HC-One Limited

Pendleton Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Pendleton Court is a large converted house situated in an elevated position at the rear of a residential estate. Accommodation is across two floors. Bedrooms are for single occupancy and have en-suite facilities. The home has three units including general nursing, residential and dementia. A passenger lift provides access to each floor. The home is within walking distance of a local park and shops. It is also close to the local bus routes into Manchester city centre and Salford/Eccles and is close to the motorway network.

This unannounced focused inspection took place on Thursday 05 January 2017. Our last full comprehensive inspection at Pendleton Court was in September 2016 where the home was rated as 'Good' in each of the five key questions against which we inspected. These included Safe, Effective, Caring, Responsive and Well-led. This full comprehensive report from this inspection can be found on our website at www.cqc.org.uk/location/1-320530068 .

Following this inspection, we received information of concern relating to two areas; management of pressure sores and management of pain. This focused inspection was conducted to look at these two areas and this report is based around these findings only. As such, we have reported only on the 'Safe' and 'Well-led' key questions.

There had been a failure to send us a notification about the concerns relating to a grade four pressure sore in May 2016. We are following this up outside the inspection process. The registered manager told us they were aware that notifications of this nature should have been submitted. Since this time the home has consistently sent notifications to the CQC about all other incidents such as deaths, serious injuries and safeguarding incidents.

We looked at how the home cared for people who had, or were deemed to be at risk of developing pressure sores and found good systems were in place. People's skin was assessed on admission with any marks or areas of potential skin break down recorded on a body map. This would enable staff to monitor people's skin if there were concerns and take necessary action. The feedback from people living at the home who needed assistance to re-position, was that it was done well by staff.
We found 'waterlow' risk assessments were also undertaken for each person. This meant staff could respond accordingly if people were deemed to be at risk. Where people were deemed to be at risk, action for staff was recorded in the skin integrity care plans.

We looked at 13 skin integrity care plans during the inspection. This provided an overview of each person's skin and the care staff needed to provide to help keep people safe. There was also accompanying information for staff to refer to about how frequently people needed to be turned/re-positioned, any equipment to be used and what to do if they had concerns.

Where required, we saw people received adequate pressure relief during the day and at night with accurate records maintained by staff. This provided people with the pressure relief they needed if they were unable to

manoeuvre themselves in either their chair or when they were in bed. When people were re-positioned, staff also made a record of if their skin was intact.

Several people living at the home required the use of specialist equipment such as pressure relieving cushions and mattresses to help keep their skin safe. Where this requirement had been identified, we checked in bedrooms and lounge areas and saw this equipment had been provided for people. One pressure relieving mattress we checked was at the wrong setting and we immediately raised this with the manager who rectified this.

We found people received visits and that the home worked closely with services such as District Nurses. People's care records clearly detailed when District Nurses had visited and if creams were applied to people's skin or dressings were changed or applied.

We looked at how the home managed people's pain. We found each person's Medication Administration Record (MAR) detailed if they required any pain relief such as paracetamol, morphine or codeine. The staff were also able to give a good account of people who frequently asked for, or routinely asked for pain relief and that a time gap of four hours needed to be left in between each dose. People living at the home and their relatives told us they felt their pain was well managed. We observed staff giving pain relief when asked, with several people telling us staff offered pain relief at regular intervals rather than them having to make the request themselves.

Where people were administered pain relief, we found PRN (when required) protocols were in place. This provided staff with guidance for staff around when pain relief needed to be given, under what circumstances and what signs to look for if people were unable to communicate pain such as through facial expressions and body language.

Staff received training in relation to 'Promoting Healthy Skin'. The registered manager had also introduced themed supervision sessions in relation to people's skin where staff were asked about their knowledge and understanding and they had an opportunity to discuss any concerns.

The home also had quality assurance and governance arrangements in place with regards to pressure sores. The registered manager completed a monthly overview of pressure sores, the current waterlow score, when the sore developed, when it healed and how it was progressing. This fed into the homes internal quality assurance system known as 'Datix. and was monitored accordingly. This system would ensure the home could respond accordingly if there were concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The home had appropriate systems in place to care for people with, or at risk of developing pressure sores.

Feedback from people living at the home was that staff kept their skin safe and carried out tasks such as re-positioning as required.

People told us their pain was managed well by staff.

Is the service well-led?

Good

The service was well-led.

Despite the fact there had been a failure to send us a notification relating to a grade four pressure sore, the registered manager routinely sent other notifications to the CQC about deaths, serious injuries and safeguarding incidents.

The home had appropriate systems in place to monitor the service. This included audits of pressure sores and medication.

The registered manager had introduced themed staff supervision sessions in relation to pressure care management.

The home had relevant policies and procedures in place with regards to pain relief and pressure sores.

Pendleton Court 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 unannounced focused inspection took place on Thursday 05 January 2017. The inspection was undertaken by one adult social care inspector from the Care Quality Commission (CQC) and one specialist advisor (SPA). Our specialist advisor was a Tissue Viability Nurse (TVN) with particular expertise in the management of pressure sores.

At the time of the inspection there were 54 people living at the home. This consisted of 22 people living on the general nursing unit, 23 people living on the residential unit and nine people living on the dementia unit. During our inspection, we spoke with the registered manager, seven people who used the service, three visiting relatives', nine members of care staff (from both the day and night shift) and one visiting health care professional. The feedback we received was used to help inform our inspection judgements.

During the inspection we looked at the care plans for 13 people using the service and 14 Medication Administration Records (MAR). In addition we reviewed a range of records relating to how the service was managed. This included staff supervision records, training records, quality assurance documentation and policies and procedures.

Good

Is the service safe?

Our findings

Prior to our inspection we received some information of concern relating to management of pain relief and pressure sores. We carried out this focused inspection, looking specifically at these two areas to ensure people living at the home were safe.

We looked at how the home cared for people who had, or were deemed to be at risk of developing pressure sores. At the time of our inspection, there was one person living at Pendleton Court with a current pressure sore and we reviewed this persons records.

The people we spoke with told us they felt staff looked after their skin well. One person living at the home said to us; "The staff come in and re-position me every two hours or so. They do it quite well actually". Another person said; "It's very good here and they can't do enough for you. If I need to be re-positioned the staff always offer, but sometimes I can do it myself". A third person added; "I am turned at night time, but they have to do it and it doesn't disturb me".

Staff had a good understanding of people's skin and the types of care they needed to provide to help keep people safe. The staff also knew which people were at risk of potential skin break down and who had a high risk score on their assessment. One member of staff said; "There are several people on this unit who have red skin patches. We carry out positional changes and appropriate equipment is in place. If I had concerns I would contact the district nurses or seek advice from our nursing unit". Another member of staff said; "There is currently one person with skin break down and they are on two hourly turns and also on an air flow mattress. Other people are also re-positioned due to being at high risk on their waterlow assessment. I would consider making a referral to tissue viability nurses if the skin was broken or threatening to break. I would not wait any longer to report concerns".

The visiting relatives we spoke with told us they were satisfied with the level of care provided at the home. One relative told us; "I am obviously happy with the care here. Nothing needs changing here. I have been to a few places and this is one of the best. The staff really look after my wife very well". Another relative said; "I am happy with the care here and believe me I scrutinise everything. I looked all over for a decent care home before I chose here". Another relative commented; "Mum has not been in long. My first impressions are that the place is lovely. It's like a hotel. I have no worries at all about Mum being here".

People's skin was assessed on admission with any marks or areas of potential skin break down recorded on a body map by staff. In one person's care plan we looked at, a record had been made that it looked like a pressure sore was developing. Staff had responded to this quickly and sought additional advice from the district nursing team who came in and offered support and guidance. Photographs had been taken of wounds for one person with a pressure sore. This was good practice as photographs made assessing for wound improvement or deterioration easier than descriptions of wounds from care records.

We found 'waterlow' risk assessments were undertaken for each person. This is a document used to assess the risk of a person developing a pressure sore. This meant staff could respond accordingly if people were

deemed to be at risk. We saw an overall score was given for each person which identified if they were at low, medium, high or very high risk of developing pressure sores. Based on the overall score, control measures for staff to follow were then referred to in the corresponding skin integrity care plan.

We looked at the skin Integrity care plan for 13 people who lived at the home. This provided an overview of each person's skin and the care staff needed to provide to help keep people safe. There was also accompanying information about how frequently people needed to be turned/re-positioned and any equipment to be used such as a pressure relieving cushions or mattresses. There was also clear guidance for staff to follow about what action to take if they had concerns when observing people's skin. This included noticing redness, bruising, broken areas and friction marks. Details of any immediate actions were also recorded such as reviewing all equipment/frequency of re-positioning and making appropriate referrals to services such as the GP or district nursing team. The care plans we looked at were updated each month by staff. This meant staff had sufficient guidance available to them about how to keep people's skin safe.

Where required, we saw people received adequate pressure relief during the day and at night with accurate records maintained by staff. This provided people with the pressure relief they needed if they were unable to manoeuvre themselves in either their chair or when they were in bed. When people were re-positioned, staff also made a record of whether their skin was intact. Several people living at the home required the use of specialist equipment such as pressure relieving cushions and mattresses to help keep their skin safe. Where this requirement had been identified, we checked in bedrooms and lounge areas and saw this equipment had been provided for people and was being used.

The registered manager told us the home stocked three types of mattress. These included standard divan mattresses for people at no risk of pressure damage, high specification foam mattresses for people at risk and dynamic alternating air flow mattresses for patients considered to be at high risk. We were told there were no issues with the supply of mattresses for people who were deemed at high risk as they were purchased by the home themselves. This showed us the home were keeping appropriate mattress stock levels to be used as necessary.

During the inspection, we identified two pressure relieving mattress were set at the wrong setting. Whilst mattress settings are only an indicator of comfort, the correct setting should be used to ensure the mattress does not "bottom out", especially when people are in a sitting position on the mattress. We raised this immediately with the manager who rectified the settings and we found these people had not been placed at harm as result.

We found people received appropriate visits from healthcare professionals and the home worked closely with services such as District Nurses. People's care records clearly detailed when District Nurses had visited and if creams were applied to people's skin or their dressings were changed. The registered manager told us there are no issues with working with other members of the external (Multi-Disciplinary Teams (MDT) with regards to wound care. We were told referrals were made where there were concerns and that the home were able to specify how soon they wanted the service to attend. One visiting health care professional said to us; "I am in most days and I have no concerns. The staff are pretty good, in fact very good on pressure area checks. People get two hourly turns if they need it. The staff really seem to care about the residents".

We looked at how the home managed people's pain. We also spoke with people living at the home and asked them for their opinion of how their pain was managed. The people we spoke with told us staff routinely offered them pain relief throughout the day as opposed to them having to request it from staff. One person said; "I receive paracetamol for my pain. I feel it is managed quite well". Another person told us; "At times, I am in a lot of pain but the staff give me pain relief when I ask for it. It does improve and I feel it is

under control". Another person told us; "If I have pain the staff give me paracetamol. Sometimes the staff give me it without asking me if I have pain but mostly the staff ask first if I need it". A fourth person added; "I am never in pain. If I was the staff would help me I am sure". A visiting relative also commented; "My wife is never in pain or looks distressed. She has limited ability to communicate herself but always looks comfortable".

We also spoke with staff to determine their understanding of pain and how it was controlled. One member of staff said; "Some residents sometimes ask for pain killers. If appropriate, I would dispense what was prescribed and then evaluate if it had been effective". Another member of staff said; "People who cannot ask for pain relief here are observed. We use our observational skills and assess people for any signs of pain. We know the people here so we know when they are in pain or there is something wrong". Another member of staff told us; "There is nobody here who is in uncontrolled pain. If analgesia was not working we ask the GP to visit or get the out of hours Doctor in". A fourth member of staff added; "If people were agitated, unrelaxed and irritable that would give me concerns. I would contact the GP for advice or even ring the out of hours 111 service if needed". When we asked a fifth member of staff about pain management, we were told; "Signs of discomfort could be not passing urine or be constipated. If people can't point to where the pain is I would look for facial expression. If a person's pain wasn't improving, I would contact the GP".

We found each person's Medication Administration Record (MAR) detailed if they required any pain relief such as paracetamol, morphine or codeine. The staff were also able to give a good account of people who frequently asked for, or were routinely administered pain relief and that a time gap of four hours was needed in between doses. Where pain relief had been administered, this was clearly documented on the MAR chart. We found PRN (when required) protocols were in place. This provided staff with guidance around when pain relief needed to be given, under what circumstances and what signs to look for if people were unable to communicate pain such as through facial expressions and body language. The staff administering medication also maintained accurate records of when pain relief had been offered to people (up to four times a day), but not necessarily administered. This showed us staff were routinely offering pain relief medication to people throughout the day where needed.

The staff told us of one person who didn't tolerate oral medication. This was clearly recorded in the care plan and as a result, a (transdermal) pain relief patch was used to keep their pain under control. In another person's care plan we noted they had appeared more agitated than normal in the past. This person had communication difficulties although advised staff they were feeling 'Okay'. Staff indicated in the care plan that facial expressions and restlessness indicated they were in pain. As a result, staff administered morphine, re-assessed after a short time and noted this person was more settled. These examples demonstrated pain relief medication was given appropriately and that staff were aware of how to identify if people were in any discomfort.

Good

Is the service well-led?

Our findings

At the start of the inspection, we met with the registered manager and provided them with an overview of the reason for our inspection, the concerns that had been identified and the information we would need to review. The registered manager facilitated our requests throughout the day and listened to any feedback we had to offer. The manager displayed a good knowledge of people living at the home and knew which people had a pressure sore and which people were considered to be at high risk.

There had been a failure to send us a notification about the concerns relating to a grade four pressure sore in May 2016. We are following this up outside the inspection process. The registered manager told us they were aware that notifications of this nature should have been submitted. Since this time the home has consistently sent notifications to the CQC about all other incidents such as deaths, serious injuries and safeguarding incidents.

The home had quality assurance and governance arrangements in place with regards to pressure sores. The registered manager completed a monthly overview of pressure sores, the current waterlow score, when the sore developed, when it healed and how it was progressing. This fed into the homes internal quality assurance system known as 'Datix and was monitored accordingly. This system would ensure the home could respond accordingly if there were concerns. The registered manager also told us they audited six people's care plans each day. This was to ensure risk assessments and care plans were up to date, turns were being done and bed rail assessments were in place.

Staff received training in relation to 'Promoting Healthy Skin'. This would ensure staff had the correct skills and knowledge to look after people safely. The staff we spoke with told us they had completed this training, with one member of staff commenting that it was 'Very thorough'. The registered manager had also introduced focussed supervision sessions in relation to people's skin. We looked at a sample of these during the inspection and saw topics of discussion included positional changes for pressure relief, the importance of good fluid intake, completing appropriate documentation, reporting concerns, who to report concerns to and the potential impact of skin damage to people living at the home. Staff were also able to give their opinion about their current knowledge and were also given relevant exercises, tasks and research to complete before the next supervision session.

The home had a 'Pressure Ulcer Prevention and Wound Care Management' policy and procedure in place. This was last updated in July 2016. The policy and procedure covered areas such as re-positioning and equipment, management of current pressure sores, wound management, nutrition and tissue viability, training requirements, responsibilities and internal monitoring systems. The home also had a 'PRN Medicines' policy and procedure in place detailing how people's pain would be managed. This took into account that pain relief was not restricted to medications rounds and should be administered if a resident was displaying a select set of symptoms. These documents provided staff with guidance and information in relation to pressure care and pain management if they had any concerns.