Pilgrim Homes

Pilgrim Homes - Evington Home

Inspection report

Grocot Road
Evington
Leicester
Leicestershire
LE5 6AL

Tel: 03003031455
Website: www.pilgrimsfriend.org.uk

Date of inspection visit:
29 September 2016

Date of publication:
04 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Pilgrim Homes – Evington Home is a care home that provides residential and nursing care for up to 30 people. The service specialises in caring for older people including those with physical disabilities, people living with dementia and those who require end of life care. Accommodation is over two floors accessible using the stairs or the lift. Bedrooms are all single ensuite. There is a choice of communal lounges and a dining room.

We previously carried out an unannounced comprehensive inspection of this service on 24 and 25 February 2016. We found that the provider was not meeting the standards we expected and there were breaches of legal requirements. We found people's care needs and risks were not assessed or reviewed regularly. The care plans were not centred on people's needs, were not kept up to date and lacked information for staff to support people safely. People were not provided with food and drink that met their dietary and health needs. The management, administration and recording of medicines were not safe. The provider's quality assurance and governance system was fragmented and ineffective. Audits and quality checks were not always carried out, which meant improvements were not made to the quality of service provided. We issued requirement notices as the provider was in breach of legal requirements. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We carried out an unannounced focused inspection of Pilgrim Homes – Evington Home on 29 September 2016. This inspection was carried out to check that the provider had made the required improvements in order to meet legal requirements. At the time of our inspection there were 25 people in residence. We found that some improvements had been made.

We inspected the service against four of the five questions we ask about services. Is the service safe, is the service effective, is the service responsive and is the service well-led. This is because the service was not meeting some legal requirements. This report only covers our findings in relation to those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Pilgrim Homes – Evington Home' on our website at www.cqc.org.uk.

A registered manager was not in post. 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.

The service has been without a registered manager since September 2016 but has not yet cancelled their registration. The registered provider who visited the service at the time of our inspection told us that they were in the process of recruiting a suitably qualified person to manage the service. The care nurse manager who facilitated this inspection was in charge and was supported by the operations manager.

Some improvements had been made in relation to how the provider checked the quality and safety of service provided, however these systems were not yet established. We saw that some actions had been taken as a result of checks however further action was needed to demonstrate improvements made were sustained. People's views influenced their care and the development of the service. Staff continued to receive the training and support to carry out their roles. This was in order to drive improvement at the service.

We found some improvements had been made that ensured people's needs were assessed and measures were in place to ensure risks could be managed safely. Care plans were being updated to ensure people's needs were accurately reflected and there was clear information for staff to follow to ensure people were supported safely.

Improvements had been made so that people's nutritionals needs were met. Staff sought advice from health care professionals where people's appetite and weight was of concern. Care plans included the guidance provided by health care professionals for staff to follow to help monitor and ensure people's nutritional needs were met.

People received their medicines at the right times, as prescribed. We found nurses' medicines competency was carried out to help assure the provider and people that their prescribed medicines would be given as prescribed. The systems to store, manage and administered medicines were safe and there was guidance for staff to follow to ensure people's health needs were met. However, further action was needed to demonstrate the improvements made were sustained.

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 consistently safe.

Risks to people's physical and health needs had been assessed and care plans provided staff with clear information to ensure people were supported safely and their independence was promoted. People received their medicines as prescribed. The management, storage and recording of medicines were safe. Further action was needed to ensure the improvements were established and sustained in order for people to maintain their health.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's nutritional needs were assessed and met. Staff sought advice sought from health care professionals, which helped to ensure people were provided with a choice of food and drink that met their dietary needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's assessed needs were met and they were involved in the review of their care. Care plans were being personalised to ensure staff promoted and respected people's lifestyle choices and preferences. The service should ensure the systems for reviewing and monitoring were established and improvements sustained in order for people to receive care that is responsive and tailored to their needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager in post. The provider has a quality assurance system to monitor the service provided. Improvements were made to ensure people's care was safe, the management of medicines and supporting staff were monitored. However, further action was needed to ensure monitoring

systems were established. This was in order to sustain improvements made and to drive further improvements.

Pilgrim Homes - Evington 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.

We carried out an unannounced focused inspection of Pilgrim Homes – Evington Home on 29 September 2016. The inspection was carried out by one inspector. This inspection was to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 24 and 25 February 2016 had been made. We inspected the service against four of the five questions we ask about services. Is the service safe, is the service effective, is the service responsive and is the service well-led.

The provider is required to send us a Provider Information Return (PIR). This allows the provider to provide some key information about the service, what the service does well and improvements they plan to make. However, because this inspection was to check improvements had been made, the provider did not have an opportunity to complete a PIR.

Before the inspection we looked at the information we had about the service and notifications about any changes, events of incidents that affect people's health and safety that provider's must tell us about. We looked at the provider's action plans sent to us following our last inspection of the service. We contacted commissioners responsible for the funding of some people's care that used the service and asked them for their views.

We spoke with care nurse manager who was the person in charge, a nurse and three care staff. We spoke with the cook, the business manager and the administrator. We spoke with the registered provider who was visiting the service at the time of our inspection visit.

We spoke with two people who used the service and a relative. 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 four people's care, the medicines and medication records for nine people and the records for the medicine management systems. We looked at the staff training records, meeting minutes and some records relating to the provider's quality assurance audits to see how the provider monitored the quality of the service.

We looked at the information received from the registered provider and the operations manager following our inspection visit. Those included the provider's quality assurance audits and the service improvement plan, satisfaction surveys, staff training and the complaints record.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 24 and 25 February 2016 we found risk to people health, safety and wellbeing was not always assessed, managed or monitored. Care plans lacked guidance for staff to follow, which meant measures to manage people's safety were not always adequate to keep people safe. We found people's medicines were not managed, administered or stored safely. Medication administration records were not completed accurately and errors in recording were not reported. That meant people's health could be at risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which outlined that risks to people's health would be assessed and their care plans would include clear guidance for staff to support people to stay safe. The care plans would be reviewed and kept up to date to ensure that the measures in place to manage risks to people's health and safety were appropriate. Nurses would have their medicine competency assessed regularly. The system to monitor and manage people's medicines and the medicine procedures would be updated to ensure staff had clear guidance to follow.

At this inspection we found some improvements were made. We saw people were supported to stay safe and staff helped people who needed support to move around. Staff were vigilant and assisted people who could be at risk of falling by walking with them for support to maintain their safety. We observed two staff moving someone using a hoist. They took care and communicated with each other and the person, to assure them and check they were safe and comfortable throughout the move and when seated.

A relative told us risks associated to their family member's physical health needs had been assessed when they moved to the service and was reviewed when their needs had changed. They told us the care nurse manager explained the risks and how their family member's needs would be met as a hoist would be used to move them. They said, "I know she's safe and well cared or here."

We saw improvements made to how risks associated to people's health, wellbeing and safety were managed. People's care records showed risks to people's individual health were assessed. These were centred on people's individual needs and covered risks such as falling when moving around or out of bed, risk of developing pressure sores and choking.

Care plans provided staff with clear information about how to support people safely, whilst promoting their rights and independence. Equipment to be used to move people safely was also detailed in people's care plans such as the type of hoist and sling, use of bedrails and floor sensor to alert staff when someone at risk of falling or moved around. This meant staff knew which piece of equipment was to be used. For example, a care plan for someone stated they were able to manage some personal hygiene tasks and the care plan provided staff with information about the additional support they were to provide.

Staff we spoke with were able to describe how they supported people, which supported information written in people's care plans that we read. They told us that they informed the nurse when they had concerns

about people's safety and wellbeing. That helped to ensure any changes to people's needs could be assessed so that staff provided the support needed.

Care records showed that further risk assessments were carried out when people's health changed. People's care needs were reviewed every six months or sooner to ensure the care provided was appropriate. This supported what staff had told us and meant risks to people's health; safety and wellbeing were being managed.

The registered provider told us that senior staff were being trained to use the new electronic care planning system which was due to be implemented in November 2016. The care nurse manager had inputted information about some people and their needs. They showed us aspects of the electronic care planning system, which would ensure staff, were provided with clear information about how to meet people's needs and ensure risks were managed and reviewed regularly.

People told us that they received their medicines at the right time. A relative said, "I've got no concerns about [person's name] care and I know she receives her medicine on time."

The nurse administering the morning medicines told us that their competency to administer medicines had been assessed. We saw the nurse supported people individually to take their medicines and signed the medication administration records (MAR) to confirm medicines were taken. The nurse had followed the correct procedure for medicines administered 'as required', otherwise known as 'PRN'. They knew when those medicines were to be given and recorded the amount administered.

The staff training records confirmed that nurses' competency had been assessed by a care nurse manager. The registered provider told us that nurses competency assessment would checked every three years or sooner if required, which helped to assure medicines were managed and administered safely.

Medicines were kept secure in a locked room. The medicine trolley kept in the dining room was secured and locked when unattended. Daily temperatures were monitored of the medicine room, medicine fridge and medicine trolleys stored in the dining room to ensure medicines were stored within the manufactures recommended temperatures. That helped to ensure the medicines remained effective when administered.

Further action was needed to ensure medicines were safe to use. We found a label was removed from one prescribed topical cream that was in use for two days and another was still in use even though it had passed the 28 days shelf life. The care nurse manager took action and ordered a new label from the dispensing pharmacy and destroyed the other prescribed topical cream that was unsafe to use. They assured us checks would be carried out to ensure medicines were safely stored in fridge.

The prescribed food supplements that were unopened were stored securely in the medicine room. Adequate stock levels of medicines were maintained and stored in the secure cabinets. Care staff told us that people's prescribed opened food supplements were now kept in a secure cupboard in the kitchen. We saw staff use people's prescribed food supplements when drinks were prepared for them. That helped staff to monitor and meet people's health needs.

We checked the two files which contained the MARs for the 25 people who used the service. Each MAR had the person's photograph, the contact details for the GP and any known allergies. This helped staff to ensure people received their medicines. The medicine administration records we checked were completed correctly. The nurse told us that when any errors or omissions such as missing signatures, were found they raised the issue with the nurse on duty at that time. An incident form was completed which helped the care

nurse manager and the registered provider monitor and take action to ensure people received their medicines at the right time and that the administration procedure was followed.

We found protocols for medicines administered as and when required such as pain relief medicines were kept with the care plans and not with the medicines administration records. The care nurse manager told us that nurses followed the instruction on the MAR. However, the level of detail in the medicine protocol was not sufficient in order for the nurse to ensure the correct medicine was administered to maintain the person's health. When we raised this issue with the registered provider they told us that the PRN documentation was available for staff to complete. They took action immediately and ensured clear information was recorded in the PRN protocols for each person prescribed PRN medicines. These were kept with the MAR file, which meant the nurses could refer to the guidance to help ensure people's health was maintained.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 24 and 25 February 2016 we found risk to people were not supported to eat and drink sufficiently to maintain their health. Advice from health care professionals was not always sought, acted on or monitored in order to manage risk to people's health risks. That meant people's health was at risk because their nutritional and hydration needs were not met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which outlined that people at risk of malnutrition or dehydration would be assessed and where required staff would seek advice from health care professionals. Care plans would include any advice from health care professionals to ensure staff had clear information to meet people's nutritional needs and to monitor their health.

At this inspection we read people's care plans to check how they were supported to eat and drink. We found people's dietary needs were assessed where risks or concerns were identified. Staff had sought advice from health care professionals such as the GP, speech and language therapist (SALT) and the dietician. Care plans now included the advice from the SALT, individual dietary needs, preferences and the support people needed to eat and drink. For example, where people were prescribed food supplements or thickeners, their care plan had clear guidance for staff about how to prepare the meals and drinks. A thickener is used to thicken drinks to a consistency to enable the person to swallow without the risk of choking.

We observed staff offered people regular drinks and snacks. Staff used the people's individual prescribed thickener to prepare their drinks. Staff were able to describe how they prepared people's drinks which showed the guidance in the care plans and advice from SALT was followed.

The cook told us they were provided with information about people's dietary needs and most had been updated. When we shared the feedback received with the registered provider, they assured us that they would check to ensure that information about people's dietary needs was kept up to date. That showed people were assured their dietary needs would be met.

People were provided meals that met their dietary needs. For example, soft or fork mashable meals were prepared for people identified at a risk of choking or had swallowing difficulties. People had a choice of meals, which were served individually with a choice or fruit cordials or water. Staff supported people who needed support to eat. Staff took care and encouraged people to eat at a pace that suited them. Staff helped people to maintain their independence with eating by cutting the food into smaller pieces. People, where assessed, were provided with adapted cutlery and drinking vessels so they could to eat and drink independently.

Staff told us they worked closely with health care professionals to ensure people's dietary needs were met. Food and drink charts were used to monitor how much people ate and drank when people's appetite or weight was of concern. People's weight was measured regularly and the nurse evaluated how much the person ate and if required sought advice from the GP or SALT. That helped to ensure people's ongoing

health and nutritional needs were met and monitored.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 24 and 25 February 2016 we found people did not receive personalised care that met their needs. Assessments of people's needs were not always monitored, reviewed and people's care plans were not kept up to date to ensure the staff were provided with clear and accurate information about how to meet people's individual needs. That meant people were not always at the centre of their care and their needs were not always met promptly in order to maintain their health. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which outlined that care plans would be reviewed and personalised to reflect people's needs, preferences and how they wished to be supported. Staff would be trained to the delivery of person centred care and their work would be appraised to ensure people's needs were met.

At this inspection we saw staff were responsive and met people's needs. Staff ensured people's safety was maintained whilst their rights and choices were respected. A member of staff remained in the lounge at all times to support people when required and to maintain their safety. For example, we saw two staff used a hoist to move someone from the chair to a wheelchair. Staff kept the person informed about what they were doing, checked the person was safe and was made comfortable when seated.

Staff demonstrated a caring attitude and understood how dementia affected people. Staff were responsive, supported people who needed assistance and offered assurance when people became upset, anxious or their behaviour challenged staff or others people.

At lunch time we saw people chose where to sit, were offered the menu choices and served the meal without delay. We saw staff showed one person living with dementia the plated meals so that they could choose what they wanted to eat. Staff supported people individually to eat their meals. Staff took care, offered encouragement and talked about topics that engaged the person in conversations. That showed staff were aware of the person's abilities, what was important and of interest to them, which made the meal time experience pleasant.

Staff spent time talking with people along with the activity co-ordinator who also encouraged people to take part in the activities that were organised. There was a daily morning religious service held in the lounge, which most people attended and some people were supported by staff or their relatives. We saw someone's birthday was celebrated. Staff made the occasion special for the person and for everyone else using the service.

Care records showed people's needs had been assessed when they were referred to the service. Additional information about the person's needs was also sought from relatives and health care professionals, which was used to develop care plans. This meant staff had the information they needed about the person to ensure the care provided was responsive and tailored to their needs.

Care plans provided staff with clear information about how to support the person. Records showed people,

and where appropriate their relatives and health care professionals were involved in the review of the care plans. Guidance from a health care professional was included in people's care plans where a special diet was required. A care plan for someone living with dementia described how they expressed themselves using non-verbal facial expressions and gestures, what that meant and how staff should support them to keep them and others safe. That helped to ensure people received support that covered all aspects of their life.

Staff told us they were made aware of any changes to people needs at the daily handover meetings. A staff member said, "They [nurse] will tell us if someone's not well or they need more help. We read the care plan and write down what we did to help them every day." Care records we read showed that people's care plans were amended when their needs had changed.

Care plans also contained individual information about the people's life history, hobbies and interests, and like and dislikes. This provided an introduction to people to help staff get to know them as individuals and we saw this to be the case. A member of staff member told us that someone's appearance and ability to look after themselves was important. They described how they helped the person with other personal care tasks which they could no longer do for themselves. That showed people could be assured that they received the care that was tailored to their needs, abilities and choices were respected.

Daily records showed that people received the support they needed and their health was monitored. For example, records showed people were re-positioned at regular intervals to prevent the risk of them developing pressure sores and advice was sought from health care professionals when people's health was of concern. That meant people could be sure that the support they received was individual and tailored which covered all aspects of their life.

We were shown the new electronic care planning system, which is due to be implemented in November 2016. Information was being added about each person's needs, all aspects of their life and the contact details for the relatives including health care professionals involved in the person's care. The registered provider told us that staff would be able to tailor the care plans to people's individual needs, ensure staff had clear, accurate and up to date information in order to meet people's needs. In addition, all staff once trained should be able to update the electronic information which will help to monitor and support people as and when their needs change.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on 24 and 25 February 2016 we found the provider's quality assurance and monitoring systems were fragmented. Audits to monitor the service were not always used effectively to determine the quality of care provided. Improvements were needed in relation to how people's needs and delivery of care were assessed and monitored, the management of staff training, support and monitored the effectiveness of the actions taken to drive improvements. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which outlined that a systematic cycle of audits and evaluation of the quality of care provided would be carried out. Feedback from people who used the service would be used to determine the quality of care and develop the service. Staff would receive ongoing training, support and their work would be appraised.

At this inspection we found that some improvements had been made.

The provider wrote to us and told us that the registered manager had resigned in September 2016. However, they have not yet cancelled their registration. The registered provider told us that they were recruiting a suitably qualified person to manage the service. Therefore, the care nurse manager who assisted us on this inspection would manage the service with the support from the operations manager who would be at the service each week.

We found that that quality of information kept in people's care records had improved. People's care needs and care plans had been reviewed and where changes had been identified people's care plans were updated. Staff told us that they received updates on any changes to people's needs at the daily handover meetings. Staff were aware and understood people's needs and would read their care plans if they were unsure or had concerns about how to support someone.

We found there were improvements made to the systems to management and administration of medicines. Daily visual checks were carried out the medicine and medicine administration records. Records showed incidents such as errors and missing signatures on the medicines administration records were reported and logged as an incident. However, improvements made were not always established because we found issues regarding how medicines were stored and records. The provider assured us they would check the system put in place was effective.

Care staff told us they had essential training to ensure the skills, knowledge and how they supported people was safe. Training records showed the training topics covered, related to health and safety. One member of staff told us they had an interest in dementia care and was assured they would be supported to attend dementia awareness course. The registered provider told us the service had registered with an external training provider to ensure staffs' training was kept up to date. That showed the provider supported and invested in staff's training to help ensure staff were equipped with the knowledge and skills they needed.

Nurses' competence to administer medicines had been assessed and would be repeated frequently to ensure their practices remained safe. This helped to ensure nurses also maintained their continuous professional development for their professional registration.

Staff told us they felt supported and had regular staff meetings. The meeting minutes showed that staff were provided with information and updates, such as changes to people's care needs, planned training and also had an opportunity to influence the development of the service. That showed the registered provider was assured that staff were involved, informed and had a commitment to providing a quality care service.

The operations manager had carried out a comprehensive audit of the service in August 2016, as a result of the last inspection in February 2016. The audit looked at people's care records, staff training and their practices observed, staff support and the management information such as feedback from people who used the service, complaints and compliments. Records showed routine safety checks on the premises, equipment and fire. An action plan was developed and monitored by the operations manager and the registered provider. As a result of the audit the registered provider had identified areas that required improvements and further developments.

The registered provider had invested in a new electronic care planning systems to help improve the quality of information about people's needs, care plans and reviews. Staff were being trained to use the system and add people's information in order to develop individual care plans. An external training company would provide the essential training which would be delivered in a variety of methods, such as face to face learning, on-line training and staff's knowledge checked.

The registered provider visited the service regularly. They reviewed the progress made to the action plan and provide support to the management team and staff. They acknowledged that the improvements being made needed to be established. That meant they would continue to visit the service regularly and provide the support required to ensure quality assurance systems were being maintained to ensure the improvements could be sustained.

People who used the service and a relative we spoke with told us they were happy with the quality of care. A relative told us they had no concerns about how the service was managed and were confident that any concerns raised would be addressed.

Satisfaction surveys were used to gather the views of people who used the service, their relatives and staff. These were sent out by the provider and results were analysed. We were sent a report of the findings which showed that people were satisfied with all aspects of the service provided. The registered provider told us that areas which did not meet the expectations of the provider would be included in the action plan in order for the operations manager and the care nurse manager to address. That showed the provider was acting on feedback about the service and used the information to influence the development of the service.

Prior to our inspection we contacted the local authority responsible for the service they commissioned on behalf of some people and asked for their views. They told us they had no concerns about the service and at the last quality monitoring visit found the service met the contractually agreed quality of care.