Pressbeau Limited

Greathed Manor Nursing Home

Inspection report

Ford Manor Road
Dormansland
Surrey
RH7 6PA
Tel: 01342 836478
Website: www.pressbeau.co.uk

Date of inspection visit: 13 March 2015
Date of publication: 21/10/2015

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**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 & 22 December 2014. Breaches of legal requirements were found. A warning notice was sent to the provider notifying them that they are failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010).

We undertook this focused inspection on the 13 March 2015 to check that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection of Greathed Manor Nursing Home by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

Care plans did not reflect people's current needs or individualised choices. Three out of the six we looked at had been reviewed since our comprehensive inspection but we did not see evidence of consistent best practice. This put people at risk of inconsistent care or not receiving the care and support they need. Assessments of people were not sufficient to make sure the care is planned to meet a person's individual need.

Summary of findings

Poor pressure area prevention care put people at risk of developing pressure wounds.

Improvements had been made to the legal framework around the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff we spoke with did not always understand the requirements of the Act and how it affected their work on a day to day basis. The appointee manager had started to undertake the necessary MCA two stage assessment or applications to the local authority as required by the Deprivation of Liberty Safeguards (DoLs). This meant people without capacity were not consistently supported in agreeing to choices made about their care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were at risk of being deprived of their liberty without the appropriate safeguards being in place.

Risks to people's health and welfare posed by the care they received and the way the service was managed were not always minimised effectively.

Requires improvement

Is the service effective?
The service was not always effective.

Staff did not always understand their responsibilities under the Mental Capacity Act 2005.

Staff were not effectively monitoring people's healthcare needs, particularly when their needs changed.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's care needs had not always been reassessed to sufficiently guide staff on their current care.

Information gained to develop a plan of care to meet a person's needs was not always current.

Requires improvement

Greathed Manor Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Greathed manor Nursing Home on 13 March 2015. The inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection of 19 & 22 December 2014 had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service responsive. This is because the service was not meeting some legal requirements.

The inspection was undertaken by two inspectors. During the inspection we spoke with two people, three care staff and spoke with two healthcare staff (OT's), one relative and the appointee manager. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the different floors within the building and the main lounge and dining area.

We looked at a variety of documents which included six people's care plans, training programmes and other records in the home.

Requires improvement

Is the service safe?

Our findings

At our previous inspection we found breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Not all the practices we observed were managed safely.

We found during this inspection that there had been some improvements to safe practice made.

At our previous inspection in December 2014 four people had been identified as a risk of developing pressure ulcers we checked their pressure relieving equipment and found that all of the air flow mattresses were set to the highest level and that care plans did not reflect guidance issued by NICE in relation to management of pressure sores.

We checked pressure mattress settings and found they were set correctly according to the persons weight. However we checked the records people with pressure wounds and found that there were no up to date photos for wound mapping or corresponding body maps. We saw from the records that one persons care plan stated their dressing should be changed every three days however on two occasions the wounds had not been redressed for over five days. This meant that it the person was at risk of discomfort or further deterioration to wounds and skin integrity.

We noted that two other people had pressure wounds and records had not been updated weekly as described in their care plan. Staff did not have the correct information to reflect people's changing care needs to ensure that people were receiving care that is appropriate and safe.

Assessment of the risk of a person falling from bed not been undertaken consistently. We saw that all people with bed rails now had protective bumpers protecting the person from injuring themselves or from entrapment. Bedrails are used to reduce the risk of falls from beds. However not all people care plans had the appropriate assessment and risk assessment to confirm why the person needs these safety aids, those that had were not always up to date. One persons bed rail assessment t had not been reviewed since 30 December 2014 giving updated information on the potential risk to the person.

People were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The appointee manager had implemented strategies since our last inspection to reduce the risks to people. They said they were arranging a more appropriate wheelchair for the person. We confirmed this with the OT's due to waiting lists this could take up to 17 weeks. They said the home was doing the best they could in relation to their care and seating requirements.

Requires improvement

Is the service effective?

Our findings

At our previous inspection the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Where people did not have the mental capacity to consent the provider was not acting in accordance with legal requirements.

Staff had not received training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) . The appointee manager said that training was booked for the 18 March 2015 they confirmed this by showing us a copy of the booking email. Staff we spoke to did not always show a clear understanding of the MCA and staff had little practical knowledge of it. For example, staff did not know who was able to make decisions for people who lacked the mental capacity to make their own decisions. It was clear that they misunderstood 'mental capacity assessment'. We saw that one DoLS had been submitted for a person who did not lack capacity.

The home did not hold evidence for all people who lacked capacity of who was able to make decisions about their health and welfare i.e. a person that hold Lasting Power of attorney (LPA).

We found during this inspection that there had been some improvements to demonstrate some arrangements were in place for obtaining and acting in accordance with the consent of people as required by the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We saw that for one person who lacked capacity a best interest meeting had been held for the safe use of bedrails and a DoLS application subsequently submitted. Four further applications to DoLS had been submitted for the use of bedrails. However staff or the appointee manager was unable to explain if they felt the person was being deprived of their liberty or if the use of bed rails was the least restrictive option to protect the safety of the person.

Where people did not have the mental capacity to consent the provider was not acting in accordance with legal requirements. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Which corresponds to Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care planning did not meet the individual needs of the service users and ensure their welfare and safety.

People who use services should have safe and appropriate care, treatment and support because their individual needs are established from when they are referred or beginning to use the service. People's needs had not always been appropriately assessed before they moved to the home. One person had moved into Greathed Manor for respite care but their care needs had not been assessed for eight days after the person was admitted. A relative told us "I have not been asked for any input in X care plan.' We spoke to staff about their understanding of the persons care needs and one staff said "They have been here before; I remember what support is needed." This meant staff members may not have had the appropriate information so that consistent and personalised care could be provided.

One person's care plan showed moving and handling risk assessments had not been undertaken since 10/12/2014 and Waterlow assessment (A waterlow is an assessment that identifies the risk to the person of developing a pressure wound) since 13/1//2015. We identified that this person currently had pressure wounds. Another person's care plan had not been reviewed since January 2015. One care staff said "The care plans were all being reviewed or re-written, It is work in progress." Although there was evidence that care plans were being reviewed it was not consistent in practice.

Only one of the care files we looked at showed evidence the person had been involved in the planning of their care. The appointee manager said that they were in the process of arranging care reviews to include the person and any family member they wished to take part

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Three of the people's assessment information including information regarding people's communication, skin integrity, personal safety and mobility, mental state and cognition, breathing, eating and drinking, personal hygiene, pain and culture and social interests had been reviewed on a monthly basis.

The appointee manager said that; "Senior care staff now finish care work at 2.30pm and from then until 5.30pm focus on the paperwork."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3)(a)(b-h) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered manager had not ensured that care plans were appropriate, met people's needs or reflected people's preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. People who use services were not protected because the provider did not act in accordance with legal requirements relating to assessing capacity and consent.