Pilgrims Way Limited

Pilgrims Way Care Home with Nursing

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 took place on 15 November 2018 and was unannounced.

Pilgrims Way Care Home with Nursing is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Pilgrims Way Care Home with Nursing is registered to provide accommodation and personal or nursing care for up to 76 older people. Accommodation is provided in two buildings that are joined by a covered walkway. There are well maintained gardens and off-road parking. The service is wheelchair accessible with passenger lifts between floors. At the time of our inspection one of the two buildings was under refurbishment and only one building was occupied. There were 43 people living at the service when we inspected.

At our last inspection on 15 March 2016 we rated the service good. The Safe domain had been rated as 'Requires Improvement' as a recommendation had been made regarding the lifting slings people used. At this inspection on 15 November 2018 we found the evidence continued to support the rating of good, the recommendation had been acted on and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

There was a manager in post who had applied to the Care Quality Commission to become the registered manager, following our inspection the manager became the 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 received a service that promoted their safety whilst promoting their rights and choices. Potential risks had been mitigated. People were protected from the risk of infection with appropriate control measures. The environment and equipment had been maintained to promote people's safety.

People's care and nursing needs were assessed prior to them moving into the service. People received consistent care from trained nurses and care staff. People's specific health care needs were met with the support from health care professionals. Care records were comprehensive and reviewed on a regular basis.

People were supported to maintain their nutrition and hydration. The kitchen team ensured people had access to a variety of food choices. People that required additional support with their meals were catered for

and supported in a safe way.

Nurses and care staff had been trained to meet people's needs including their specialist needs. Staff received regular support and guidance from the management team.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People were treated with kindness and compassion. Staff understood the importance of promoting and respecting people's privacy and dignity. People were supported to maintain their independence.

People were given the opportunity to raise and concerns or make suggestions about the service they received.

Systems were in place to monitor and improve the quality of the service.

Further information is in the detailed findings below.

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's equipment had been serviced and maintained to promote their safety.

Potential risks posed to people had been mitigated.

There were enough nursing and care staff to meet people's needs. Staff were recruited safely.

People received their medicines safely as prescribed by their GP.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Pilgrims Way Care Home with Nursing

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.

This comprehensive inspection took place on 15 November 2018 and was unannounced. The inspection team consisted of one inspector, a nurse specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

Before our inspection we reviewed the information available to us about this home. The manager had completed a Provider Information Return (PIR). The PIR is a form that we ask providers to complete at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection report and notifications which had been submitted to us. A notification is information about important events which the provider is required to tell us about by law. We took this into account when we inspected the home and made the judgements in this report.

During the inspection we spoke to 16 people who lived in the service. We spoke with four relatives or friends of people living in the service. We spoke with five staff which included, the manager, two nurses and two care staff. We observed care that was provided in communal areas and looked at the care records for seven of the people who lived in the service. We looked at records that related to how the service was managed including staffing, training and quality assurance.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. People told us they would use their call bell if they needed to and when they had used it staff were prompt in responding. People's call bells were observed to be within their reach. Relative's told us they felt their loved one was safe with the staff comments included, "Because of the way they are with her. She would tell me if there was anything wrong" and "Being in here, I know she gets 24/7 care."

People continued to be protected from the potential risk of harm and abuse. Staff had been trained and understood how to safeguard people. Staff followed the provider's policy and procedure and knew what action to take if they had any suspicions. For example, contacting the local authority safeguarding team. Records showed the manager had raised safeguarding concerns with the local authority and been part of the safeguarding investigation.

Nurses and care staff had up to date information to meet people's needs and to reduce risks. The manager chaired a daily meeting between nurses and care staff to discuss the clinical risk register, potential risks and the action that had been taken. For example, following a review by the dietician one person had been prescribed dietary supplements. Risk assessments were individualised and any identified risk had been mitigated. For example, one person at risk of chocking had detailed guidance for staff to follow including, the position the person should be in to eat and drink safely, the size and consistency of their food and fluids.

Risks associated with the safety of the environment continued to be identified and managed to keep people safe. Each person had a personal emergency evacuation plan which showed staff the support the person would need in the event of an emergency. The provider continued to employee a maintenance person to monitor the safety of any equipment and the premises. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Any issues that were identified were acted on quickly. These checks enabled people to live in a safe and adequately maintained environment.

There were enough nursing and care staff to keep people safe and meet their needs. People told us they did not have to wait for support when they needed it. The manager used an assessment tool to monitor and review staffing levels. The manager reviewed staffing levels on a regular basis and records showed staffing levels had been altered based on changes in people's needs. The provider continued to follow safe recruitment practices to ensure that staff were suitable to work with people living in the service. Checks had been made against the Disclosure and Barring Service (DBS). This highlighted any issues there may be about staff having criminal convictions or if they were barred from working with people.

People received their medicines in a safe way, from nurses that had been trained and had their competency assessed. The provider's medication policy considered relevant legislation and national guidance, including guidance from the Royal Pharmaceutical Society. Medicines, including 'as required' medicines, were received, stored, administered and disposed of correctly. Medicines requiring storage in a fridge were stored in the clinical room, and the temperature of the fridge and clinical room were checked daily, to ensure that the medications were stored within temperature ranges recommended by the manufacturer. Medicines

requiring additional 'safe storage' had been stored and monitored appropriately. Nurses kept accurate records of what medicines were given, and records were audited by a member of the management team.

Systems were in place to prevent and control the risk of infection. Housekeeping staff were employed and followed a schedule of cleaning each day. The service was clean and smelt fresh during our inspection. All staff completed infection control training and followed the provider's policy and procedure. There were regular audits of the cleaning cupboards, laundry and sluice room. The manager also completed an in-depth infection control audit on a quarterly basis.

The management team took steps to learn and improve the service when things went wrong. Staff knew how to report accidents, incidents and near misses. The manager reviewed these reports to look for patterns or trends. Action was taken to reduce the likelihood of future incidents such as, requesting a review of the persons' medicines with their GP and purchasing a new piece of equipment to enable a person to move around their bedroom safely.

Good

Is the service effective?

Our findings

People spoke highly of the food they were given and the level of choice they received. Comments included, "The food is lovely. They are ever so good. If I don't like it I will tell 'em", "The food is very varied, you can have what you like. You can always ask for something different" and "There is a varied menu and there is a good cook here."

People continued to be provided with the support that they needed to maintain a balanced diet. People had an initial nutritional assessment completed when they moved into the service and their dietary needs and preferences were recorded. Nurses and care staff worked alongside external health care professionals such as, dieticians to ensure people's nutrition and hydration was maintained. The kitchen team were aware of people's specific dietary requirements such as a soft diet or diabetic diet. Some people required support from care staff to eat their meals, this was done in a dignified and calm way. Staff were observed to cut people's food into smaller pieces to enable them to eat independently.

Measures were in place to prevent the risk of dehydration. Fluid charts were used to document the person's fluid intake, and were observed in use by staff throughout the day. People who had been identified as requiring a target amount of fluid each day were discussed by the manager and senior staff at the daily meeting.

People's long-term health needs were monitored and supported. For example, one person was supported to manage their diabetes, their blood glucose level was checked twice a day, and their insulin was administered by nurses according to their prescription. The plan of care included information about the person's diabetes, and advised staff to observe the person for any symptoms of high or low blood glucose. All healthcare professional visits or interactions were clearly recorded within the person's care plan. Any changes to people's care needs were discussed within the daily meeting and updated promptly.

People's needs were assessed and their care was planned to ensure their needs were met. Care records had clear guidance for staff on how to support people with their needs in the way they wanted. Care plans and risk assessments described how to support people with their behaviour that challenges. Staff followed guidance informing them of proactive and reactive strategies to support people. Staff had received training regarding challenging behaviour. There was good use of nationally recognised assessment and management tools including for pressure wounds, pain management and wound care. These were kept under continuous review to ensure they met people's needs.

People's individual protected characteristics under the Equality Act 2010 were considered during needs assessments and within people's care plans. Each person was supported to complete a personal preferences questionnaire when they moved into the service. Staff respected people's rights and choices. For example, one person had made the decision not to follow advice from health care professionals. Staff respected this person's choice and supported them in the safest way possible whilst ensuring their rights. There were equality and diversity policies in place for staff to follow.

Staff had the skills, knowledge and experience to deliver effective care and support. Staff told us they had received an induction, on-going training, competency assessment, supervision and where required appraisals. There was a rolling programme of training to meet people's needs including their specialist needs. Nurses were supported to maintain their registration with the Nursing and Midwifery Council (NMC).

People's needs were being met by the design of the premises. Adaptations to the environment had been made to meet the needs of people living with dementia and with physical disabilities. There was dementia friendly signage being used throughout the building to help people who may be disoriented to place and time to find their way around more easily.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The service was working within the principles of the MCA and was supporting people as identified in their DoLS assessments. The manager tracked all DoLS applications, authorisations and whether any conditions to authorisations were in place.

Good

Is the service caring?

Our findings

People told us and our observations confirmed that staff supported people in a kind and caring way. Comments from people included, "The carers are lovely. They are very good", "I am waited on hand and foot", "The girls treat me well, I get on with most of them" and "They're very good. I've no complaints against them."

One persons' friend spoke highly of the staff. They said, "I think they're marvellous, very attentive. It's a lovely home. I have no faults with it at all."

People were given the time they needed with tasks such as eating to ensure they were not rushed. People were given emotional support when they needed it for example, we observed that one person who was unable to communicate verbally, was visibly distressed. A nurse entered the person's bedroom and offered them mouth care. This was accepted and the person was visibly calmer and appeared less anxious. We observed staff kneeling to speak with people to maintain eye contact, and staff holding hands with people to offer reassurance. One person that liked to keep their bedroom door open told us, "The carers come in and see if you're alright."

People's care plan's contained information about their preferences, likes, dislikes and interests. People and their families were encouraged to share information about their life history with staff to help staff get to know about peoples' backgrounds. People were encouraged and supported to remain as independent as they wanted to be. Care plans included details of what people could do for themselves and the support they required from staff. We observed staff supporting and encouraging people to eat their meals independently.

Systems were in place for people that were at risk of social isolation. Some people were cared for in their bed whereas other people had chosen to spend time in their bedroom. Staff completed hourly observational checks which were monitored at the daily meeting and audited by the manager. This ensured each person continued to receive social interaction and spent time with staff to ensure their needs were being met.

People's privacy and dignity needs were understood and respected. Staff were observed knocking on bedroom doors and waiting for a response before entering. People were asked if they had a gender preference for staff to deliver their personal care, this was respected by staff. Staff gave examples of how they maintained people's privacy and dignity whilst meeting their care needs. For example, closing doors and curtains, ensuring people were covered up as much as possible and ensuring they spoke with the person at all times.

People continued to be supported to maintain as much contact with their friends and family as they wanted. Relatives told us they felt welcomed when visiting and there were no restrictions on what times visitors could call. One relative said, "The staff are very nice. They are always welcoming and offer tea." We observed people having regular visitors throughout our inspection; spending time with their loved ones in the lounge and the privacy of their bedroom.

Good

Is the service responsive?

Our findings

People told us they were offered a range of activities to participate in however, if people had chosen not to participate this was respected by staff. Comments included, "I like being in my own company", "I can come up if I want to, there's my buzzer", "I read a lot. I have a magazine every week" and "I've been once or twice to the lounge, but I don't really enjoy it. I like to watch TV. I couldn't be without it."

The provider continued to employ an activity co-ordinator to organise and manage the activities within the service. People were supported to complete information about their activity likes and interests; the activities were then organised using this information. Activities that were available to people within the service included, arts and crafts, board games, nail care and music sessions. People could access a hairdresser that visited the service weekly. People's bedrooms contained items that interested them such as, televisions, radios and books. People were encouraged to participate in the afternoon activity of snakes and ladders.

People received a person-centred service that was responsive to their needs. People and their relatives were involved in the planning and delivery of the care and support they required. Care plans were individualised and gave guidance for the nurses and care staff to follow; enabling them to meet people's needs. For example, information to promote people's skin integrity including, monitoring checks, pressure relieving equipment and repositioning schedules. People who had specific dietary needs, such as enteral feeding via a tube, had detailed risk assessments and care plans to ensure their needs would be met. We observed that staff followed best practice by sitting people up to take their medication, to have a drink or something to eat. We saw that people were referred to Speech and Language Therapy (SALT) or to the dietitian where required, and the advice and recommendations made were incorporated into people's care plans.

People's care plans and risk assessments were reviewed on a regular basis to ensure the information was up to date and continued to inform staff how to meet their needs. Staff were knowledgeable about how people liked to be supported and used the information contained in people's care plan to meet their needs.

People's concerns and complaints had been listened to and used as a tool to improve the service. A complaints policy and procedure was in place and available to people and their relatives. Complaints were responded to and investigated. Records showed that the procedure had been followed and the complaints that had been raised had been raised and been responded to in line with the provider's policy and resolved. Information was accessible to people in line with the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.

People were supported with dignity at the end of their lives. Where people had been identified as requiring care and support at the end of their life, care was taken to ensure that the person's needs were regularly assessed and met. Care plans contained current pain levels and medication needs, as well as recommended action if pain levels increased, for example, to liaise with the person's doctor for anticipatory medicines. The advance care plan was in place, with input from the person and their family, and detailed their wishes regarding funeral arrangements.

Good

Is the service well-led?

Our findings

The manager had been in post since August 2018 and had applied to the Care Quality Commission (CQC) to become the registered manager. The manager had their registration interview following the inspection and was now the registered manager. People told us they knew who they manager was and saw them often. We observed the manager interacting and talking to people throughout our inspection.

The manager spoke passionately about providing people with a quality service and ensuring the care that was being delivered was up to date and followed best practice guidance. The manager was a nurse who kept their clinical knowledge and skills up to date by volunteering at a local hospice. The manager was supported by a deputy manager, a team of nurses and care staff. Staff understood the management structure and who they were accountable to. Staff said they understood their role and responsibilities and said this was also outlined in their job description and contract of employment.

Staff told us they felt there was an open culture where they were kept informed through regular meetings. The manager told us they were supported by the provider who was available at any time. The manager told us when they first started in their role they spent time observing staff practice and looking at the systems and records that were in place. They then developed an action plan which the team had worked through. The manager had developed working relationships with healthcare professionals for the benefit of people living in the service.

People and their relatives were involved in developing the service. Systems were in place to regularly monitor the quality of the service that people received. The manager held regular resident and relative meetings where service developments and improvements were discussed. An annual survey was sent out to people however, the manager had spent time with people on an individual basis to obtain their feedback about the service. The manager had introduced a comments box within the reception area for people and their relatives to leave anonymous feedback and suggestions. Following feedback from one person staff were reminded to offer people second helpings of meals. People and those acting on their behalf had their comments and complaints listened to and acted on.

Systems continued to be in place to monitor the quality of the service that was being provided to people. The management team completed a range of audits on a regular basis, including health and safety, medicines management, care records and an entire systems audit. These audits generated action plans which were monitored and completed by the management team and the provider's senior manager.

The manager had a clear understanding of their role and responsibility. They understood that they were required to submit information to the CQC when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that those seeking information about the service can be informed of our judgements. The provider had conspicuously displayed their rating both on their website and in the

registered office.