Pearlcare (Kendal) Limited

Gilling Reane 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**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 July and 1 August 2014 at which breaches of legal requirements were found. This was because there were not sufficient staff to assist people, people were not protected against the risk of infection and the processes used to assess the quality of the service were not effective.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

Following the comprehensive inspection we received a concern that people had not been protected against hazards to their safety.

We undertook a focused inspection on the 18 March 2015 to check if the provider had followed their plan and taken action in response to concerns we identified at our comprehensive inspection. At this focused inspection we also looked at how the provider had assessed and managed hazards to people's safety.

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

Gilling Reane Care Home provides accommodation for up to 33 people who require support with their personal care. The home mainly provides support for older people and people who have dementia. The home is a large, period property which has been converted to be used as a care home. Accommodation is arranged over two floors and there is a passenger lift to assist people to access the accommodation on the upper floor. The home has 29 single bedrooms and two double rooms, which two people can choose to share. There were 27 people living at the home at the time of our inspection.

There was a registered manager employed in the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our focused inspection on the 18 March 2015 we found that people had been placed at risk of harm because a hazard to their safety had not been identified and managed.

People we spoke with told us that they felt safe living in the home. They said that there were sufficient staff to provide the support they needed. People told us that they knew the registered manager and said the home was well managed.

We found that when people moved to the home risks to their safety had not been thoroughly assessed. Risks to people from hot drinks had not been managed safely and people had been placed at risk. There had been one significant incident which had resulted in a person being harmed.

We found that the registered person had not ensured that risks to people's safety were identified and managed. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on the 18 March 2015, we found that the provider had followed their plan which they had told us would be completed by the 1 February 2015.

We saw that there were sufficient staff to provide people with the support they required. People told us that they received the support they needed in a timely way because there were enough staff employed in the home.

We found that the home was clean. Although we noted an odour in one area we saw that this was attended to promptly. People who lived in the home and their visitors told us that the home was usually clean. They said the staff took action if areas required cleaning and told us the accommodation provided was comfortable.

The processes used to monitor the quality of the service had improved. The registered manager and senior care staff carried out a range of checks to ensure people were provided with the support they required. We saw that action had been taken to address all the areas that we identified as requiring improvement at our comprehensive inspection.

Although we found that people had been placed at risk because a hazard to their safety had not been identified and managed, we saw that the registered manager had taken action to rectify this. Risk assessments had been completed to protect people from the risk from hot meals and drinks. We found that the staff on duty were aware of how to protect people from harm.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

People were not protected from harm because hazards to their safety had not been identified and managed.

People were provided with a clean and hygienic environment to live in.

There were sufficient staff to provide people with the support they needed.

Is the service well-led?

Requires improvement

We found that action had been taken to improve how the service was led.

The processes used to monitor the quality of the service had improved.

The registered manager had taken action to improve how hazards to people's safety were managed.

We could not improve the rating for this key question from "Requires improvement" because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Gilling Reane Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Gilling Reane Care Home on 18 March 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 30 July 2014 and the 1 August had been made.

After our comprehensive inspection we received a concern that people were placed at risk because hazards to their safety had not been identified and managed. At this focused inspection we looked at how the provider had assessed and managed risks to people.

We inspected the service against two of the five questions that we ask about services: is the service safe and is the service well-led. This is because the service was previously not meeting legal requirements in relation to those questions.

The inspection was undertaken by one Adult Social Care inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements. We also spoke with the local authority safeguarding team.

At our inspection we spoke with 15 people who lived in the home, three visitors, the registered manager, four care staff and two ancillary staff. We observed care and support in communal areas, spoke with people in private and looked at the care records for eight people. We also looked at records that related to how the home was managed.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us that they felt safe living in this home. One person told us, "I always feel safe because there are always staff around". Another person said, "I'm sure we're safe here".

After our comprehensive inspection on 30 July and 1 August 2014, we received a concern that people were not protected because risks to their safety had not been identified and managed. Risks to people from hot drinks had not been managed safely and people had been placed at risk. There had been one significant incident in the home due to these risks not being managed.

We included this concern in our focused inspection. We looked at the care records for eight people who lived in the home. We saw that the risks to people from hot drinks and meals had been assessed in the week before we carried out our inspection. The assessments included the actions care staff needed to take to protect people against the risks identified.

All of the care staff that we spoke with knew how to protect people from the risks posed by hot drinks. They described in detail the actions they took to ensure people were protected. We also observed staff supporting people with their drinks and meals. We saw that the care staff ensured that people were safe.

However, the risk to people had not been identified and managed when people were first admitted to the home and people had not been protected from the risk of harm.

We found that the registered person had not ensured that risks to people's safety were identified and managed. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection of Gilling Reane Care Home on 30 July and 1 August 2014 we found that people who lived in the home were not safe because they were not protected against the risk of infection.

We found significant problems with the cleanliness and hygiene of the home. Areas of the home had not been cleaned to a hygienic standard, two areas had unpleasant odours and a hoist was dirty and poorly maintained making it difficult to clean to a hygienic standard.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the comprehensive inspection we also found that there were not enough staff to provide the support people needed and to ensure their safety. People who required support were left unattended and there were not sufficient staff to allow for a member of staff to check that people who were eating in their rooms were safe.

This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection on 18 March 2015 we found that the provider had followed the action plan they had written to meet the shortfalls in relation to the requirements of Regulations 12 and 22 described above.

People who lived at Gilling Reane Care Home and the visitors we spoke with told us they had no concerns about the cleanliness of the home. People told us they were happy that the home was clean and provided a hygienic environment for them to live in. One person told us, "It's lovely here and the staff work hard to keep it so. It's comfortable and a nice place to live".

We looked all around the home and found that it was clean and all the hoists we saw were clean and well maintained. We did note an unpleasant odour in one area of the home, but this area was cleaned promptly and the smell removed. One visitor told us that, on a previous visit to the home, they had noticed an odour in one area. They told us, "I mentioned it [the odour] to the staff and they arranged for someone to clean the area straight away. I'm here a couple of times a week and the home is usually lovely and clean".

We spoke with the two housekeeping staff who were working in the home during our inspection. They said that they had the time they needed to clean the home thoroughly. The housekeeping staff and care staff told us that all the staff shared the responsibility for ensuring people were provided with clean and pleasant accommodation. They all told us that when the housekeeping staff had finished their duties and left the building, care staff took responsibility for cleaning any areas which required attention. We also saw that this happened during the afternoon of our inspection.

Requires improvement

Is the service safe?

People who lived in the home and their visitors told us that there were enough staff employed to provide the support people needed. One person told us, “This home is terrific, there are always staff about, even if I need help at night the staff always come quickly”.

Two relatives who visited the home frequently told us there were always staff available when they visited the home. One person said, “You can always find staff if you want to speak to them, there is always someone about”. Another person said, “I’ve never had any concerns, there seems to be plenty of staff around”.

We observed the midday meal being served. We saw that care staff were deployed to support people in each of the three communal areas where people were eating. We observed that the staff were patient and provided people with the support they required at the time they needed it.

A staff member we spoke with told us, “Meal times are much better now, each member of staff knows what they are meant to be doing and we all have an area to work. We have time now to give people the support they need”.

We spoke in private with two people who had chosen to eat their meals in their rooms. They told us that the staff checked on them regularly to ensure they were safe and to assist them if they required. We also observed staff checking on people who were taking their meals in their rooms.

One person told us, “I like to eat in my room, it’s my choice”. They said the registered manager had advised them to use the call system in their room to summon staff if they needed support. People had been given guidance on how to maintain their safety and were checked by staff to ensure that they were safe.

Requires improvement

Is the service well-led?

Our findings

Everyone we spoke with told us that they were asked for their views about the service they received in this home. People told us that they knew who they could speak to if they had any concerns or wanted any changes to their care. One person told us, "[The registered manager] is lovely, she's always around if I need to speak to her, I'd tell [the registered manager] if I wasn't happy, I know she'd sort out any niggles I may have".

At our comprehensive inspection of Gilling Reane Care Home on 30 July and 1 August 2014 we found that the systems used to assess the quality of the service were not effective and people were placed at risk of receiving inappropriate or unsafe care and support. During that inspection we found that there were times when there were not enough staff to support people, people were not protected against the risk of infection and some people's needs had not been thoroughly and appropriately assessed. We also found that people did not always receive support in the way they needed it. The processes used to monitor the quality of the service had not identified these issues.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection on 18 March 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 10 described above.

The processes used to monitor the quality of the service had improved. The registered manager and senior care staff carried out a range of checks to ensure people were provided with the support they required. We saw that checks were regularly carried out on areas such as the cleanliness of the environment, care records and records of medicines administered to people. The systems used to assess the quality of the service had ensured that there were sufficient staff to assist people and that staff had accurate and up to date information about how to support people. Action had been taken to address all the areas that we identified as requiring improvement at our comprehensive inspection.

Although we found that people had been placed at risk because a hazard to their safety had not been identified, we saw that the registered manager had taken action to rectify this. Risk assessments had been completed and the staff we spoke with were aware of how to protect people from harm.

People we spoke with told us they thought the home was well managed. They told us that they were happy living at Gilling Reane Care Home. One person told us, "This is a lovely home, [the registered manager] makes sure everything is right, she has her eye on the ball". Another person said, "My family and I looked around lots of services before we chose this home, I liked the feel of the place as soon as I walked through the door and I'm very happy here".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People were placed at risk of harm because hazards to their safety had not been identified and managed in a timely way. Regulation 17 2 (b)