Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Pentlands Nursing Home

42 Mill Road, Worthing, BN11 5DU

Tel: 01903247211

Date of Inspection: 26 September 2012

Date of Publication: November 2012

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	South Coast Nursing Homes Limited
Registered Manager	Mrs. Debbie Hathaway
Overview of the service	Pentlands Nursing Home is a care home with nursing services that provides accommodation and care for up to 32 older people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 26 September 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

We spoke with five people living in the home and one relative. People told us they experienced a good quality of care by staff who were respectful, professional and skilled. One relative said the home had "a very friendly team" employed there who "take a great interest in people." One person living in the home said of their care, "It's been great. The care is terrific . . I am so well looked after."

People told us that they are treated well and with respect. We were told that staff respect people's privacy by closing doors and curtains during care. A person living in the home said, "I'm treated with the greatest kindness and respect . . . I couldn't wish for better." Another person described staff members as "kind and friendly" and added, "they're very good to me."

People said that they had choice in how they spent their days and there were activities available for people. A person receiving respite care stated, "I'm treating it as a holiday . . . I'm having a good time!"

People said they felt safe living at the home and relatives stated that they felt their family members were safe there. One family member said, "I don't worry about about [my family member's] care." People said staff understood their needs and provided the support and care that was appropriate for them. People told us that staff were responsive when people asked for assistance. People told us they were supported with their medications.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People told us that their care was delivered in a way that protected their privacy and dignity. One person said, "I'm treated with the greatest kindness and respect." Another person commented, "the girls [staff members] are so nice." People told us that when personal care was given, staff closed people's doors and drew curtains to protect people's privacy. One relative said that staff expected everyone, including visitors, to respect people's privacy.

People told us they had choices in how they spent their days. One relative said their family member told staff when they wished to go to bed and this was accommodated. People told us there was ample choice in food and people were informed of menu choices ahead of time. Most people said they were happy with the food choices available. One person said they weren't always happy with the menu but they were able to get alternatives upon request.

Most people we spoke with preferred to spend their days in their room due to personal choice and physical limitations. We found that people had materials in their rooms that they enjoyed including newspapers, puzzles, and television. One person enjoyed watching television but was unable to use the remote to change the channels. They told us that staff regularly checked on them and offered to change the channels to find programmes they enjoyed. People told us that there were activities available in the home, but the people we spoke with said they were not interested in joining in. The deputy manager told us there was an activities coordinator employed at the home who planned and implemented group and 1:1 activities for people. People's care plans included a section on "social stimulation and activities." This section included information about people's preferred leisure activities and recorded people's participation in group and 1:1 activities.

People and their relatives told us that they were involved in care decisions but had confidence in the staff to meet people's needs. Relatives told us that they were informed promptly of any problems or concerns with their family member's care.

People said they could not recall being involved in any formal quality assurance measures (such as surveys or questionnaires), but most people said that staff asked people daily about their comfort, satisfaction, and needs. One family member said, "they [the staff] are all very accommodating." One person living in the home said that staff asked daily, "Are you alright? Is there anything you want?" This meant that people's opinions and comfort were monitored by staff, albeit informally.

We observed the care staff treating people with dignity and respect. Staff knocked on people's doors before entering. People's doors were closed when personal care was being given. Staff were polite, courteous and appropriate in their interactions with people. People were addressed by their preferred names.

We viewed several of the private rooms in the home. Many rooms were decorated with personal items including family photographs, cards and decorative items. We were told that people were encouraged to decorate their rooms in their own way. This demonstrated that people were encouraged to have choice and individuality in their environment.

The deputy manager explained how people and their families were included in on-going care planning and delivery. She said that from pre-admission, "we try to involve everyone to share input" although some families were more involved than others. People's care plans included an "agreement review form" which people and/or their relatives were encouraged to sign when the care plans were reviewed annually. We found that some people had signed the form and others had not. The deputy manager said that people and their families were encouraged to read people's care plans and sign, but not all relatives were available or interested in doing so.

The relatives we spoke with said that upon admission they were included in developing their family member's care plans, but now preferred to be consulted only where there was a problem or concern. Families stated they trusted the staff to deliver people's care appropriately. One person living in the home said that although staff talk to them about their care needs, staff "seem to do things automatically" and they had "no concerns" about this.

People's care plans also had a record of monthly reviews. These monthly reviews of peoples' needs took into account people's verbal and non-verbal communication of needs, patterns of behaviour, consultation with other professionals such as GPs, and any significant changes noted. These reviews ensured that even when people were unable to verbalise their needs, other methods were used to determine people's needs and overall well being.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We spoke with five people living in the home and a relative. They told us that staff discussed care needs with people and/or their families. One family member said, "[The manager] was wonderful. She gave us [the family] a lot of time in her office and we went over everything." One person living in the home said the staff talked to them about their care and said "the care is terrific."

Most people said they were involved in developing a care plan upon admission, but had confidence in the staff to continue to meet their needs. One person living in the home complimented the care they had been given and said "they [the staff] seem to do things automatically and I have no concerns." Relatives said that the staff were quick to notify them of any problems or concerns. One relative said, "I don't worry about [my relative's] care."

We viewed five care plans of people living in the home. Each person had a completed admission form with details about people's admission, reason for admission, and important contacts. There was a health assessment form which described people's medical history, vital signs, communication methods, skin integrity issues, height, and weight. These key documents were completed upon admission and served as a bench mark with which to judge the progress of people's health over time.

People's care plans were divided into specific areas of people's health and well being. This included: hygiene and grooming, mobility, deep venous thrombosis (DVT) risk, nutrition, continence, night time care plan, pain management, social stimulation/activities, communication, medication, and as needed (PRN) medication. To address more complex needs, some people also had care plans to address dementia care needs, diabetes, infection, and changes in behaviours. This meant that people's actual and potential needs were assessed in order for their care to be planned effectively.

We saw that people's mobility and manual handling assessments included information about what assistive equipment and pressure relieving devices people use. One person's mobility assessment specified the correct sling size and type to use for the over-head track hoist and that two members of staff were required to assist with hoisting.

The care plans were personalised, detailed, and gave clear guidance to staff of the

support people required. Care plans reflected people's individual preferences related to food, managing personal hygiene and both morning and evening routines. People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We found there was an agreement review form which people and/or their relatives were encouraged to sign when the care plans were reviewed annually. We found that some people had signed the form and others had not. The deputy manager said that people and their families were encouraged to read people's care plans and sign, but not all relatives were available or interested in doing so.

People's care plans assessed risk related to pressure sores, nutrition and hydration, use of bed rails, use of wheelchairs and other assistive equipment, self-medication, falls, and manual handling. These risk assessments were regularly reviewed and significant changes were documented. The risk assessments also provided guidance to staff for reducing risk and identifying significant changes. This meant that people's care and treatment was planned and delivered in a way that was intended to ensure safety and welfare.

People's care records included a record of professional visits including GPs, community health services, social services, and chiropodists. Consistent consultations with other professionals ensured better continuity in meeting people's health and care needs. It also meant that an interdisciplinary team could work together to prevent and alleviate people's health problems swiftly.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We spoke with five people living in the home and one relative. People told us they were supported to take medications and they were administered as prescribed.

We found that staff used a Medication Administration Record (MAR) form to record when medications were given to people. Staff administering medication wrote their initials on the date and time medications were given to ensure an audit trail. We found that the medications listed on people's MAR charts were colour coded to indicate the time of day they were supposed to be given (morning, mid-day, afternoon, evening). This colour coding corresponded to the packets of medications kept in the medication cabinets. This served as a visual reminder to staff to administer people's medications at the correct times. The completed MAR charts we viewed indicated this colour coding system was working effectively as people's medications were administered properly and at correct intervals. Appropriate arrangements were in place in relation to the recording of medicine.

We found there were two medication cabinets, one for each floor of the home. This separation ensured that people's medications were stored on the same floor where they resided, reducing the likelihood that medications would be administered to the wrong person. People's medications were also clearly labelled with their name and room number. The doors of people's rooms were labelled with their names, ensuring people were given the correct medication. We found that people's medication was stored in blister packs rather than in original containers. This made it clear when medication had been given and reduced the risk of people receiving an incorrect dosage. Medicines were prescribed and given to people appropriately.

Medicines were stored safely. We observed that medication cabinets were kept locked and secure when not in use by trained staff. All confidential documents related to people's medications were kept inside the locked cabinets or in people's care plans. We found that the nursing staff were generally responsible for medication administration and had the appropriate training to do so. However, the senior care staff also had medication administration training and said they were able to assist with medication where it was needed.

We found that the home had included PRN ("as needed") medication in people's care plans. People's PRN medication care plans included information about PRN medication

prescribed by the GP, when people required this medication, and how people communicated (verbally or non-verbally) their need for PRN medication. For example, some people required PRN pain medication. Some people were able to ask for medication verbally while others communicated non-verbally through facial expressions and hand gestures. These methods of communication were described clearly in people's care plans. This meant that staff were aware of signs and signals to indicate the need for PRN medication. We found that people's PRN medication care plans were also evaluated regularly to record how often PRN medication was given and whether these medications were still meeting people's needs.

We found that people receiving Warfarin to prevent blood clots were also given regular blood tests (INR) to ensure people's blood clotting was within normal range. Warfarin dosage and subsequent blood tests were recorded clearly in people's care plans and their MAR charts. This meant that people receiving this medication were monitored for the risks it could cause.

People's care plans included a record of professional visits, including visits from the GP. These visits or consultations included a discussion of people's medication and whether they were still meeting people's needs. Care plans documented where changes to medication were made based on people's changing needs. Where a medication change was needed, people's care plans were updated immediately and clearly. This meant that people's medication needs were planned, delivered, and monitored appropriately.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We spoke with five people living in the home and one relative. People told us that staff responded quickly to call bells or other requests for help. One person living at the home said that staff were quick to respond to call bells and said, "I don't feel I'm neglected." Another person said that staff came quickly, even at night. One relative said, "they always come very quickly." We observed a person using their call bell and a member of staff came immediately.
We spoke to a person who was unable to use their call bell due to physical limitations. They told us that staff checked them regularly to ensure they were comfortable and their needs were met. They added, "they [the staff] don't leave me too long, especially in the day." People said there were enough staff around to assist them safely and in a timely manner.

We spoke with four members of staff who said they felt there was enough staff at all times of the day to meet people's needs. Staff said that sickness and holiday were usually covered well and agency staff were rarely used.

At the time of our visit there were 29 people living in the home. Caring for people in the morning (8am - 2pm) were two trained nurses and 8 health care assistants. In the evening (2pm - 8pm) there was one trained nurse and five health care assistants. Overnight (8pm - 8am) there was one trained nurse and three health care assistants. The registered manager and deputy manager had nursing training and were also available during business hours.

Nursing and care staff were supported by kitchen staff (including a chef and kitchen assistant) and domestic/cleaning staff who cooked for and cleaned the home daily. This meant that care staff could focus their time and energy on care tasks during their shifts.

We found that most people living in the home had physical limitations which required assistance from two members of staff. As a result, most people also preferred to stay in their rooms during the day. Staffing levels meant that when people were receiving support, there were still sufficient numbers of staff available to respond to other people. Staffing levels indicated that there were sufficient numbers of staff to assist people who needed support from two members of staff at any time of day or night.

We observed staff walking through the corridors of the home, offering assistance to people

and checking on people's comfort. This meant that people who were unable to use the call bell were checked regularly by staff to ensure their safety and well-being. Members of staff were easily accessible and responded quickly to people's requests for help.

The members of staff we spoke with had worked at the home for nearly ten years or more and had an in-depth knowledge of the home's procedures and of the people who lived there. Some of the staff we spoke with came from a background in care or nursing and all had achieved their National Vocational Qualification (NVQ) level 3 in health and social care. We observed staff supporting people in a manner that showed they were skilled, knowledgeable and trained to care for people safely.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

We spoke with people who lived in the home, but their feedback did not relate directly to this standard. We relied on our observations and our discussions with the deputy manager and three members of staff to form our judgement.

We viewed five care plans. The care plans included detailed information about people's health and personal care needs, key contacts, nutritional assessments, risk assessments, a record of professional visits, and individual preferences. Care plans indicated where people's end-of-life care choices were made. The home maintained a daily record of care to monitor people's care needs and progress. Care plans were reviewed on a regular basis and the five care plans we viewed had been reviewed and updated in September 2012. People's health and care needs were appropriately assessed and routinely reviewed to ensure people received the right support. People's personal records including medical records were accurate and fit for purpose.

Care plans had a record of professional visits and consultations, including visits with the GP or District Nurse. These visits were held on a regular basis to ensure that individual health conditions were stable and that current medications were still appropriate.

We observed that the care plans were stored in a lockable office which was only accessible to staff. This ensured that records were kept securely and could be located promptly when needed.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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