Care Quality Commission

Pilling Care Homes Limited

Pilling 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 effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 24 March 2015 with a follow up visit on 01 April 2015. The visit on 24 March 2015 was unannounced which meant the home did not know we were coming. The follow up visit was by arrangement in order that the manager could be present.

The last scheduled inspection of this home took place on 12 April 2013 when two areas of non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were highlighted. These were around regulation 15 (Safety & suitability of premises) and, 10 (Assessing and Monitoring the Quality of the Service). The provider was asked to submit an action plan telling us how they would address these concerns. A follow up inspection to check on these areas took place on 31 October 2013 when the home was found to have met the requirements of those regulations.

Pilling Care Home provides nursing and residential care for older people and people with dementia. Long term and short term care is provided. The home is close to the centre of the village of Pilling, which has a small number of cafes, churches, shops and pubs. Communal lounges are on the ground floor, with bedrooms on the ground and first floors. The home has a lift. There is a car park at the front of the home and gardens to the rear. At the time of our inspection there were 29 people living at the home.

Summary of findings

The home has a condition of its registration with the Care Quality Commission (CQC) that a registered manager is in place. 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.

There had not been a registered manager in place for some time. At the time of this inspection the current manager had only been in place a number of weeks. This person was in the process of making their application to the CQC.

We found that although people who displayed behaviour which challenge had a range of risk assessments on their care plan with instruction for staff. When incidents did occur there was no learning from these incidents and no measures put in place to prevent a reoccurrence and keep people safe.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We had serious concerns that the principles of the MCA were not being followed. There was a lack of staff training and knowledge about the MCA and some people who lived at the home due to their cognitive level of understanding were restricted and deprived of their liberty without lawful authority.

Care planning and the home's response to people's changing needs was not good and we found a number of areas where recommendations and treatment plans put in place by health professionals had not been followed up and care plans not updated. Subsequent reviews of care plans had not picked these discrepancies up. This put people at risk of receiving unsafe care and treatment.

The home was not dementia friendly in respect of the environment and there were several areas where the home was in a poor state of maintenance. Several items of furniture were broken and in need of replacement. There were no handrails for people to hold onto.

We found a number of audits and checks in place but many had been put in place by the current manager and as such were still in their infancy. Those which had been in place previously had not picked up on the concerns our inspection highlighted which was a cause for concern.

During our time in the home we came across a number concerns around infection control procedures and we have made a recommendation in respect of this.

People we were able to speak, with and their relatives, did tell us that they or their relative was safe at the home. Policies and procedures were in place and staff we spoke with had a good level of understanding on how to recognise and report incidents of abuse.

We found there were sufficient numbers of staff on duty to keep people safe. The home was fully staffed with no use of agency staff. Recruitment processes were robust to ensure as far as possible that only suitable staff were employed.

Mealtimes at the home were somewhat chaotic but people seemed to enjoy the food and some people were able to confirm this with us. We were concerned with the process in place to address concerns where people lost weight. There was a lack of evidence to show what the home had done to address people's weight loss.

Training levels of staff within the home varied. Some had been reliant on e-learning whilst others had completed NVQ qualifications. A training coordinator had been appointed by the manger to improve this. All the staff we spoke with felt supported and told us they received regular supervision and appraisal but this was not recorded with any consistency.

Staff were caring and passionate about caring for the people they supported. We saw staff were respectful and showed dignity and respect to people they cared for. We observed the staff treating people with kindness and compassion. One health and social care professional involved with the home told us: "Firstly I would say that the staff are all very caring and appear to be genuinely interested in getting the best from their residents".

We observed very few activities for people during our time at the home although there was an activities coordinator in post and relatives and staff were able to give us examples of some activities which had taken place.

Summary of findings

Relatives we spoke with were happy that when they had made any complaints they had been dealt with to their satisfaction and the home had policies, procedures and systems in place to handle complaints.

There had been some upheaval at the home in respect of the manager's position as well as the administration of the home. The manager informed us that the home was now in a more stable position in respect of these areas.

The current manager was open and honest with us about the issues within the home. She had been aware of most of the concerns we found and had started to take steps to address them. We found she had the full support of the staff and in between our visits to the home had been in contact with the owner, this despite him recovering from an operation, to get his support to make the changes required.

A major problem with the home was its lack of connectivity in respect of telephone, fax and internet connections. This had a detrimental effect on the home and its ability to submit required documents to the local authority and the Care Quality Commission (CQC). We have made a recommendation in respect of this.

During this inspection we found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010. These also amounted to breaches of the new Health and Social care Act 2008 (Regulated Activities) Regulation 2014 which took effect as of 01 April 2015.

You can see what action we have asked the provider to take at the end of this report.

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.

Systems to manage the risk from people who displayed behaviour which challenged were not effective to keep people safe.

People who lived at the home and their relatives told us that they or their relative was safe. Staff had received training in recognising signs and symptoms of abuse and how to report those concerns. There were sufficient numbers of staff on duty.

People received their medication in a safe manner but we found concerns over the infection control measures in place.

Is the service effective?

Requires Improvement

The service was not effective.

There was a lack of staff training and knowledge about the MCA and DoLS. We found some people who lived at the home who lacked capacity were restricted and deprived of their liberty without lawful authority.

Staff had received a variety of training and felt supported but the supervision and appraisal records were not well recorded.

The home was not effective in addressing concerns where people lost weight. There was a lack of evidence to show what the home had done to address people's weight loss.

The home was not dementia friendly in respect of the environment and there were several areas where the home was in a poor state of maintenance.

Is the service caring?

Good

The service was caring.

People we spoke with and their relative's told us staff were caring and looked after them well.

We saw staff were respectful and treated people with dignity and respect. We observed staff were caring and passionate about caring for the people they supported

Visiting health and social care professionals confirmed that staff were caring.

Is the service responsive?

Inadequate

The service was not responsive.

Care planning at the home was inadequate. Care plans did not reflect people's changing needs and the review process had not picked up on these omissions.

Summary of findings

There was an activities coordinator in post, staff and people we spoke with described some activities which had taken place but we saw none during our time in the home.

People we spoke with were confident that any complaints would be handled and dealt with in an appropriate manner.

Is the service well-led?

Requires Improvement

The service was not well-led.

However there were signs of improvement. There had been problems with the manager's position but the new manager had the full support of the staff, was open and honest about the problems at the home and had started to take steps to address these concerns.

Audits and systems in place were ineffective and had not picked up on any of the concerns we found during this inspection. Regular meetings were held with relatives, people and staff but these were not well recorded.

Connectivity in respect of telephone, fax and internet connections for the home were problematic and affected the day to day running of the home.

Pilling 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 March 2015 with a follow up visit on 01 April 2015. The visit on 24 March 2015 was unannounced which meant the home did not know we were coming. The follow up visit was by arrangement in order that the manager could be present.

The inspection team consisted of two adult social care inspectors. A specialist advisor in nursing care 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. This particular expert also had previous experience in district nursing.

Before the inspection we looked at information and intelligence held on our own systems. This included notifications sent to us by the provider and any whistleblowing or safeguarding information provided to us. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During this inspection we spoke with 12 people who lived at the home and two relatives. Due to the lack of relatives present at the time of our inspection we made contact with seven people by telephone to gather their thoughts on the care of their relative at Pilling Care Home. We spoke with twelve care staff, the manager and senior care staff. We also spoke with commissioners from local authorities who commissioned services from the home and health and social care professionals who visited the home to seek their views. We have included some of their comments in this report.

We observed care provided throughout our inspection. 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 looked at a sample of six care plans during the inspection and medicine administration records. We used a system of pathway tracking. Pathway tracking looks at the support people receive at each stage of their care.

Requires Improvement

Is the service safe?

Our findings

We looked at incident and reporting systems in the home. Where people who lived there displayed behaviour which challenged we saw a range of risk assessments in place with instructions for staff on how to manage and deal with such behaviour.

The home had several systems in place for recording incidents and in particular those incidents which had resulted in some form of injury to residents such as falls or altercations of a physical nature between people who lived at the home. We also saw a number of incidents recorded where staff had also been assaulted by people who lived at the home. As one example we saw a recorded incident where a person had received some bruising during an incident which had been reported and dealt with well at the time. We found no evidence of lessons learned or measures put in place to prevent this from happening in the future.

We also looked at a number of incidents where staff had been subjected to assaults. We saw seven recorded incidents of assault on staff by one person alone. Whilst these incidents had been well documented in accident and incident reports, again we found no evidence to say what had happened next to address the issue or prevent reoccurrence. There was no referral to external professionals to address these issues and support staff. Staff we spoke with seemed to accept that this was the norm and just part of their role.

This lack of oversight and learning from incidents amounted to a breach of regulation 10(1) (b) and (2)(c)(i) of the Health and Social care Act 2008 (regulated Activities) regulations 2010. This also corresponds to a breach of regulation 17 of the Health and Social care Act 2008 (regulated Activities) regulations 2014.

Not all of the people we spoke with who lived at the home were able to speak with us in any detail about their experience. However one person did say to us: “The people around me make me feel safe”.

Relatives we spoke with told us: “Yes, they have her welfare at the front”. “Overall yes, but he has had incidents where he has fallen”. “Generally yes, I think the staff are very good, but there have been a few incidents with other residents some of which shouldn’t have happened, i.e. a resident went into her bedroom and took the bed clothes off her, this has happened a few times”. And: “I would say so overall, I couldn’t say anything makes me feel uneasy”.

Some of the relatives we spoke with had concerns over property going missing and in some cases the relatives told me they didn’t know how spending money was being used. Three relatives told us a particular member of staff had rung saying the resident needed more money. Some relatives got receipts for spending money and some didn’t. We did speak with the manager about this and were told that there had been some issues with the last administrator who had been asked to leave. One relative did say to us that since the new administrator had taken over financial statements had improved.

We saw safeguarding policies and procedures were in place to protect people. Staff we spoke with had received training in the safeguarding of adults at risk and all of those we spoke with could clearly explain how they would recognise and report abuse. Staff confirmed what training they had completed, which we saw was confirmed with the training records we viewed. One member of staff we spoke with was able to tell us about an incident they had reported which had been dealt with appropriately.

We found there was a mixed response from relatives we spoke with about staffing levels at the home. We were told: “I think so”. “There’s enough when we go unannounced”. And: “There’s always staff around”. However some relatives told us: “Sometimes when I go in the evenings they have to bring all the residents into one lounge, this has happened 3 or 4 times in the last month”. “Some days there’s not many staff, some are brilliant, but some just sit watching TV all day”. Two other relatives thought there were enough staff but didn’t comment further.

On the first day of our inspection which was unannounced we were informed by the manager that there were always six care staff on duty all day working an 8am to 8pm shift pattern. There was always a qualified nurse on duty and during the day the manager and clinical lead were also present. After 8pm there would be four care staff until 10pm and then three care staff during the night-time period. Two care staff then came on duty at 7am in the morning to assist with people getting out of bed and breakfast. The staffing levels during the daytime were confirmed by our own observations on the day. Care staff were supported by domestic staff who were employed to

Requires Improvement

Is the service safe?

undertake cleaning and laundry duties which kept the care staff free to look after the needs of people who lived at the home. The manager confirmed that the home was fully staffed and there was no use of agency staff.

We observed a handover during a change of shift for staff. Safe handovers were carried out with good information to ensure staff coming on duty were able to understand current requirements of people who lived at the home in order to keep them safe.

We saw that robust recruitment and selection procedures were in place to ensure as far as possible that any staff employed were safe to work with vulnerable people. Staff we spoke with told us they had completed an application form, been interviewed and had been asked to provide proof of identification and references. We were also told that no one was allowed to start work until such time as checks had been completed with the Disclosure and Barring Service (DBS). The DBS provides a criminal record and background check on people who are trying to gain employment in certain designated employment fields. Staff records we looked at confirmed that such recruitment checks had taken place and references had been checked and followed up.

We looked at the policies and procedures for medication which were in place. They also covered such medicines as homely remedies. The staff we spoke with told us they had received training in medication and training records we looked at confirmed this.

People who were able to speak with us told us they received their medicines on time. We found appropriate arrangements for the recording, safe administration and storage of medicines. This included controlled drugs kept by the service. Controlled drugs are those which are controlled by law under the Misuse of Drugs legislation. Records we checked were complete and accurate. These included audits and checks on medication stocks. Medicines could be accounted for because their receipt, administration and disposal were recorded accurately. We did note that there had been one incident which had involved a controlled drug. A controlled drug patch had been refused by a person who lived at the home. The relevant patch had been disposed of in an incorrect manner and the staff member responsible had not reported this to the manager. However the error had been picked up by another member of the trained staff and the incident had been dealt with in an appropriate manner.

We found infection control measures in the home were not good. Clinical waste bins were broken, yellow bags (those which contain clinical waste) were in plastic bins without lids. We found bed quilts drying in a bathroom and personal toiletries left out. Tubs of 'sudocrem' prescribed for one resident were left out and one member of staff admitted to us that there was a risk that it could be used by other people who lived there. We looked at the training records for staff and saw that whilst all staff had received training in infection control many staff had not received a refresher on this subject since 2013. A visiting health care professional told us staff and visitors did not have access to adequate hand washing facilities or easy access to protective equipment.

We would recommend that the provider contacts the Clinical Commissioning Group or Local Authority Commissioners to arrange for a full infection control audit, to address these concerns.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We spoke with the manager on the first day of our inspection and were informed that of the 29 people who lived at the home only one person had full capacity to make decisions around their care and treatment. This person was due to transfer to another home soon. We were therefore concerned to find that staff had not received any face to face training in the MCA or DoLS. Some staff we spoke with had completed some e-learning. However those staff we spoke with including senior staff had little knowledge around the main principles of the act or the relevant codes of practice.

The six care plans we looked at during this inspection contained no evidence of capacity tests in line with the act or code of practice. We saw no evidence that valid consent had been obtained for a number of actions such as the taking of photographs. As another example a number of people had received flu jabs. Many decisions and entries on peoples care plans which gave instructions to staff were based totally on comments from relatives. For example one read '[named's] wife has stated that if [named] shows [certain signs and symptoms] NOT to send to hospital as she feels this may be too traumatic for [named]'. We were unable to see any valid consent , capacity test of best interest decision around this instruction. Whilst relatives should always be consulted, where people lack the capacity to make decisions for themselves the MCA and codes of practice must be adhered to.

Relatives we spoke with told us: "I haven't been involved here, she had bed rails, we talked about it. They've moved her downstairs now for her own safety." When asked about DoLS this relative replied: "I don't know if they applied 12 months ago". However other relative's told us: "I'm generally fully involved." And: "Sometimes she gets anxious and they asked my permission to apply cream to her skin".

The lack of valid consent being obtained for people amounted to a breach of regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010. This also amounted to a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a number of people who lived at the home were subjected to unauthorised restrictions which may amount to a deprivation of their liberty. Of the 29 people who lived at the home we were told only one person had the capacity to make decisions around their care and treatment. The home had locks on all exits and many internal doors had 'Chubb type' star locks on them which prevented free access around the home for people who lived there.

We were also informed that 25 people who lived at the home had bedrails attached to their beds. Of those 25 people at least ten had these rails in use. We looked at the care plans for a number of these people and saw that risk assessments were in place. Bedrails amount to a restriction and we saw no evidence of valid consent in place. There was some evidence that a small number of relatives had been spoken to but we saw no evidence of capacity tests and best interest decisions around the use of bed rails.

We asked the manager how many people who lived at the home were the subject of DoLS authorisations. The manager explained that no one was. We were told that some time ago six people were deemed to have needed DoLS authorisations. The manager in place at the time had printed off the relevant forms and completed them. The home has problems accessing the internet and email communications. As such these forms had been passed to the administrator at the time to post the applications to the local authority. There had been no follow up to ensure they had been received. There were no copies retained at the home. The manager at the time and the administrator had since left the home and there was no evidence to show this process had ever been completed.

The unauthorised restrictions on people who lived at Pilling Care Home amounted to a breach of Regulation11 of

Is the service effective?

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This also amounted to a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at nutrition for people who lived at the home. We looked at a sample of care plans for people with special dietary needs and how their weight and health had been monitored. We saw people were weighed on a regular basis and weight charts were in place. However where the charts indicated concerns over a person's weight we saw that appropriate action had been not been taken. As an example we saw one person's weight chart indicated that there had been a substantial loss in weight. The weight on admission had been 61kgs. The weight chart indicated 55.3kg in March 2015. This was a loss in weight of 5.7kgs over an eight month period. The risk assessments in place for this person stated 'needs monitoring'. However the risk assessments had failed to capture this weight loss and there was no evidence of onward referral to GP, dietician or other professional to deal with this.

We saw another such pattern with another person. There had in this case eventually been some consultation with professionals which had resulted in a hospital admission. Since discharge the persons weight had stabilised. This hospital admission could have been prevented with appropriate systems in place to pick up on such issues in a timely manner. We also observed the same poor quality of recording around fluid intake for both of these people.

These shortfalls in monitoring and recording of weight and fluid intake amounted to a breach of Regulation14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This also amounted to a breach of regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We observed the meal time sessions at the home. Meal times appeared somewhat chaotic but people seemed to enjoy the food. The one thing that people were able to consistently tell us was that they enjoyed the food with the exception of one person who said they did not but did not expand on this comment.

We asked the relatives if they thought the staff were trained to deal with resident's needs. We were told: "Yes, definitely". "Yes, there have been drastic changes, with quite a changeover of staff. [named] gave me what I've been asking for, for months". "I think on the whole they are". And: "In some cases yes, sometimes they are surprised by the residents' behaviour".

Staff we spoke with confirmed they had received a mix of training some face to face with a lot of e-learning. One member of staff said: "I had moving and handling training three years, ago. First aid and food safety more than three years ago. Fire safety within the last six months, control of infection two years ago on line, and end of life care within the last six months". Other staff we spoke with were able to tell us that they had completed NVQ level 2 training. All staff we spoke with told us they had received a full induction when they started work at Pilling care Home which they felt had given them sufficient knowledge to care for the people who lived there. We did note, and staff confirmed with us, that over a period of time the home had been viewed by commissioners as a specialist placement for people with behaviour which was challenging. However we found staff had not received training in this area. We were informed by the manager that one member of staff had been given the role of training coordinator. This person was able to tell us what they had planned and how they were making inroads to improve the level of relevant training for staff.

All of the staff we spoke with were able to tell us that they had received regular supervision and appraisal. However we found recording of this was poor. Staff were able to confirm they had regular contact with the manager and senior staff. One senior member of staff said:" I have a meeting with [Manager] every month". Other care staff we spoke with told us: "I feel quite well supported". Whilst another said: "I have daily contact and discussion times with the manager, if I have any nursing issues I go to [named]" This member of staff said they felt supported in their job.

We spoke with the manager about this who was aware that the recording of supervisions and appraisals required improvement. We were told her door was always open and staff could speak with her at any time. Staff we spoke with confirmed this and many told us that since this manager had taken over things in the home had improved greatly. One said: "It used to be very regimented. It's better now".

The home supported people to receive on going healthcare. They had a good working relationship with a local Hospice. People did tell us that there were regular visits from GP's. One relative told us: "I've been to meetings

Requires Improvement

Is the service effective?

with a mental health guy and a social worker in October". Comments from one visiting professional person were: "We visit fortnightly to review and support their patients". "There have long been issues and we have been aware of the CQC inspections and reports". Another told us: "The understanding of medication and requests for visits, along with the use of the GP rather than Mental Health team for dementia needs could be improved".

The home had 29 people who lived there at the time of our inspection. We were told by the manager that 28 of those people were living with some form of dementia. We saw the two lounges had been recently redecorated, however the décor in the rest of the home was not dementia friendly and rather tired looking. There was little in the way of signage and we only saw two bedrooms with resident's names on them and these had been partially erased. Many of the corridors were dark and there were no handrails. This could result in a risk of falls to people who lived there. Locks on doors consisted of three key pad electronic locks with the remainder of the doors which required securing from time to time being locked by means of 'Chubb type' Star locks. This meant staff had to keep one of these keys on their person at all times. There were a number of occasions during our inspection when staff had to break of from duties to allow us access to some areas. Many of these were worn and made access to some room difficult.

The furniture we saw in the two of the bedrooms we visited were in need of repair and there were paper towels but no bins to put the used towels in. In another bedroom there was a clock opposite the bed but it wasn't working. There was an odour in the entrance hall, that one relative commented on though she couldn't identify it. They said: "We have smelt similar when near people who do not wash frequently". Health and social care professionals told us: "The home appears dirty and smells". "The cleanliness of the premises and often malodourous entrance are issues". Other issues we found whilst walking around the home were dirty soap dishes on walls. Windows which opened but only for a short distance. We found two hand gel dispensers did not work. Some carpets were worn and in need of replacement.

The home did have a full time maintenance person. We spoke with this person who had a full list of jobs and repairs to complete. The records kept by this person were of a very good standard. However one person dealing with repairs and general maintenance would have no effect on the overall appearance of the home.

We judged that the lack of dementia friendly décor and fitments along with the overall poor condition of the home amounted to a breach of Regulation15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This also amounted to a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

During this inspection we observed good interaction between the care staff and people who lived at the home. Staff were caring and those we spoke with were passionate about caring for the people they supported. We saw staff were respectful and showed dignity and respect. They were patient with people.

Relatives we spoke with when asked if they though the staff were kind and caring told us: “Definitely, she always looks well cared for”. “We’ve never seen any staff mistreating or shouting at them, they’re always pleasant and helpful”. “On the whole, she only complains about one person being abrupt, but I’ve not experienced that, they generally do more than they should”. “Yes with the resources available”. “They’re very approachable”. And: “They’re very friendly and open; they give us a fair assessment of what we are asking for”. However one person did tell us: “Most of them, I don’t trust the manager or the owner, they tell you what you want to hear, then shut the door and forget about it”. This person failed to expand on this statement.

We observed the staff treating people with kindness and compassion, they spoke to them calmly and if one resident was bothering another they took them away from the person who had complained. The staff were very patient when repeatedly explaining to one person why they could not do something. The majority of staff supervising people in the lounge were interacting with them.

Comments from our own team were: “The staff were lovely towards the residents, very patient with them and spoke to them kindly”. “The staff were very pleasant and helpful to me throughout the day; there was always someone around to let me through locked safety gates”.

Health and social care professionals involved with the home told us: “Firstly I would say that the staff are all very caring and appear to be genuinely interested in getting the best from their residents”. And: “I have seen first-hand, for example, staff spending lots of time helping residents eat their meals”.

We asked relatives if they felt their relative was treated with dignity and respect. We were told by one person: “When she needs changing they’re very discreet and put her mind at rest”. All of the other relatives just replied “Yes,” with the exception of one person who said: “He looks after himself”. We followed this up and found this last person shared a room so we asked about privacy within the room; however we were told the two men just use their room as a base to sleep and privacy isn’t an issue.

Staff we spoke with told us: “I like getting to know them [people they cared for]”. “We have a key worker system, all care plans are reviewed monthly”. We asked the staff member how they knew how people prefer to be looked after, and we were told: “If they are able to understand we discuss it informally, but we have a good rapport with the relatives”. And: “We try to get them to do as much as they can for themselves and we assess daily”.

Two members of staff we spoke with told us they had received training in equality and diversity although this had been on line and some time ago.

Inadequate

Is the service responsive?

Our findings

People who lived at Pilling Care Home were unable to verbalise their care planning experience with us.

We therefore spoke with relatives to see if they had been in involved in review process for their relatives at the home. Some told us: "No not since she came in but I ask questions". "I can't say I know, a review hasn't been mentioned". And: "I've had one in two years". However others told us "We've just had a review, the home engages with the providers and we're kept informed". And "Yes," but didn't explain further.

The other relatives' we spoke with just said yes, or is wasn't applicable as the residents had only been there a short time. We did note however that two people who lived at the home had independent advocates who had been involved in discussions around their client's care.

The manager informed us that care planning was done by the manager and the clinical lead for the home. The deputy manager would assess people at home or in hospital prior to admission to the home. We were told that care plans were in the process of being upgraded so that they all followed a new model of care. As an example a detailed paper had been produced by the clinical lead, who was relatively new in post which clearly stated who is responsible for specific people who lived at the home and identified 'key workers' for people. At the time of our inspection care files consisted of a mix of the old and new systems.

We looked at the care planning for six people who lived at the home. We found pre admission assessments were basic, and the recording due to the mix of old and new was confusing. Several documents on care files had not been completed. As an example one person had a form entitled 'This is my life' at the beginning of the care file but it had not been completed. There were also marked discrepancies in care files. Care plans did not always reflect the detail written in updated paperwork. For example one person's care plan review had an entry dated 23 March 2015 (written 23.3.15) which stated 'change to care plan 4'. We saw no evidence of this on the care plan form.

On the same persons care plan we saw entries stating dates for blood sugar monitoring. The date 02/12/14 was written on one form whilst the date 23/3/15 was written on a white sheet of paper at the front t of the file. There was nothing to show how often this blood sugar reading was taken, why and the results. This person also had a form entitled 'GP form' We saw an entry dated 06/01/15 with the instructions 'Blood monitoring to be done once a week'. The record stated 'resident remains at risk'. There was nothing to say what the specific risk was.

One resident had recently been discharged back to the home from hospital and yet this person's care plan had not been updated to reflect her changing needs. On another person's care file we saw a letter from the person's GP about use of covert medication due to difficulty in swallowing. However a care plan review had taken place after the GP had written a letter and yet there was no mention of this in the care plan update.

We did not see on any of the care files we looked at a 'Hospital Passport'. Sometimes known as 'Traffic Light' documents they highlight in Red, Amber and Green sections, the must have, should have and can have requirements to give hospital staff a clear overview of a person needs and requirements if and when they are taken into hospital.

Health and Social care professionals we spoke with about the home told us: "There is a lack of organisation when I visit (which I do on a two-weekly basis) with notes scrawled in a book which staff (and myself) sometimes struggle to decipher and staff seemingly unaware of the history of presenting problems. We recently had to spend several weeks chasing them for their flu vaccine record as nobody seemed to know where it had gone. Other records sometimes appear disorganised such as patient weight records and blood pressure recordings".

We found that the gaps and poor recording in care plans put people at risk of receiving unsafe care and treatment as the service did not respond to people's changing needs. This is a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) regulations 2010. This also amounted to a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014.

We did witness a staff handover during our inspection. We found that this was good and gave staff coming on duty a very good overview of what had happened, clear details about people's care and issues which needed addressing.

Inadequate

Is the service responsive?

Other comments from health and Social care professionals we received were: “We have looked at supporting and advising them with regards end of life, wound care and some aspects of dementia care”.

We spoke to relatives about activities within the home. Activities are an important part of people’s care as they keep people active and can prevent social isolation. Comments were mixed from the relatives we spoke who said: “It’s very difficult because she doesn’t see very well. I’ve seen them catching a ball. They do her nails and they sit talking to her”. “They have musical afternoons which we enjoyed as much as [named relative]”. “I honestly don’t know apart from watching TV. They have singsongs for birthday parties and Christmas. They didn’t ask about hobbies when she came in”. “That’s one area that might concern me, there's a lack of stimulation. I’m not sure how many activities they put on, I’ve been to the Christmas party, but I don’t know on a day to day event, It depends on resources. Staff take him out for a walk and I appreciate the difficulties”. “They play music and do her nails, that was really nice”. “She does nothing, occasionally they have sing songs.” And: “They do activities with him, he’d rather be outside than indoors, but he does play dominoes”.

Staff we spoke with about activities told us: “We have an activities coordinator, they do bingo, dominoes and they’ve made some Easter bonnets. They make cakes and do painting; we take them to tea parties”. We asked a staff member how they would reduce the risk of social isolation, they replied: “Gain their confidence and trust. Spending time talking to them and finding out what they want from us”.

We observed very few activities for people during our time at the home. We observed staff painting nails and one member of staff sat with a person encouraging them to draw. A health and social care professional told us: “Lack of tactile input for the residents. Need to increase activities for the residents”.

There was an activities coordinator in post and we saw her engaging with several residents throughout the day. It was always on a one to one basis. We were told by one of the care staff that he has provided a large selection of different types of music to suit all tastes. Music was playing in one of the lounges whilst we were in there and many of the residents looked as though they were enjoying it, tapping their feet.

The home had policies and procedure in place to deal with any complaints.

We asked relatives if they had ever raised a complaint or concerns about their relatives. Some had never raised a complaint. Those people who had said: “My main complaint was about missing the meeting, they apologised, they weren’t defensive”. “When she was sharing the first room, it smelt strongly of urine but they addressed that”. And: “I’ve raised several and they’ve never been dealt with to my satisfaction".

We asked a staff member how they would deal with a complaint, they said: “Bring them into the office and listen. I would make sure the manager is aware and try to put things right”. We asked if they were aware of the complaints policy, they replied: “There is one but I’ve not had to refer to it”.

Requires Improvement

Is the service well-led?

Our findings

On our arrival at Pilling care Home we explained the inspection process to the manager and we requested a range of documents and records to be available. These were provided promptly and without hesitation. The manager was completely open and honest with us and was aware of the failings in the home.

The manager in post at the time of our inspection took over in December 2014. The previous manager had left in December 2014 following a period of sick leave. The current manager and the owner had thought the previous manager had applied to the CQC to become the registered manager for the home however her application was found in her drawer after she left.

The current manager had originally been a care assistant at the home but had left to take up a post with the local authority. She had returned to help out with care planning and due to the upheaval at the home was now in the position of manager. She had an NVQ level two and three qualification in care and was half way through completing level five. She told us she was working with the clinical lead and nurses to improve the care planning and systems in the home and it was her intention to apply to be the registered manager with the CQC.

We found the manager to have the complete support of the staff. Staff told us they felt listened to and supported. There was an open culture within the home and every member of staff we spoke with told us they thought there was now a big improvement and that they felt comfortable in approaching and discussing any concerns with the manager. One member of staff did say – they felt listened to but [named] has a battle to get money from the owner. We discussed this with the manager on our second day at the home. Although the owner was in hospital at the time recovering from a serious operation we were informed that following the issues discovered on our first day she had already had discussion and had been told to do whatever was necessary to get things right.

One health professional who visited the home did tell us: "Fortunately things have turned a corner and they appear to be improving. There is some way to go but hopefully they can improve".

We were also told that a meeting had already been held between the manager and the nursing staff to discuss and address the concerns we had found. We were shown the minutes of the meeting. This showed that the concerns had been taken seriously and the manager was doing everything to try and turn the home around.

We asked relatives for their views on the home and on the management of the home. We were told: "The managements just changed, I've very rarely seen this one, I can't say she's conspicuous, but it's managed very well". "Very good, I've met the proprietor as well." "It's alright, I've not had much dealings with them, they're very helpful".

However others said: "We've only met [named] a couple of times. The phone wasn't being answered there was a message saying ring back later. This manager's not there as often as the previous one". "That's a very good question; I don't know who the manager is". And: "That's difficult, they're not an upfront management team, it doesn't come across as an in house management team their presence is vague".

We saw that people's feedback was welcome. There was a residents'/relatives meeting scheduled and we saw an advert for this in the foyer of the home. We were informed that they took place every quarter. The manager was unable to produce minutes but was aware that this was a practice which needed to start. We asked the relatives if they were kept informed about management arrangements and were told: "Yes, they keep me informed, but I don't know the new managers name". "We've only been told that [named] was there". "Other relatives either said: "No". Or: "I'm not sure".

Regular staff meetings took place. The manager was unable to show us any minutes for these but staff did confirm with us that they took place. Staff told us that they were able to provide honest feedback and felt that it would be acted upon. Staff told us: "We meet with the manager daily and she's always on the end of a phone". "They [management] are open to suggestions, I don't expect every suggestion to be taken up but they do what they can within the budget".

We asked staff members what arrangements were in place for leadership when the manager wasn't there, one replied: "The deputy manager is in charge".

We looked at checks and auditing systems used by the home to monitor the quality of the service provision. The manager was more than aware that much of this had not happened in the past and was determined to get these

Requires Improvement

Is the service well-led?

processes back and running smoothly. We saw annual checks were done on such items as lights, TV, commodes, windows, wardrobes radiators and sinks. Smoke detectors were checked regularly. Monthly checks were also completed on lights equipment and water temperature.

We saw there were weekly checks on bedrails, shower heads (to show they had been disinfected) and other equipment. We saw records that checks had been made for 'Legionnaires disease' and PAT (Portable Electrical Equipment) testing had been completed.

The manager had started to put a range of fresh checks and audits in place. An example we were given was regarding pocket money. Previously there had been no system. This had resulted in some comments made to us by relatives. Now, as result of this issue raised at a meeting a pocket money audit and full record was now in place. We were shown details of staff question and answer forms as well as new formal satisfaction surveys due to go out to families.

A 'Safeguarding log' had been started to link in with records of challenging behaviour which is on each person's record.

The manager had started care plan audits in December 2014 but these were still in their early stages and had not picked up on the issues we had found. Medication audits were in place and we looked at these for December 2014, January 2015 and February 2015. The manager had found a number of recording issues and these had been addressed at nurses meetings, the minutes of which we were shown.

We found the shortfalls in the auditing systems in the home to be a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) regulations 2010. This also amounted to breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014.

During our visit we discussed the sending of notifications and other information to the CQC and also to the local authority. The internet connection was not available during our time on site. There had been a concern about DoLS applications not being received by the local authority which we had discussed with the manager. Some had gone missing as they had to be posted and it was not sure if this had been done. Partly because of the lack of connectivity in the home and partly because there had been issues with the home administrator, who had since left.

There was a new administrator in post who was assisting the manager to get systems up and running. However the internet connection, fax and telephone lines remained an issue. This affects the daily running of the home and can prevent some statutory requirements being met. The home administrator and manager did inform us that they had been chasing the telephone/internet provider for some time over this but the problem had not been resolved.

We would recommend the home looks into all possible ways to improve the connectivity of the service in order to allow statutory notifications, contact with the local authority and other people to be achieved in a timely manner.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There was a lack of oversight and learning from incidents of aggression or violence to keep people safe. Regulation 17(1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The home did not have effective systems and staff did not obtain valid consent from people who lived at the home. Regulation 11(1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment There were unauthorised restrictions on people who lived at the home which deprived people of their liberty. Regulation 13 (1) (b) and (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Shortfalls in monitoring, recording of people's weight and fluid intake and no evidence of action taken. Regulation 12 (1) (a) and (b).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment There was a lack of dementia friendly décor and fitments along with the overall poor condition of the home. Regulation 15 (1) (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Gaps and poor recording in care plans put people at risk of receiving unsafe care and treatment as the service did not respond to people's changing needs. Regulation 12 (1) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The shortfalls in the auditing systems in the home were ineffective and unable to pick up on concerns in relation to peoples care and allow the home to improve the quality of service provision. Regulation 17 (10 (a) and (b).