give staff clear guidance. This had not been followed up by the service. Management made immediate efforts to resolve this concern.
- Where people required support to protect them from the risk of skin damage an accurate record had not always been kept. One person had ulcers which required redressing every three to four days. There was not always a clear record of the support the person received. We discussed this concern with management and the clinical lead who informed us that healthcare professionals and agency staff also assisted with redressing these ulcers, however a consistent record of the care the person received had not been maintained. Which meant the management could not be assured the person had received their care as planned.

Preventing and controlling infection

- The service had not always followed government COVID-19 guidance. When people had been admitted to Pine Tree Court from the community, appropriate testing had not always been followed. We discussed this concern with the management who took immediate action to address this concern.

The provider and management team did not always assess and do all that was reasonably practicable to mitigate the risks to people who received care. This placed people at risk of harm. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was preventing visitors from catching and spreading infections. One relative told us, "Always so clean everywhere."
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the

premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The provider was following current government guidance in relation to visiting at the time of the inspection. People and their families spoke positively about their experience of visiting throughout the pandemic.

Staffing and recruitment
● There were not always effective systems to ensure new staff were comprehensively vetted to provide care to people. The required pre-employment checks had not always been undertaken. Reference checks from staff's previous social care employers were not always sought to gather assurances about staff conduct.
● Interview records were in place to support the manager's decisions to employ staff, but records did not always show that recruiting managers had explored the previous employment histories of staff and their suitability to work at the home. There were gaps in some employment histories.
● We discussed these concerns with the management, who advised us they would take action.

Safe recruitment practices had not always been followed. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough skilled and suitable staff deployed to meet people's needs. People and relatives told us, "Care staff are always about and always courteous" and "[Pine Tree Court] is safe because the staff are always around us."
● Staff told us there were enough staff to ensure people received effective person-centred care. Comments included "I think we have enough staff" and "I do feel we have enough staff. The staff numbers do change based on how many residents we support."
● The provider and management were trialling a staffing system as a result of recruitment difficulties, which included remote nursing support at nights. Care staff working at nights had been supported to complete advanced training, including recognising the deteriorating needs of people. Staff spoke positively about this system. Comments included "Nights are working well, we've been given training and support. I know if I need support it is there" and "I feel it is working well. There have been very few calls. The way we work we are aware of any potential issues before night shifts."
● The management were reviewing this trial, including how many times nursing support had been required during the night. While the trial was ongoing, management ensured that the needs of people being admitted to Pine Tree Court were manageable with these arrangements. The management and provider were also looking at new technology to further support and develop the trial.

Using medicines safely
● People received support with their medicines from suitably trained staff. Staffs' knowledge and their practice in this area was regularly checked to ensure people remained safe. One person told us, "I get medication morning and night. They give them and wait."
● Appropriate arrangements ensured people's medicines were available when they needed them. This included medicines that had been prescribed in between the service's monthly ordering cycle, such as antibiotics and end of life medicines.
● Reviews by the attending GP and healthcare professionals ensured people received the medicines they required, and which had been prescribed for them.

● Clear protocols were in place for people who were administered their medicines covertly. Some people were prescribed medicines which were administered when they were anxious. Staff had clear guidance on when to administer these medicines to ensure that any administration was appropriate and safe.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives told us they felt the home was safe. Comments included; "Oh yes, very safe"; "yes it is safe here, I get on with the carers" and "[Relative] is safe in the environment. Staff are very good, they are really hard working."

● The management team and senior staff were visible and regularly worked alongside staff and met people's visitors.

● Staff had read the provider's whistleblowing policy and procedures and felt able to report any concerns about poor practice or inappropriate staff behaviour. One member of staff told us, "I know I can speak with the management, and contact safeguarding if I need to."

Learning lessons when things go wrong

● The management team had effective systems in place to learn from any incident and accidents. The Operations Director discussed incidents with us that had occurred at Pine Tree Court. Lessons learnt and recommendations had been implemented to ensure the risk of these incidents reoccurring was reduced. This included clear communication and action for staff.

● The management and provider were taking action in relation to fire safety to ensure actions had been implemented following a local fire service visit. Clear guidance was provided to staff on how to assist people in the event of an emergency. While work was being undertaken the management had carried out risk assessments to ensure the risk of people was reduced.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- At the time of our inspection there was not a registered manager in post. Pine Tree Court requires a registered manager as part of the provider's registration with CQC. The provider and management were taking action to recruit a manager for the home and had implemented an interim management team. The team ensured leadership was provided to the staff team. We observed members of the management team engaging with the staff and providing clear direction. The management stated that the lack of manager had had an impact on following up actions identified from their audits, including reviewing and updating people's care plans.
- The provider and management operated systems to monitor the quality of the service. This included audits in relation to the management of medicines, incidents and accidents, the environment and care plans. Audits in relation to care plans had identified people's care plans required updating. However, there was not always a clear record of how the risk to people would be mitigated while improvements were being made. The management told us they would take immediate action to address our concerns and prioritise care plans based on risk.
- The provider and management had not identified the recruitment records concerns we found through their own monitoring. Additionally some areas guidance in relation to COVID-19 had not always been consistently followed, however the management took immediate action to ensure this was now followed.

We recommend that the provider reviews their oversight of the monitoring systems so that it would always support and contribute to effective learning and improvement of the service.

- The provider and management used systems to monitor the quality of a trial they were carrying out regarding nursing care within the home. This included monitoring the quality of care and continual assessment of risk. They had assessed risks and taken appropriate action to ensure the service ran safely whilst this trial was running.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The management worked directly with staff and people and led by example. One manager told us, "The staff are very good and we have a good team. Everyone is dedicated to Pine Tree Court." One relative told us, "From what I can see the home is in good working order, all seem to know what they are doing, all seems to

be fine. Management make it interesting there. It seems to be very well run."
● Staff and management were motivated to provide compassionate and individualised care to people living with dementia. We saw and heard many examples of people receiving care which was tailored to their needs.
● Staff told us they felt able to raise concerns with the management without fear of what might happen as a result.
● Staff felt respected, and valued by senior staff which a positive culture which helped to drive improvement across the service.
● People's relatives spoke positively about the home and the staff culture. Comments included: "would recommend [Pine Tree Court] as it is a small friendly place and because you have the same staff seeing the same people.''

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People's relatives spoke positively about the management. Comments included: "Perfectly alright, it works for me" and "to me it is all running very smoothly. If I ask to see somebody they are found within a few minutes."
● The management team understood their responsibilities to be open, honest and apologise if things went wrong. Records showed relatives were contacted appropriately to inform them of incidents or near misses affecting their family member. Where learning had been taken following incidents, this had been shared with people's relatives and their views sought. One relative told us, "They rang me up and told me they had seen the GP and they were calling the ambulance. They let me know so I could meet them in hospital. They recognised their symptoms and acted swiftly so they were able to treat it quickly."
● The management made sure CQC received notifications about important events so we could monitor that appropriate action had been taken.

Continuous learning and improving care; Working in partnership with others
● The service worked closely with external mental health professionals and we heard examples of how this joint working had enhanced people's care especially when supporting people's anxiety related behaviours. One healthcare professional told us, "I think they work very hard. They find good ways to engage people. They do manage some quite complex needs."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not always taken appropriate action to protect people from the harm associated with the care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe staff recruitment practices were not in place to reduce the risk of unsuitable staff from being employed.