

Bupa Care Homes (BNH) Limited

Pendean House Care Home

Inspection report

off Oaklands Lane
West Lavington
Midhurst
West Sussex
GU29 0ES

Date of inspection visit:
12 September 2017

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Ratings

Overall rating for this service

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We inspected Pendean House Care Home on the 12 September 2017 and the inspection was unannounced. Pendean House Care Home provides accommodation and nursing care for up to 40 older people. The home has 34 bedrooms, some of which could be used as double occupancy. The home offers long stay, palliative, respite and day services. At the time of our visit there were 29 people living at the home.

The service has a registered manager. 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 last inspection on the 26 and 31 May 2016, the service was rated Good overall and Requires Improvement in the 'well-led' domain. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. At this inspection we found the provider had followed their plan and they were now meeting the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. 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 Pendean House Care Home on our website at www.cqc.org.uk

Steps had been taken to drive improvement and the provider was now meeting the legal requirements. Wound care plans were now in place and diabetes care plans now included detailed information. However, further work was required to strengthen the provider's internal quality assurance framework. We have identified this as an area of practice that needs improvement.

There was a friendly, warm and homely atmosphere and a positive culture. People, staff, relatives and visiting healthcare professionals spoke highly of the registered manager. One healthcare professional told us, "I have the highest regard for the manager. She is always very professional, incredibly kind to families and patients. She will always offer the best service she can."

The values and ethos of Pendean House Care Home were embedded into everyday practice. People were at the forefront of the running of the home and people's views mattered. Staff understood the importance of delivering personalised care and people received care that met their needs and was personalised to them. One visiting healthcare professional told us, "The care here is good, the nurses are all committed."

People received care that promoted their wellbeing and was personalised to them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Pendean House Care Home was not consistently well-led.

The provider's internal quality assurance framework required strengthening. Wound care plans had not consistently been maintained. There was a lack of oversight of air mattresses within the home.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

People and staff were positive about the management and culture of the home.

Requires Improvement ●

Pendean House 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.

We undertook an unannounced focused inspection of Pendean House Care Home on 12 September 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our 26 and 31 May 2016 inspection had been made. Two inspectors inspected the service against one of the five domains we inspect: is the service well-led? This was because the service was previously not meeting some legal requirements. The provider had not completed a Provider Information Return (PIR), because we had not requested one before this focused inspection. This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before the inspection we reviewed all the information we held about the service; we looked at previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the registered manager, two visiting healthcare professionals, an administrator, four registered nurses, three care staff, an activity coordinator, two visiting relatives and six people who lived at the service. We looked at six care plans and the associated risk assessments and guidance. We looked at a range of other records including incident and accidents, audits and policies and procedures.

We last inspected this service on 26 and 31 May 2016. Breaches in the regulations were identified at this inspection and the service was rated as 'Good' overall.

Is the service well-led?

Our findings

There was a positive culture at the home that was supported by a registered manager who took steps to ensure this was inclusive and empowering for people who lived there. People, relatives and staff spoke highly of the registered manager. One visiting relative told us, "The manager is excellent. We have a very good relationship with her. The manager is very caring, compassionate and efficient. Always has time to listen and has a very good sense of humour. If she thinks we should know something she will ring." A staff member also told us, "The manager is approachable and friendly. I can ask her anything. She's been great."

At our last inspection in May 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because accurate and complete documentation had not been maintained. In addition, systems to monitor risks and ensure compliance with the regulations had not been effective in all areas. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by July 2016. At this inspection, we found improvements had been made and the provider was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. However, the provider's internal quality assurance framework required strengthening.

Guidance produced by the 'National Institute for Health and Care Excellence (NICE) advises on the importance of effective wound care management. At the last inspection in May 2016 we found that nursing staff had failed to maintain accurate records of the wound care support provided. For some wounds there was no wound care plan to set out the treatment required to heal the wound and manage any pain. At this inspection we found improvements had been made. Wound care plans were now in place for all wounds. However, when a wound had healed, documentation failed to reflect that. One person's wound care plan identified that they had sustained a skin tear to their hand. A dressing was applied on the 12 July 2017 and the date of reassessment was noted as 17 July 2017. However, documentation failed to reflect that the dressing was changed on the 17 July 2017 and no further information was recorded. A member of the nursing team told us that the wound had now healed but agreed that the documentation had not been updated to reflect that. Some people had wounds that required ongoing dressing. Documentation identified that most people's wound care plan had been updated when the dressing was changed; however, we identified one person who required their dressing to be changed every three days. Documentation reflected that the dressing was last changed on 2 September 2017 and the date of reassessment was 5 September 2017. No further documentation was in place to confirm that the dressing had been changed since the 2 September 2017. A member of the nursing team told us, "This person will often pull off their dressing up to three times a day, so we change the dressing up to three times a day. It has been changed since the 2 September 2017." The management of wounds was safe and people received care which enabled their wounds to heal, however, documentation did not always reflect when dressings were changed or when people's wounds had healed. Subsequent to the inspection, the provider informed us of the actions they had taken which included a new air mattress monitoring form.

A number of people received care and support on an air mattress (inflatable mattress which could protect people from the risk of pressure damage to their skin from prolonged immobility. It is important that the setting of the air mattress matches the person's weight, otherwise, it may increase the risk of a person

sustaining skin breakdown. At the last inspection in May 2016 audits of pressure relieving equipment had failed to identify that some equipment had 'bottomed out' (this is where it no longer provides effective support). At this inspection improvement had been made. For example, pressure relieving equipment had not bottomed out. However, nursing staff advised that the settings of people's air mattresses would be recorded within their skin integrity care plan and maintenance staff checked the air mattresses. However, we found that people's skin integrity care plans did not consistently record the setting of the air mattresses. For example, one person who had recently moved into Pendean House Care Home was receiving care and support on an air mattress which was set to 80kg. We asked a member of the nursing staff to check their weight and we were informed they weighted 53.3kg. This meant the air mattress was on the wrong setting. Another person's air mattress was set to 70kg when they weighted 50kg. No harm had occurred to people through receiving care on the incorrect air mattress settings and a number of people were receiving care on air mattresses set to the correct setting. We brought these concerns to the attention of the registered manager who confirmed that all air mattress settings would be reviewed.

Systems were in place to monitor risk and ensure compliance with the regulations. At the last inspection in May 2016, the provider's system to ensure compliance with the regulations was not effective in all areas. This was because care plan reviews had not always identified missing information. At this inspection, we found improvements had been made but the provider's internal system to monitor risk and compliance required strengthening. On a monthly basis, the provider visited the home and produced monthly reports. The monthly reports from August, June and May 2017 raised concerns about air mattress settings and recording of wound care documentation. These shortfalls had been identified internally but the improvements and actions had not yet been embedded or sustained. Although care plans were subject to a monthly review, we found a number of discrepancies within care plans. For example, a mental capacity assessment had been completed for one person regarding the decision about bed rails. The assessment of capacity recorded that the person was unable to retain the information but then stated the person had capacity. The principles of the Mental Capacity Act 2005 advise that if a person fails one of the four questions, they are deemed to lack capacity. However, this assessment reflected that they had capacity despite being unable to retain information. There was no further information to demonstrate why they felt the person had capacity when they were unable to retain information. Another's person's care plan identified that a mental capacity assessment was needed but we were unable to locate any. These shortfalls in documentation had no direct impact on the quality of care people received. However, the provider's monthly audits failed to identify this shortfall. We brought these concerns to the attention of the registered manager who was responsive to our concerns and agreed to review care plans.

Steps had been taken to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. However, certain areas of care were in need of improvement. The shortfalls in documentation had no direct impact on the level of care that people received. The registered manager was responsive to our concerns and the provider's quality assurance framework had identified a number of shortfalls, but the required improvements were not yet embedded or sustained. We have identified this as an area of practice that needs improvement.

At the last inspection in May 2016, the provider had made changes to how staff training was delivered by removing home-based trainers and providing courses centrally. When courses were completed, the provider's team was alerted so that records could be maintained centrally. The staff training matrix indicated that training was out of date for many of the staff. At this inspection we found the same system remained in place and the training matrix continued to reflect that staff's training was out of date. The registered manager told us, "Some training is now coming back to us to deliver home based here at Pendean such as fire training which will be good. However, it is frustrating that we can't maintain our own training matrix. For example, one staff member had completed the care certificate but according to the

training matrix they hadn't. Staff had also recently completed moving and transferring training but according to the training matrix this training was out of date." Staff had received the training and the registered manager had taken steps to inform the provider's central team, however, the provider had failed to update the training matrix. Failure to update the training matrix had no direct impact on the care that people received but we have identified this as an area of practice that needs improvement.

Care and support was provided to a number of people living with diabetes. People living with diabetes can have an increased risk of disability, pressure ulcer development and hospital re-admission. At the last inspection in May 2016 we found that some diabetes care plans lacked information compared to others. At this inspection, improvements had been made. Diabetes care plans were all robust and provided sufficient information on the steps required in the event of high or low blood sugar readings.

At the last inspection in May 2016, we found there was a lack of recording around the monitoring and management of pain. At this inspection, improvements had been made. The provider now utilised the abbey pain scale (tool for assessing pain for people who may be unable to verbalise if they are in any pain). A member of the nursing team told us, "We have the abbey pain scale in place, although at the moment, people are able to verbalise to us if they are experiencing pain but we have it in place ready."

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. The service's policies and operating procedures were appropriate for the type of service and were clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were kept securely and confidentially.

The culture and values of the provider and the service were embedded into every day care practice. Staff recognised and understood the importance of person-centred care and people living at Pendean House Care Home were at the fore-front of the home's care practices. The registered manager told us, "This is their home and we are continually thinking about how we can improve it for them." Observation of care demonstrated that people were treated with kindness, respect and it was clear that people received personalised care. One person was sitting in the lounge with a tie, shirt and jumper on. Staff members told us that it was important to this person that they dressed smartly. Another person was sitting in the lounge with their teddy which brought great comfort to them. They were also dressed smartly with their nails painted and jewellery on. People and their relatives told us that they were extremely happy with the care provided at Pendean House Care Home. One relative told us, "I couldn't wish for my mother to be in a better place. We spend a lot of time out of the country, and they will still ring my mobile. We trust them. They don't cry wolf." Visiting healthcare professionals spoke highly of the service. One visiting healthcare professional told us, "They have the skills and they are responsive. I've never been worried that they won't react to what I've asked. If they have given something for pain or sickness and it hasn't had desired effect, they will always ring us. They won't just leave it. We will often leave a plan in the notes and they will follow it. They deal with things. I have the highest regard for the manager. She is always very professional, incredibly kind to families and patients. She will always offer the best service she can."

People's views were at the forefront of the running of the home. 'Resident' meetings were held regularly which provided people with the opportunity to make any suggestions or raise any concerns. Minutes from recent resident meetings in August 2017 reflected that menus and activities were discussed. Where people had made suggestions, these had been acted on and implemented. For example, some people requested that roast lamb be added to the menu and the following Sunday, the menu reflected that Roast Lamb was an option. People had also requested cake stands for afternoon tea, which were now in place.

Links with the community had been established and the registered manager was committed to the on-going improvement of Pendean House Care Home. The registered manager told us, "We have links with Portsmouth University and recently we had three student nurses here as part of their placement. That was a wonderful experience. We will also be having placements for pre-paramedics students as part of their training and they will be focusing on nutrition during their placement here." As part of the home's ongoing improvement, the home was part of a pilot project being undertaken by BUPA. The registered manager told us, "We are one of eight care homes that are part of this project and the project is looking at staff's uniform, the implementation of waitresses alongside other ideas. It should really improve and heighten the quality of care that we are already providing."