Pilling Care Homes Limited

Pilling Care Home

Inspection report

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26 January 2016
12 February 2016
23 February 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 20 January 2016 with follow up visits on 26 January 2016, 12 February 2016 and 23 February 2016. All visits were unannounced which meant the home did not know we were coming.

The last scheduled inspection at Pilling Care Home home took place on 24 March 2015 and 01 April 2015. The home was rated as Requires Improvement overall with an inadequate rating in the Responsive domain.

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. At the time of the first two visits of the inspection 20 January 2016 and 26 January 2016 there was a registered manager in place. However, they submitted their resignation on 8 February 2016, so the service did not have a registered manager in place after this date.

Pilling Care Home provides nursing and residential care for older people and people with dementia. Long term and short term care is provided and the home is registered to accommodate up to 29 people. There were 26 people living in the home when we first visited. 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 passenger lift. There is a car park at the front of the home and gardens to the rear.

We engaged with all people who lived at the home. Feedback varied due to some people having limited communication skills. We spent time observing care delivery and spoke with people who visited the service.

We found that people were not protected against avoidable harm and quality assurance systems at the home failed to identify or resolve associated risk and therefore people were placed at significant risk of harm and neglect. We communicated our concerns to associated commissioning teams.

We found that people's safety was being compromised in a number of areas. This included how people were assisted to eat and drink, use of equipment during moving procedures, how well medicines were administrated and suitability of pre-employment checks for staff prior to recruitment.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. For example, the provider had not ensured that people's rights were actively assessed under the Mental Capacity Act of Deprivation of Liberty Safeguards, even though their liberty was being significantly restricted.

We found that people's health care needs were not appropriately assessed and therefore individual risk factors had not been fully considered, which placed people at risk of avoidable harm.

People's views about the service varied. Some people were very happy, but others were not. Also, our own observations did not always match the positive descriptions people had given us.

We did not find evidence of robust management systems in the home and quality assurance was not effective in order to protect people who lived at the service from risk.

Staff were not provided with effective support, induction, supervision, appraisal or training. The home did not have any effective governance systems in place to ensure that improvements could be made.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for safe care and treatment, need for consent, person centred care, good governance, safeguarding service users from abuse and improper treatment, dignity and respect, meeting nutritional needs, staffing and fit and proper persons employed. In accordance with our judgement framework we have deemed the overall rating for this service to be inadequate.

As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures and further enforcement action has been taken. Our guidance states that services rated as inadequate overall will be placed straight into special measures. We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore, we have introduced special measures. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
•Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration.

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Appropriate and effective systems were not in place to identify the possibility of risk and to prevent harm to people who lived at the service.

The processes in place to ensure that people received their medicines as prescribed were not robust and therefore placed people at risk of harm.

People were not safeguarded against risk of neglect and avoidable harm.

Recruitment systems were not robust to ensure the safety of people who lived at the service.

Staffing levels at the home did not support effective provision of care.

Is the service effective?

Inadequate

The service was not effective.

People were not supported in line with the Mental Capacity Act 2005 to ensure that their ability to consent was appropriately assessed prior to decisions being made on their behalf.

Some people were being unlawfully restricted.

The systems in place to ensure that people received nutrition and hydration appropriate to their needs were not robust, therefore placing people at risk of choking and malnutrition.

Staff training and supervision were not effective to ensure that staff were competent and had sufficient skills to meet the needs of people they cared for.

Is the service caring?

Inadequate

The service was not caring.

There were not appropriate and effective processes in place to make sure people were involved in discussions regarding their preferred care and treatment.

The systems and procedures operated at the home were not designed to enable people to live their lives in the way they choose, so that they could be as independent as possible.

People were not always treated with dignity and respect and the standard of personal care people received was found to be unsatisfactory.

Is the service responsive?

Inadequate

The service was not responsive.

There were not appropriate and effective processes in place to make sure people's' health and social care needs were properly assessed and planned.

We found peoples' care needs were not appropriately planned for by the service.

The service failed to respond to peoples' changing needs by ensuring amended plans of care were put in place and liaison with other health care professionals at times of deterioration in health status.

Is the service well-led?

Inadequate

The service was not well led.

Appropriate and effective processes were not in place to make sure that the quality of service was assessed and monitored so that people received safe and appropriate care.

The service was unable to demonstrate progression since the last inspection and had not met regulatory actions outlined in the provider's action plan.

We found that due to insufficient awareness of people's needs by the management team people were at risk of avoidable harm.

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 20 January 2016 with follow up visits on 26 January 2016, 12 February 2016 and 23 February 2016. All visits were unannounced, which meant that the home did not know that we were coming.

The inspection team consisted of two adult social care inspectors, except for the visit on 12 February 2016, when there were three adult social care inspectors present.

Prior to this inspection, we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us. We received feedback from social work professionals, a community psychiatric nurse, an occupational therapist and a psychiatrist. Their feedback is included within this report.

During this inspection we spoke with seven people who lived at the home. Due to the lack of relatives present at the time of our inspection we made contact with six family members by telephone to gather their thoughts on the care of their relative at Pilling Care Home. We spoke with nine care staff, the registered manager and the provider. We have included some of their comments in this report.

We observed how staff interacted with people who used the service and viewed nine people's care records. We also looked at a wide range of records. These included; the personnel records of 13 staff members, a variety of policies and procedures, training records, medicines records and quality monitoring systems.

Inadequate

Is the service safe?

Our findings

During our last inspection at Pilling Nursing Home we found short falls regarding procedures for keeping people safe. We found that people at risk of falling had not been adequately assessed and monitored, therefore placing them at increased risk of injury. The provider failed to
have suitable arrangements in place to identify the possibility of abuse. The provider was asked to submit an action plan in response to the regulatory breeches we found.

During this inspection we reviewed the required improvements, as outlined in the action plan received following inspection of the service in March and April 2015.

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. We spoke with visiting relatives and they told us: "My relative is quite safe here". And: "The staff try their best in a challenging environment".

We found staff knowledge of safeguarding principles variable. Some staff members we spoke with were able to explain the main principles of protecting people from abuse. Staff were not confident in reporting safeguarding concerns. This was further evidenced when inspectors looked at care files and daily records and found three safeguarding concerns that had not been recognised by the staff or reported to the manager or other senior staff. We asked for these to be reported to the local authority on the day of our inspection. This meant that systems and processes were not in place to prevent incidents of abuse to people who used the service.

We found that people were not protected against avoidable harm or risk. Due to inappropriate systems at the home to assess and monitor people's health and social care needs. Accidents were recorded in the accident book. However, there was no evidence available to show that this information had been reviewed, in order to identify and analyse any trends or patterns. Failure to maintain robust recording systems around accidents and incidents meant that the service was not effectively monitoring and auditing its daily practices, which resulted in people not being effectively protected from risk of avoidable harm.

We found that risks associated with every day care provision were compromised. Appropriate risk assessments were not in place for people who lived at the home. This placed people at risk of receiving care that was not appropriate for their needs and preferences, in order to keep them safe.

As an example we saw that one person had returned to the home after a period in hospital. On return to the service risk assessment and care planning was not undertaken to ensure that the person's needs were met. This persons needs had changed during their stay in hospital and they now required a higher level of care and support. Changes in the person's ability to mobilise and nutritional needs were evident. The provider had failed to assess the persons needs and provide the level of support now required.

We found that another person who lived at the home was being provided food that put them at risk of choking. This person required a soft diet consistency, due to swallowing difficulties and it was evidenced

that the home had failed to protect this person from avoidable harm, due to providing foods that potentially could have caused them to choke. The provider had failed to take necessary precautions to ensure that instructions were followed and adhered to by all staff, in order to protect the persons safety and therefore mitigate known risks.

We found that risk assessments were in place in relation to people's clinical needs. However, individual risks around inappropriate behaviour had not been appropriately assessed. We were informed of specific circumstances, which had not been recorded in the individual's care file and no risk assessment had been completed in relation to their identified behaviour. Therefore, the provider had not done all that was reasonably possible to mitigate the impact this behaviour could have on fellow residents.

This lack of risk assessment and care planning amounted to a breach of regulation 12 (1)(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed poor infection control practices within the home; staff failed to remove protective clothing following the provision of care and were seen to walk around the service in aprons and gloves that had been used during personal care interventions. We communicated to the manager that this increased the risk of cross contamination. However malpractice continued to be observed.

The home was malodorous and the environment was observed to be dirty. We observed the chairs in the communal areas were stained with food and faecal matter.

Inspectors observed unsafe moving and handling during both visits to the service. We observed two staff drag lifting a person who used the service in the lounge. Inspectors found in this person's care plan for mobility it clearly stated that staff were to use a handling belt on all transfers. Moving and handling of people is a regular task in health and social care, which if not done safely, could cause serious injury to service users and staff.

Under current fire safety legislation it is the responsibility of the registered manager to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan (PEEPs) needs to be completed for each individual living at the home. The home did not have PEEPs in place for all people using the service during initial visits.

On our return to the service PEEPs had been put into place for all people who used the service. However the PEEPs we saw were generic and did not contain personal information to show how each individual could be best assisted to evacuate the premises, should the need arise. In addition when we spoke with staff members about the PEEPs, we were told: "I don't know what a PEEP is". And: "I have heard of a PEEP but I don't know where these are kept".

We found the registered provider and registered manager, had as a form of control, put in situ throughout the premise a number of wooden 'adult gates' that sat at waist height to an adult (akin to 'Baby Gates'). These were situated at the bottom of the stairs, main entrance and a lounge. In addition keypad locked doors were being used in the corridors on the ground floor and first floor of the home and at the top of the stairs. This presented as a form of restraint and control to people who lacked capacity to consent to this practice. In addition it was an extreme fire hazard in the event of trying to evacuate in an emergency situation. When we asked to see risk assessments as to the suitability of the wooden gates and their use, the provider was unable to supply this.

A lack of sufficient fire safety plans for individuals, lack of safe infection control practices and unsafe moving and handling practices amounted to a breach of regulation 12 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at the recruitment records for three people who worked at the home and found that the provider had not made sure that suitable referencing was obtained prior to agreement of employment. Robust recruitment processes help to ensure that the applicant is suitable to work with people who may be vulnerable. A further completed audit of staff files was undertaken and it was found that 16 members of staff did not have valid DBS clearance and 17 did not have adequate references.

The above failings to ensure the suitability of staff resulted in a breach of regulation 19 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed medicines. We found inappropriate 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 not always completed and accurate. Omissions in the recording of administration were identified. Medicine administration records (MARs) showed that medicines had been given and signed for. However the stock did not reflect this, which suggested that some medication had been signed for, but had been given or had not been given at all.

By way of example, we found evidence to show one person had their medication signed for on two days and and yet not given. The medication was a once daily dosage, missing doses on two days would reduce the amount of drug available in the person's system and could put their health at risk and thus expose the person to the risk of harm.

Another person was prescribed 10mls of a prescribed medicine three times a day, on the MAR chart this was signed off as completed 2 doses before the medicine should have finished. The medicine in question was an antibiotic. Antibiotic courses must be completed over the correct period of time to maximise a person's chances of recovering fully from the infection. This put the service user at risk of not fully recovering from the infection. This exposed this person to the risk of harm in terms of health and wellbeing.

We found that recording of the topical treatments was inconsistent. Treatments were being applied by care workers, however records to evidence this application were not available to ensure that correct application was achieved. The person administrating these treatments should have clear direction and demonstrate accountability by signing administration records.

This amounted to a breach of breach of regulation 12 (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that equipment used to undertake physical observations of residents was faulty. The equipment that was not in good working order was the thermometer used to take the temperatures of the residents. In addition, the blood pressure monitor that was used by staff was not accurately recording blood pressures. This lack of diagnostic equipment being in good working order, resulted in an inappropriate and unnecessary admission to hospital for one person who lived at the home. This lack of equipment put service users at risk of avoidable harm, as it was unclear if people presented with high blood pressure or raised temperatures.

This lack of working diagnostic medical equipment resulted in a breach of regulation 15 (1) (c) (e) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager and the provider during our inspection. The service did not have a staff dependency tool to identify how many staff were needed. However, staff informed us that they felt that the service was suitably staffed.

Inadequate

Is the service effective?

Our findings

We found that the provider had not taken appropriate steps to ensure that there was sufficient numbers of suitably qualified, skilled and experienced persons employed in order to safeguard the health, safety and welfare of service users.

We reviewed a selection of training records and found that staff training was not always evidenced with certification of training courses attended or completed. The training records did not identify how the provider had assessed staff understanding, knowledge and competency skills.

Staff told us that they had received training via a DVD or on-line, however they were unable to provide a satisfactory level of feedback to us when we asked them about subject areas such as the Mental Capacity Act 2005. Staff told us: "Training needs massive improvement": "I don't know how to assess if someone has capacity". And: "We don't gain consent if someone has a diagnosis of dementia we just give them medication".

We spoke with one relative who told us: "There is a lack of understanding from the staff about dementia".

When we asked to see evidence of staff training records this could not be provided. The provider had let the lease for the online training provider lapse, so records could not be obtained.

We found training had not considered for key areas for all staff at the service. Such as safeguarding, managing behaviours that challenge, breakaway techniques and advanced dementia. Despite the fact that 26 service users at the Pilling Care Home presented with cognitive difficulties and DOLs applications were in process for these 26 service users.

Lack of trained and competent staff amounted to a breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

During our last inspection we found short falls in systems to ensure that the service involved people in

decision making and the ways people were supported when considering consent to treatment or restrictive practices. We found continuing concerns that the provider had not met the
required standard and was in breach of this regulation.

We found evidence that a number of DoLS (Deprivations of Liberty Safeguards) had been applied for and the manager confirmed that these restrictions were active. However, the service provider failed to ensure that restrictive practices were appropriately recorded and, urgent authorisations to deprive a person's liberty were reviewed in a timely manner and considered by the managing authority for being authorised for an agreed period of time.

For example people were being prevented from leaving the service as the home had a locked front door that needed to be opened with the use of a key. The home also had locks on all exits and some internal doors had 'Chubb type' star locks on them, which prevented free access around the home for people who lived there.

We were informed that some people had bed rails in place. 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. We saw no evidence of capacity assessments and best interest decisions around the use of bed rails.

We could not find written evidence to show that people and or their representatives had been involved in considerations for these deprivations of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005.

Care files did not contain decision specific mental capacity assessments. There was documentation that stated when a person lacked capacity, but no information on the assessment, which took place. Some care files contained 'consent' forms, although not all had been signed. These forms were not specific. In the care files we looked at we found consent for medication was not clearly recorded.

There were no qualified or competent staff at the service able to undertake capacity assessments or care for people in line with the MCA 2005. Considerations around their continuous control and restraint, in line with the Mental Capacity Act 2005, were not recorded. We found that suitable arrangements were not in place for obtaining consent from people living at the home, and as a result care practices were not provided in accordance with people's wishes or best interests.

This amounted to a breach of breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found evidence that one person at the service had been unlawfully restrained during personal care by several care staff. This person lacked capacity to consent to the receipt of personal care and staff used force. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm. We found no care documentation to support this practice.

This practice resulted in a breach of regulation 13 (1) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff had not received training in safe restraint. This put people who used the service and the staff at risk of avoidable harm.

We looked at several care records relating to nutritional risk management and individual preferences and found evidence of inadequate risk assessment and involvement procedures in all the records we viewed. This meant that people had not been appropriately supported to maintain their individual nutritional and hydration needs. For example, we saw one person being assisted to eat food, which was not appropriate to their assessed nutritional needs. In addition, we found that another person who returned from hospital had been assessed by professionals as requiring a special diet. However, this information had not been cascaded throughout the staff team and the kitchen staff were not aware of the changes in this individual's dietary needs.

These shortfalls in meeting people's nutritional and hydration needs amounted to a breach of regulation 14 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed meal times across both of the first two days of our inspection and found that staff appeared rushed and task focused. People in the dining area were not offered the use of clothing protectors and during the meal one person was observed to have spilt food on their clothing. A staff member was then observed to cover this up after the event. Staff did not offer this person support to clean this up, and did not respond to this person's needs or consider the person's wellbeing.
This amounted to a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure people's respect and
dignity was preserved.

People were not offered a choice of snacks between meals, but were served biscuits, which were not put onto plates for people to eat from. There were no snacks on offer for those who required a soft diet. Inspectors asked the chef if they could consider this and they did provide something once it was highlighted.

We looked at supervision and appraisal records and could not find evidence that formal supervision had taken place with staff members. We asked staff if they were able to tell us when they last had supervision. Staff told us: "I have informal supervision". "I can't recall my last supervision". And: "My last supervision was over a year ago". Staff were not well supported in their work performance.

The provider's appraisal policy stipulated staff would receive annual appraisals. However, records demonstrated that none of the staff had received an annual appraisal.

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. This lack of recording for supervisions was identified within the last inspection and documented on the improvement plan following the inspection in March/April 2015.

We found evidence that staff members registered with professional bodies had not been supported to maintain their professional development. Five registered nurses employed at the service could not provide any evidence of continuing professional development. Staff competencies had not completed within the service in order to facilitate ongoing safe practice. This exposed service users to the risk of harm due to insufficient training.

These shortfalls in supervision of staff amounted to a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home supported people to receive on going healthcare. People did tell us that there were regular visits from GP's. Comments from one visiting professional person were: "We visit fortnightly to review and support

their patients". And: "The service would benefit from more qualified staff".

The home had 29 people who lived at Pilling Care Home at the time of our inspection. We were told by the manager that 28 of those people were living with dementia. The décor in 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.

There was an odour in the entrance hall. We spoke with relatives who told us: "The home is not fresh smelling, cleanliness is not one of its strengths". And: "Cleanliness could be improved". Health and social care professionals told us: "The home appears dirty and smells". And: "The cleanliness of the premises and often malodourous entrance are issues". Some carpets were worn and in need of replacement.

This resulted in a breach of regulation 15 (1) (a) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

We observed the provision of care and support across the four inspection days. We found that staff had good intention, but they significantly lacked knowledge of how to effectively support people living with dementia.

People's views about the service varied. While some people were very happy, others were not. Also, our own observations did not always match the positive descriptions people had given us.

Relatives told us: "Staff are friendly": "Basic compassionate care is fairly good": "Staff seem to really care". And: "There's not much interaction with Mum from staff". We spoke with a visiting professional who said; "I have noticed a decline in the care provided over the last two years".

We saw that support for people who lived at the service was variable. Care workers were observed to be kind and considerate during some interventions, however delayed response times to people's requests were observed on a number of occasions. For example, we observed one person who was left in a hoist and when staff were asked to help they stated they had finished their shift. The person required support to get back in bed and confirmed that this was their request, but they could not summon staff help. The person had to wait an unreasonable amount of time for assistance.

We found the use of negative language was common practice in the service and we found this did not have positive outcomes for people who lived at the home.. An example of this was the use of the word 'aggressive' when reporting on behaviours that challenged.

We noted some interactions to be task focused and care workers failed to actively communicate with people when assisting them on some occasions. Another person was observed to request support from staff several times during the meal service, as they wanted a drink, but this request was ignored until we asked staff to respond. We did however observe one care worker sit with a service user for a short period of time. The interaction showed a substantial level of warmth and the person was genuinely comforted by the staff's presence.

We found that end of life support for one person was insufficient and not person centred. The person was observed to be in discomfort, they were dressed in a hospital gown and their dignity was not respected. We found that end of life care planning had not been fully considered. The provider had not adequately assessed the person's needs in line with best practice principles, as outlined in the provider's end of life care policy. This impacted on the quality of end of life care for this person.

We found that partnership working with people at the home, and other agencies was not planned or effectively put into action. Relatives told us that they would like to be involved in discussions about service provision, however they were not always given the opportunity to do so.

This amounted to a breach of Regulations 9 (1) (b)(f)(g)) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 as the provider did not ensure people were cared for in a person centred way with consideration of consent to care and treatment.

Inadequate

Is the service responsive?

Our findings

During our last inspection of Piling Care Home we found short falls regarding procedures for ensuring people who lived at the home received appropriate care and treatment, that suited their individual needs. The care we observed was not outlined in the person's care plan and care records had not been updated to reflect the person's current needs and preferences.

We found an improvement in care planning detail. However, care plans were not effectively updated as people's needs changed. In addition people's care records were not always followed by staff who delivered care and support.

We found that the registered person has not protected people against the risk of unsafe care or treatment, because care planning and assessment processes were not always sufficiently person centred and potential risks had not always been well managed. For example, we saw staff complete an unsafe moving and handling procedure with one person. When we reviewed the care records for this individual they showed that staff should have always used a slide sheet and moving belt for all transfers. Despite highlighting this to senior members of staff we continued to witness similar unsafe moving and handling practices during our inspection.

We found that the provider had not taken efficient steps to ensure that people who lived at the home received appropriate assessments of their needs and preferences. The care records of ten people showed that the care provided was not accurately recorded, in line with people's wishes and best interests, which put people at risk of receiving care that was inappropriate or unsafe. For example one person's care plan stated that they were able to mobilise unaided, however care workers informed us that this person was predominantly nursed in bed. Evidence of safety assessments were not available and we discussed this with the manager, who agreed that this significantly increased the risk of injury during care giving.

One resident was due to be discharged back to the home on the day of our inspection. However, no re-assessment of their needs had taken place. There was documented information from the hospital in this person's care file. We returned to the service and again checked the care file once the person had returned. This person's care plan had not been updated to reflect their changing mobility and nutritional needs.

We found that the service was not responsive to known risk factors. Staff showed a lack of understanding around behaviours that challenged, and staff were not equipped to respond to people's changing needs, which placed people at substantial risk of deterioration in their health and wellbeing.

We found that the service did not follow professional advice and support with regards to behaviours that challenge. This demonstrated a lack of effective outcomes for people. For example, behaviour charts were not being completed fully for people, as requested by community professionals. Advice had also been given around limiting the number of staff supporting one person to avoid them becoming distressed. We observed that this advice had not been followed and further examples that this advice was being disregarded were found in documented notes.

Care plans were not helpful in understanding people's needs, likes and dislikes and preferred daily activities. Therefore, staff who did not know people would have found it challenging to provide person centred care to people, who often found it difficult to communicate their needs.

This amounted to a breach of Regulation 9 (1) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed how the service responded to complaints and found that the manager did not keep robust records or show how complaints were responded to in a timely manner. People told us that they were aware of the complaints procedure and one relative explained: "I can tell the manager at any time, if I have a concern".

We spoke with relatives about activities within the home. They told us: "They have been out to a party at the local church. And: "They had a birthday party with a birthday cake and everyone got involved. Activities are an important part of people's care, as they keep people active and can prevent social isolation. There was an activities coordinator and we observed people playing catch with an inflatable ball and saw people playing dominoes.

Inadequate

Is the service well-led?

Our findings

We asked staff if they felt supported by the registered manager. Staff told us: "Yes I feel supported": "The manager is approachable". And: "Sometimes with the manager I don't always know where I stand".

During our last inspection of Pilling Care Home we found short falls regarding systems in place at the home to assess and monitor the quality of service provided. We found that the provider had failed to implement consistent and robust auditing systems to monitor safety and quality at the service.

We found that the service had systems in place to monitor the delivery of care; however, the systems were inadequate to ensure the delivery of high quality care and the systems were not always followed. During our inspection, we identified failings in a number of areas. These included person centred care, premises safety, managing risk to people and nutrition. We saw some records of audits that had been completed; however these issues had not been sufficiently identified or managed by the registered manager prior to our visit, which showed that there was a lack of robust quality assurance systems in place.

We looked at the audit records and found that some areas of concern had been identified. However, the manager was unable to evidence systems put into place to rectify and address the areas which required improvement. For example the medication audit for five consecutive months documented that omissions were found on the MAR charts. No action had been taken to investigate this and a plan had not been devised, in order to prevent further errors.

Another example was the infection control audit, which was carried out between May 2015 and September 2015. The audit documentation demonstrated that bathrooms were not clean and free from communal items across the five months the audits were completed. This was observed on the day of inspection. The bathrooms were unclean and not free from communal items. This placed people at risk of cross contamination and showed that the governance systems used to identify risk were not protecting people from harm.

These issues had not been sufficiently identified or managed by the registered manager or provider, which showed that there was a lack of robust quality assurance systems in place.

The shortfalls in quality assurance and risk management amounted to a breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These were reviewed and updated regularly and covered areas, such as The Mental Capacity Act, Deprivation of Liberty Safeguarding, medicines, appraisal, staff supervision, individual planning and review and health and safety. However, our finding throughout the inspection demonstrated that the service was not always following their own policies and procedures.

Prior to our inspection, we examined the information we held about this location, such as notifications,

safeguarding referrals and serious injuries. We found that we had not been notified about things we needed to know. For example, one person who lived at the service had been in hospital following a fall, where an injury was sustained. This is classed as a reportable incident.
We found that incidents had not been referred to the local safeguarding team and the Care Quality Commission did not always receive notifications.

This resulted in a breach of Regulation 18 (2) (a) (b) CQC (Registration) Regulations 2009.

Meetings for people that lived in the home and their relatives had not been held, so that they could discuss any issues or suggestions for improvements.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not always inform us of incidents that require submission of a statutory notification to the Care Quality Commission. Regulation 18 (2) (a) (b)

The enforcement action we took:

Section 31a Remove Location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not have effective arrangements in place to ensure that the care and treatment of service users was appropriate, outlined to meet their needs and reflected their preferences. Regulation 9 (1) (3) (a) (b) (c) (d) (e) (f) (g) (h) (i).

The enforcement action we took:

Section 31a Remove Location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not have suitable arrangements in place to ensure that people are treated with dignity and respect. Regulation 10 (1).

The enforcement action we took:

Section 31a Remove Location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the

Treatment of disease, disorder or injury	relevant person in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3) (4).

The enforcement action we took:

Section 31a Remove location

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 The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users. Regulation 12 (1) (2) (a) (b) (c) (e) (g) (h).

The enforcement action we took:

Section 31a Remove Location

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 The provider did not have suitable arrangements in place to protect service users from abuse and improper treatment. Regulation 13 (1) (2) (3) (4) (b) (5) (6) (d) (7) (b).

The enforcement action we took:

Section 31a Remove Location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have suitable arrangements in place to protect service users from malnutrition and risk of choking. Regulation 14 (1) (2) (3) (4)

The enforcement action we took:

Section 31a Remove Location

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 The provider did not have suitable arrangements in place to ensure that the premises and equipment were clean, suitable for the purpose which they are being used and properly maintained.

	Regulation 15 (1) (a) (c) (e) (2).

The enforcement action we took:

Section 31a Remove Location

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 provider did not have suitable systems in place to establish effective assessment, monitoring and improvement of the service. Regulation 17 (1) (2) (a) (b) (c) (e) (f).

The enforcement action we took:

Section 31a Remove Location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure that robust recruitment processes were in place to ensure that vulnerable people are protected from abuse. Regulation 19 (1) (a) (b) (2) (a) (b).

The enforcement action we took:

Section 31a Remove Location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing The provider did not have sufficient numbers of suitably qualifies, competent, skilled and experienced persons deployed in order to meet the needs of people at the service. Regulation 18 (1) (2) (a) (b).

The enforcement action we took:

Section 31a Remove Location