Homerton University Hospital NHS Foundation Trust

Mary Seacole Nursing Home

Inspection report

39 Nuttall Street
Shoreditch
London
N1 5LZ

Tel: 02073013180
Website: www.homerton.nhs.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6, 7 and 24 April 2016. The first day of the inspection was unannounced and we informed the provider that we were returning on the second day. The third day of the inspection was an unannounced visit during a weekend.

Mary Seacole Nursing Home is a purpose built 50 bedded NHS care home with nursing, which provides accommodation for people who require permanent or respite nursing care. This includes care and support for people who are living with dementia. The premises are arranged over three floors, with the second floor used for administrative areas. The ground floor and first floor provide single occupancy bedrooms with ensuite facilities, communal dining rooms, lounge areas, adapted bathrooms, an activity room and two passenger lifts. There is a seven bedded transitional neurological rehabilitation unit for people who have had a neurological injury or have been diagnosed with a long term neurological condition, which offers dedicated areas for people to develop and improve upon their independent living skills, including a laundry room, a therapeutic exercise room and a kitchen. There are landscaped gardens and a terrace at the rear for use by people on all of the units and the premises is within short walking distance of local shops, cafés and other amenities. At the time of the inspection 45 people were using the service; 43 people were receiving permanent or respite nursing and two people were using the neurological rehabilitation unit.

There was a registered manager in post, who has managed the service for several years. 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 previous inspection in September 2015 we found three breaches of regulation and made one recommendation in relation to improvements the provider needed to implement. The breaches of regulation were in regards to the provider not ensuring that people were protected from the risks associated with receiving a medicine service not safely managed, not protecting people against the risks associated with receiving a service that did not have sufficient numbers of staff deployed at all times and not protecting people from the risks associated with staff not receiving appropriate supervision to enable them to carry out their duties. A recommendation was for the provider to seek good practice guidance for the use of mobile armchairs. Following the inspection the provider sent us an action plan which highlighted the action they would take in order to improve. At this inspection we found the provider had met the breaches of regulation and had taken action to implement the recommendation.

The provider had achieved improvements in relation to the management of medicines. However, we found that medicines were not being stored at an appropriate temperature in line with the manufacturers' guidance. This meant that people were at risk of receiving prescribed medicines that could have changed composition or deteriorated. We also found that although staff told us they visually assessed if people who were not able to verbally express their views were in pain, we did not find evidence of the use of structured

clinical assessment tools to support staff to make appropriate judgements about people's pain management.

There were sufficient staff on duty to provide people with care and support; however, staff were not always safely and effectively deployed. This placed people at risk as they were not able to locate staff at all times. Robust systems were in place to ensure that staff were safely recruited.

Assessments were in place to identify potential and actual risks that could harm people, restrict their independence and impact on their safety and wellbeing. Information about how to manage these risks was contained in people's care plans.

Staff were aware of how to protect people from the risk of abuse and were familiar with the provider's policy about how to raise concerns about the conduct of the service.

Suitable training and support was offered to staff to enable them to effectively meet people's needs. This included the recent introduction of one to one formal supervision and the introduction of training to meet the needs of people living with dementia.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is necessary to restrict their freedom in some way, to protect themselves or others. The provider demonstrated that mental capacity assessments had been carried out in accordance with MCA legislation and applications for DoLS authorisations were made when required.

People were provided with a balanced diet that met cultural and medical needs. They were assisted by staff to meet their nutritional needs, however some staff needed additional guidance about how to support people at mealtimes and provide a calm, pleasant environment.

Care plans demonstrated that people's health care needs were suitably identified and met. People were supported to access a wide range of health care professionals as required.

It was noted that although staff were aware of people's resuscitation status, concerns were expressed that some staff were not as computer literate as others and would benefit from the security of having a secondary system that recorded if people were subject to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).

We observed some positive interactions between people and staff, and received complimentary comments from people and their relatives about the kindness of some staff. However, we saw that some staff did not present a sensitive and compassionate manner.

People's privacy during personal care was promoted, however people's confidential files were not always stored safely.

The provider ensured that people and their representatives were supplied with useful information about how the service operated.

People's health, care and support needs were assessed and regularly reviewed. However, we found that the care plans did not demonstrate a person – centred approach that took into account people's relevant

history and personal interests.

Information was given about how to make a complaint and people were confident that their complaints would be dealt with professionally and sympathetically. The provider had clear systems for investigating complaints and where necessary, learning from complaints.

Relatives told us they were pleased with how the service was managed by the registered manager.

There were clear practices and systems in place to monitor the quality of the service, although ongoing auditing was required to make sure that staff followed guidance about their safe deployment within the premises.

The provider sought people's views about the quality of the service and how to make improvements.

We have made three recommendations to the provider. We have recommended that improvements are made to address the storage temperature for medicines and address the lack of clinical guidance for staff to assess people's pain. It is recommended that the provider implements a supplementary system to enable staff to quickly access DNACPR information and that the provider seeks guidance from a reputable source about how to put in place person centred care planning that reflects people's wishes and interests.

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 always safe.

Although improvements had been achieved in relation to the management of medicines, the medicines were not being stored at a safe temperature and appropriate clinical assessment tools were not being used to demonstrate safe pain management.

There were sufficient staff to provide people with care and support; however, staff were not consistently safely and effectively deployed. Staff were safely recruited.

Staff understood how to protect people from the risk of abuse.

Is the service effective?

Good

The service was effective.

Staff received suitable training and support to enable them to effectively meet people's needs. This included the recent introduction of one to one formal supervision.

Mental capacity assessments had been conducted in line with the Mental Capacity Act 2005 and staff were aware of their responsibilities.

People were provided with a nutritious diet and assisted to meet their nutritional needs, although some staff needed additional guidance about how to support people at mealtimes.

Health care needs were properly identified and addressed.

Is the service caring?

Requires Improvement

The service was not always caring.

Although positive observations were made of the conduct and kindness of some staff, other staff did not demonstrate a sensitive and compassionate approach.

People's privacy during personal care was promoted, however people's confidential files were not always stored safely.

People and their representatives were provided with helpful written information about the service to enable people to settle at the service for permanent and respite care

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's health, care and support needs were assessed and reviewed. However, we found that the care plans did not demonstrate a person –centred approach.

Complaints were welcomed and noted to be properly investigated.

Is the service well-led?

Good

The service was well-led.

Relatives told us the service was properly managed to meet people's needs.

There were good systems in place to monitor the quality of the service, although ongoing auditing was needed to ensure that staff adhered to guidance about their deployment within the premises.

The provider involved people and relatives in initiatives to improve the quality of the service.

Mary Seacole Nursing 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. The 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.

The inspection took place on 6, 7 and 24 April 2016, and was unannounced on the first and third days. Prior to the inspection we reviewed information we held about the service and spoke with representatives from the local authority safeguarding team and Healthwatch Hackney, to find out their views about the quality of the service. (Healthwatch Hackney is an independent consumer champion that gathers and represents views of the public in regards to health and social care).

The inspection team comprised an adult social care inspector, a pharmacist inspector, a specialist professional advisor and an inspection manager. The specialist professional advisor was a GP who worked outside of London. Throughout the three days we spoke with 10 people who used the service, eight relatives, eight care staff, six registered nurses, the rehabilitation unit service lead and the registered manager. We gave feedback at the end of the inspection to senior management staff from the provider.

During the inspection we checked the safety and suitability of the environment and looked at a variety of documents, which included nine care plans, two recruitment folders and staff records for training, development, appraisal and supervision. We also checked a range of records relating to the management of the service. Following this inspection we contacted health and social care professionals with knowledge and experience of the service and received two comments

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we checked the systems for the storage, administration and disposal of medicines within the units for permanent and respite nursing care but had not carried out any checks on the transitional neurological rehabilitation unit. We had noted that some aspects of the management of medicines were not as safe as they should have been.

At this inspection we found that medicines were stored securely, including controlled drugs (CD). There were records of daily room and fridge temperatures monitoring, however we noted that the room temperature was consistently above most medicine manufacturers' storage recommendations. This meant that some medicines were potentially at risk of changing their composition or deteriorating due to unsafe storage conditions. The provider informed us that they were aware of this concern and were looking at systems to address this. We checked controlled drugs on the first floor units and balances were found to match that recorded in the CD register.

Medicine administration records (MAR) were clear and administrations were accurately recorded. Medicines were received on a four weekly basis from the local community pharmacy. Medicines that might be required urgently when the pharmacy was closed, for example palliative care medicines, were supplied by the Homerton University Hospital pharmacy. The provider was able to maintain accurate and up to date medicines records by implementing policies that allowed people referred from Homerton University Hospital to come with already transcribed MAR charts. For people being admitted for respite, their GPs were required to provide documented records of their medicines history.

Records showed that staff who administered medicines had received training and attended regular updates as part of their annual mandatory training. Monthly medicines management audits were carried out by staff who worked at the service in addition to the quarterly audits conducted by the medicines safety nursing lead from Homerton University Hospital

There was evidence that people receiving medicines that needed regular blood monitoring and dose changes were appropriately managed. Staff told us how they rotated the sites used for administering medicines supplied in patch form. Some medicines taken as needed or as required are known as 'PRN' medicines. Some people were prescribed PRN medicines for pain relief. However there was no administration or pain assessment tool for staff to follow when administering these medicines. Staff told us that they were able to carry out pain assessments for people who were not able to communicate by observing facial expressions or when the person cried out in pain. However we did not see any documented evidence that staff carried out regular pain assessments for people prescribed these medicines. This meant that people's pain may not be appropriately managed. Whilst checking people's own medicines in one person's room, the person informed us that they needed a pain killer. We informed the staff nurse who went to speak to the person. We observed that the nursing staff ensured that the CD preparation was double-checked by another staff, correctly completed the controlled drugs register and promptly administered the medicine in a caring manner to the person.

At the time of the inspection, no person in the units for permanent and respite nursing care was self-administrating their own medicines and none were receiving their medicines covertly. We confirmed that the service had the right policies and procedure to follow should they have people requiring covert administration or people who wish to manage their own medicines. Staff told us that people's medicines were reviewed as part of the six monthly multidisciplinary team meeting (MDT), and we saw documented evidence of these meetings.

We recommend the provider seek good practice guidance about how to ensure that medicines are stored at the correct temperatures and the use of pain assessment tools for people who are unable to verbally communicate about their pain.

At the previous inspection we had received mixed views about the staffing levels, with some relatives and staff stating that there were not always enough staff around to meet people's needs, and staff were overstretched. We had observed that no staff were visible on the ground floor nursing unit when three members of staff were needed in a person's bedroom to change their dressing. At this inspection people who used the service and relatives commented, "They are short staffed at times but not very often", "Staffing levels are quite consistent and in between satisfactory and good", "Visibility is a problem. There are times you don't see staff and you can't find someone" and "[My family member] is here for a short respite stay. The staffing levels have seemed fine yesterday (Saturday) and today."

At this inspection the registered manager informed us the provider had now completed a benchmarking exercise in relation to the staffing levels, which had involved looking at expected staffing ratios for similar care homes with nursing. We advised the registered manager that Mary Seacole Nursing Home was unique in terms of the building layout and the needs of people who used the service, hence any information gathered from the benchmarking exercise needed to take these factors into account when considering the number and skill mix of staff required and how to safely deploy staff. The registered manager told us the provider had not increased numbers of staff but had reassessed the deployment of staff to ensure people's needs were met.

One person told us they were unable to use the call bell and said that staff came and checked on them throughout the day, so they felt confident they would be able to get assistance as required. We observed staff going to check on people in their rooms at various points during the day and call bells were being answered in a reasonable amount of time. A registered nurse on the ground floor told us that staff predominantly worked long days from 8am to 8.30pm and said that there was always a qualified nurse and three care staff scheduled to work on the ground floor nursing care units, and always two staff deployed on each side of the ground floor as these were separate areas in terms of the physical layout of the premises. However, we found that staff did not always follow this direction and on two occasions during an afternoon there were no staff available in one section of the ground floor, which meant staff would have been unaware if people needed assistance. The registered nurse confirmed that staff were deployed from the rehabilitation unit or other nursing units to help at busy times if needed.

We discussed our findings with the registered manager who told us that he would remind the staff team of the need to comply with the provider's procedures in relation to ensuring that at least one member of staff was visibly available at all times.

We checked staffing levels on a Sunday afternoon shift, as we had received prior information to suggest that the service appeared short staffed at weekends. We observed that there were sufficient staff on duty to respond to people, and comments from people and their relatives indicated they were satisfied with their care and the staffing levels. The number of staff on duty was in accordance with the staffing rota and the

staff recorded on the night-time rota were observed to arrive at 8pm for the night shift.

At the previous inspection we checked the recruitment records for five staff members and found safe practices to protect people who used the service. The minutes of the 'Friends of Mary Seacole Nursing Home' showed that people's relatives and friends had been invited to contribute questions for staff recruitment interviews and the registered manager confirmed that a question devised by a relative was used to ascertain how candidates demonstrated caring values. At this inspection we looked at the staff recruitment files for two care staff who had been employed since the previous inspection. There was evidence of the required recruitment checks and we saw references, proof of identity and any gaps in employment had been explored to ensure staff were suitable to work with people using the service. We were provided with evidence to demonstrate that Disclosure and Barring Service (DBS) checks had been completed before a prospective employee was allowed to start employment at the service. (The Disclosure and Barring Service provides criminal record checks and barring function to help employers make safer recruitment decisions). There were systems in place for the provider to check if any staff were related or connected to each other, to ensure that the service operated in an open and transparent manner.

At the previous inspection we observed the transfer of three people from the dining room to the lounge whilst seated in their mobile armchairs. The armchairs appeared to be difficult to manoeuvre, their width made it a tight fit to get through the lounge door and there appeared to be a potential risk of people getting their arms or legs caught whilst being pushed. However, no injury or incident was actually witnessed and our review of accidents and incidents in the past six months confirmed there had not been any accidents related to these armchairs. We had discussed our observation with the registered manager, who told us that occupational therapists had been consulted about the use of and safety of the armchairs, although this was not recorded in people's care plan or risk assessment. We recommended the provider seek good practice guidance about the safe use of these mobile armchairs. At this inspection we noted that although individual risk assessments had not been carried out for the people who used these armchairs, the registered manager had organised for a relevant professional to visit the service to speak with staff about the safe use of the chairs.

The care records viewed during this inspection contained individual risk assessments in relation to pressure areas, nutrition, the prevention of falls and for the use of bed safety rails. The risk assessments we looked at were focussed on practical safety; however no risk assessments were seen in relation to people's needs due to their behaviour or vulnerability. The actual risk assessments did not contain details about how staff were to manage the risks but this information was included in people's care plans.

People told us they felt safe and protected from harm. We spoke with two members of staff about their responsibilities in relation to safeguarding. Although they were clear about their responsibilities they were unsure about who they could contact outside of the service if they wished to report any concerns. Both staff told us they had been given this information by the provider but could not recall it. Records showed that staff had received safeguarding training and the provider's whistleblowing policy advised employees how to report any concerns, including guidance about how to seek independent advice and how to contact relevant external organisations. (Whistleblowing is the term used when a worker passes on information concerning wrongdoings).

On the ground floor it was noted that the laundry door was tied open. When we entered the room it was noted that there a significant number of bottles of cleaning fluids in the room, which were inappropriately accessible to people who used the service. We informed the registered manager who attended to this and shut the door immediately.

Good

Is the service effective?

Our findings

At the previous inspection the registered manager told us the service did not have a system in place for one to one formal supervision of staff. Records showed that staff attended monthly meetings, which were used as an opportunity to have general discussions about training and development, and update staff about new policies and procedures. The registered manager had told us that the plan was to commence one to one supervision sessions.

At this inspection staff told us that they had started receiving formal supervision sessions and one staff member said they had had an appraisal in the last six months which asked about their strengths, areas for development and any issues they wished to discuss. Staff told us they felt supported and one employee said, "We're just happy when we come to work." The registered manager told us that there was ongoing work around providing staff with formal supervision but stated that he had started to use a document, and meetings had been held with staff since the last inspection. The records of supervision meetings that we looked at confirmed this and we saw a schedule of planned supervision meetings. The records showed that a wide range of competencies were discussed during supervision, such as training, medicines, nursing duties, safeguarding and Deprivation of Liberty Safeguards (DoLS). There was also evidence of reflective learning, for example, we saw learning after a staff member reflected on a medicines error that had occurred. The registered manager supervised the qualified nurses, whilst the senior staff nurses supervised care staff. The registered manager informed us that all staff would receive supervision once every three months, as well as a six monthly and end of year appraisal. This showed that formal systems were in place to provide staff with the support and guidance they needed to safely undertake their duties, identify their learning needs and develop their knowledge and skills.

We noted that staff were reminded about refreshing their mandatory training at a recent staff meeting. This included infection control, cardio pulmonary resuscitation, fire safety, moving and handling, equality and diversity, human rights, health and safety, and safeguarding vulnerable adults. Records demonstrated that staff were mostly up to date and staff had been reminded if there were any gaps in their refresher training. During this inspection staff attended dementia training which was part of a plan for 12 staff to become dementia champions. There was also planned training for care workers that included communication skills, end of life care and how to assist people with their meals. The registered manager told us that each training session was to be offered to 16 staff and then rolled out quarterly.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working in accordance with the principles of the MCA, and found that the provider was meeting the requirements of the MCA. Staff had been provided with training in regards to

understanding the MCA and they described to us how they supported people to make daily decisions and choices, wherever possible. We saw that capacity assessments were completed and retained in people's care files.
The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager was aware of his responsibilities in making an application to the supervisory body (local authority) if a person assessed as lacking mental capacity was potentially being deprived of their liberty. We noted that the provider ensured that the conditions of authorisation were appropriately adhered to for DoLS authorisations that were in place.

People and their relatives told us they were generally satisfied with the quality of the food service. Comments from people included, "The food has improved, there's more variety" and "I always have rice and curry because that's what I want." One person said, "I'm on a special diet, it's all mashed so I don't always know what it is, they don't tell me" and another person described their lunch as "a lovely bit of roast beef." The registered manager told us he had increased the number of visits made to the units by the catering staff so that people could give their feedback and make requests.

Our observations regarding how people were supported with their food and beverages showed that there were some positive ideas in place. We observed that drinks were offered throughout the day and not just at set times, and people were given a choice of hot and cold beverages. We noted at lunchtime that staff asked people if they wanted soup before their main meal and offered people a choice of roast or mash potatoes. People were given a choice of drinks and offered more if they finished. We saw that people were supported to eat in their bedrooms in accordance with their wishes and/or needs.

However, we saw that staff placed paper towels on trays and then served people their food on the trays rather than placing plates directly on the table which would have been more pleasant for people. One member of staff who was assisting a person with their meal was standing over the person whilst supporting them and was then observed to leave the plate on a chair in the lounge as the food was too hot. The staff member left the room without telling the person what they were doing. All other observations during the inspection showed that people were not left with food in front of them and staff assisted people in a patient manner. Staff were talking quite loudly amongst themselves during lunch on one of the units which affected the atmosphere and did not create a relaxed ambience for people who used the service. Also, a member of staff kept getting a person's name wrong but did apologise for this afterwards. Therefore, some of our observations indicated that people were not consistently assisted in accordance with the provider's standards for care and support at mealtimes.

Care plans contained information about people's health care needs, including evidence to demonstrate that people's weight was monitored at least once a month. The care plans we viewed showed that people's weight appeared to remain stable and within clinically acceptable boundaries. Care plans contained information about appointments with health care professionals and this appeared to be managed well, for example appointments and their outcomes were recorded. One care plan showed that staff had noted changes in a person's health and promptly made an appointment for their GP to see them and another care plan contained evidence of good wound care and monitoring, with up to date records kept of dressing changes and the condition of the person's skin. Care plans demonstrated that people were also receiving dental and eye care, and were referred to audiologists, dietitians and speech and language therapists, in line with changes to their health and wellbeing observed by the staff and visiting doctors. One external health care professional told us that staff did not always work in a clear multi-disciplinary way.

The registered manager informed us they were using a paperless system for documenting if people were not

for attempted cardiopulmonary resuscitation. The information was now computerised, in line with the practice at the Homerton University Hospital. We were informed that staff was aware of people's individual status and this information was also known to the London Ambulance Service, who had access to these records in their vehicles. We observed during a handover between day and night staff that clear information was communicated so that people received the right care in the event of an emergency. However, a member of staff told us that not all staff were sufficiently computer literate to access to access Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) information quickly.

We recommend that the provider implements a supplementary system to enable staff to quickly access DNACPR information.

Requires Improvement

Is the service caring?

Our findings

People commented, "They've done marvellous for me" ,"All been very kind" and "They're polite, they're friendly". People appeared comfortable with staff. During lunch we observed a member of staff reassuring a person who was anxious about their relative visiting. One person was supported by staff to listen to radio stations from their home country. This person was very keen to tell us about their hobby and the happiness they derived from it. The registered manager told us that one person did not speak English. Although none of the current staff team spoke this person's language, the registered manager reported that interpreters were booked for meetings to support the person to understand and contribute their views. This person also had a visitor from their place of worship.

However, we found that staff were not always caring in their approach. When we spoke with one person, they told us that their only complaint was that they could not wash their hands in their ensuite bathroom. We asked why and the person showed us their ensuite. We noted that two wheelchairs that did not belong to the person were stored in their ensuite blocking the sink so the person was unable to wash their hands. Staff could not tell us why these items were stored in this person's room but said they would arrange to have them removed. We observed one member of staff trying to wake a person in a communal lounge and asked them to sing for the people in the room. The person was obviously unhappy at being disturbed and pushed the member of staff's hands away but the staff member persisted and was quite loud. The staff member eventually did leave the person to continue sleeping.

We overheard another member of staff say, "Their families just dash them here and leave them" in front of people using the service in the lounge and then repeated this again a few minutes later. This comment was not sensitive to people's needs and circumstances. We noted there were four care staff in the lounge when several people were in their bedrooms and might have welcomed some engagement with staff. During lunch we observed that a member of staff told a person to say "please" when they asked for something which was inappropriate as this approach treated the person like a child. Another staff member responded to a person who voiced that they felt confused about what they were doing by stating, "You just need to eat your lunch, that's what you need to do" rather than offer guidance and support in a sympathetic and reassuring way that took into account the difficulties faced by people living with dementia.

People and their representatives were provided with an information booklet, which provided useful information about living at the service permanently or staying for short respite periods. This included information about how to access hairdressing and chaplaincy services. We were informed by staff that the service had links with different religious representatives such as imams and priests, who could be contacted to provide people with spiritual support in accordance with people's wishes. One person told us they were visited by volunteers from the local Roman Catholic church, which was important for the person as they used to be an active parishioner at the church.

The information guide also gave information about how to make a complaint with accompanying timescales for when to expect a response. People were provided with contact details for the Patient Advice and Liaison Service (PALS), which offers confidential advice, support and information on health related

matters and can assist people resolve concerns related to their use of an NHS service.

The provider used a discreet signage system (a picture of a flower) to remind staff and professional visitors that a person was living with dementia and needed an individualised approach that was tailored to their needs. At the previous inspection the registered manager told us that the service was now receiving more referrals to provide permanent and respite care for people with dementia, which had not previously been the case. We were shown evidence of how the service was working with the provider's Lead Nurse for Dementia in order to develop compassionate services for people with dementia, which included staff training, and plans to create reminiscence focused bedrooms and other spaces. The proposed additional staff training was noted to be in progress and the registered manager told us that the provider had recruited an activities co-ordinator with knowledge and experience of providing Namaste care. (This is a programme designed to improve the quality of life for people with advanced dementia, which provides a range of meaningful activities that bring pleasure to people with advanced dementia or people with other physical and mental health needs). We noted that posters were displayed in the premises to inform visitors about a local support group for the relatives and friends pf people living with dementia.

We observed that staff knocked on people's bedroom doors before entering and closed doors when they were providing people with personal care. The provider's Dignity Policy explained how dignity and diversity was incorporated into every day care practices, for example people were offered personal care from staff of their own gender if they wished. This was confirmed by people and their relatives. One person commented, "I used to think that I only wanted female nurses and carers but the male nurses were so good in the hospital and they are here, it is fine." However we observed that people's confidential information was not always stored securely, which placed people and their relatives where applicable, at risk of having their privacy infringed. For example, we found three people's care records left on an armchair in a communal lounge with no staff present in the room.

The registered manager informed us that people accessed a range of support and guidance from palliative care professionals within the NHS Trust, to ensure that people experienced a dignified and comfortable death. Prior to the inspection we spoke with a relative who expressed concerns about how the service supported their family member at the end of their life. We were not able to speak with other relatives that could comment on their experiences but noted that the provider had received written comments from relatives that were complimentary about the quality of the end of life care.

At the previous inspection we noted that the provider had set up a memorial book for people who used the service and their representatives to record their condolences following a person's death. The registered manager had told us that this had been originally suggested by family members that attended the Friends of Mary Seacole Nursing Home group. At this inspection we noted that some people who possibly wished to express their condolences perhaps needed additional staff support to do so, as the book was not yet being properly utilised.

Requires Improvement

Is the service responsive?

Our findings

We visited the Transitional Neurological Rehabilitation Unit on the first day of the inspection and met both people using the service. People told us they were pleased with their care and support, and felt they had made good progress with their rehabilitation goals. The unit lead informed us that there had been a hiatus in admissions while waiting a funding decision for the unit, and confirmed that the local Clinical Commissioning Group had now approved funding for the unit for a further two years. Admission requests had come in since the funding decision and the provider expected the unit to be at full capacity within the next few weeks.

The unit provided people with single bedrooms. One bedroom had an ensuite bathroom and the other bedrooms provided shared bathroom and toilet facilities. Facilities within the unit had been designed to support people to reach their rehabilitation goals, for example there was a kitchen for people to prepare their own drinks, snacks and meals, and people were supported to manage their own personal laundry needs within the unit's own laundry room. There was a therapy room for sessions with physiotherapists, occupational therapists and rehabilitation workers, and a lounge for socialising and relaxing.

We looked at the care records for both people using the service, which showed that people's needs were assessed at the Homerton University Hospital before they moved over to the unit. Each person had recorded outcome measures in line with national standards for this level of neurological rehabilitation. We noted that discharge planning formed a key part of the care planning process. This took into account that people's stay on the unit was short-term and it was important to work with people and their representatives where applicable, to enable people to either return home or move to suitable accommodation in the community such as a supported living service.

Care plans were well structured and comprehensive, with clearly defined goals and information about how to support people to meet their goals. The care plans used photographs to illustrate the use of braces and splints, as well as how staff should position people in bed. The weekly schedule of physiotherapy sessions and other activities were clearly communicated to people by the use of pictograms.

On the third day of the inspection we returned to the unit and noted that three people were receiving a rehabilitation service. The staffing levels were satisfactory and people told us they were enjoying a pleasant weekend, which included a film night with popcorn served. One person had gone out shopping with a staff member to a local market and people had cooked a traditional British breakfast that morning. One person told us, "They are nice people, everyone is nice and they help me. It's a good place."

We spent time on the ground floor and first floor units for people who needed nursing care on each day of the inspection. We looked at a range of care files including the care plans for three people with complex health care needs. We found that people's needs were appropriately assessed and there were individualised care plans for people's needs, which included elimination, personal hygiene, mobility and maintaining a safe environment. The care plans contained clear instructions about how to meet people's needs and were kept under review. For example, one person's care plan had been reviewed by a dietitian and a tissue

viability nurse, which was appropriate for their medical needs. The person's friend told us "he/she is so much better" since moving to the service and the person told us that they "can't ask for more" in relation to the quality of their care. Another person told us, "Everyone's been attentive with my needs, you know." Other comments from people included, "You are looked after" and "The food is good and it is clean here. I am quite happy, people are nice. I go downstairs for the activities."

We also looked at the care file for a person with diabetes. We noted that their care plan contained relevant assessments and care plans to identify and address their needs, which took into account how their condition impacted on various activities of daily living. The care plan documentation showed that the person's health and wellbeing were closely monitored, and appropriate actions were carried out on a daily basis to support the person with their fluctuating blood sugar levels.

We found that the care plans contained some information that showed inclusion such as comments like '[Person] like to be at Mary Seacole Nursing Home for a break', however care plans were very task led and there was little mention of people's preferences and likes and dislikes in order to meet people's individual needs. The provider used a pack called 'Getting To Know Me" which was designed to house biographical information to support care planning, particularly where people had dementia and were not able to inform staff about their earlier life, former occupation and social interests. At the previous inspection we had looked in a care plan for a person living with dementia and found the "Getting To Know Me" pack was empty. There was no other information recorded in the care plan in regards to how the person liked to spend their time or how their social needs were met. We had looked in the care plans of two more people and they both had blank "Getting To Know Me" packs. At this inspection we found some completed packs, including one that contained detailed information. The registered manager told us that the new activities organiser planned to review the social information held about people and where possible, liaise with people's relatives and friends in order to gather a more comprehensive level of useful information.

We recommend that the provider seeks guidance from a reputable source about how to implement person centred care planning that reflects people's wishes and interests.

At the previous inspection we noted that we saw limited evidence of activities. At this inspection the registered manager acknowledged that scheduled activities had remained limited as it had taken the provider a while to find a suitable new activities organiser. The provider had recruited an activities organiser, who was due to commence their position soon after the inspection. During the inspection we observed that some people went to the activities room on the ground floor for an arts session. On one of the units we observed that staff engaged people in conversation and included people when speaking to each other. We saw a lively game of dominoes take place but only two people were involved, the rest of the people sitting in the lounge were not engaged in meaningful activity when not talking to staff. Photographs on display in the premises evidenced that the provider organised some entertainments and seasonal events including a Halloween party, Christmas celebrations, a summer barbecue in the garden and visits from singers and musicians.

People and relatives told us they knew how to make a complaint and thought the registered manager would take complaints seriously. At the previous inspection we checked the management of complaints and found that although the registered manager was able to explain how all of the complaints had been processed, resolved and what learning had been identified, we were only able to track one out of 11 complaints received during 2014 and 2015. This had meant that an audit trail was not available in the absence of the registered manager. At this inspection we found that there was thorough written information to show how complaints were dealt with, in accordance with the provider's complaints policy and procedure.

Good

Is the service well-led?

Our findings

People told us that the service was properly managed. One relative said, "I have read about homes and watched documentaries. This is well run and highly recommended. They are pretty busy staff and might do with some more" and another relative told us, "There is a well organised system here. The regular staff are good and I can speak with [registered manager]. I will complain and [registered manager] has taken action. I have taken part in staff recruitment panels and other relatives have been invited." A third relative commented, "I have recommended the service to other people to use. [My family member] is always well looked after and the staff are very friendly."

The registered manager told us that he walked around the premises four times a day, particularly at mealtimes, to look at how people were being cared for and to check the deployment of staff. However, we noted that further monitoring was needed of staff as staff did not always remain where they were deployed or ensure that all areas of the home were staffed at all times.

At the previous inspection we found that the registered manager belonged to a group that carried out benchmarking visits to other care homes with nursing. At this inspection the registered manager confirmed that he continued to make these visits, with a current focus on services that cared for people living with dementia in order to develop new approaches for supporting people who used Mary Seacole Nursing Home.

At the previous inspection we noted that the service had received 'an enter and view' visit from Hackney Healthwatch and a visit by representatives from the local Clinical Commissioning Group (CCG), who spoke with people and their relatives about their experience of using the service. At this inspection we found that the service had received monitoring visits by the provider since the previous inspection. This included a 'rounding' visit carried out in January 2016 by the Trust's Chief Nurse and visits by two non-executive directors to speak with people, their visitors and staff. Records also demonstrated that quarterly unannounced visits to audit the management of controlled drugs and an unannounced in-depth audit of all medicines held at the service. This showed that there were clear systems for the provider to check on the quality of the service.

The provider sought the views of people using trust-wide quality assurance systems, such as questionnaires. Relatives confirmed that they had been given questionnaires to complete and one relative said that the registered manager had personally given them a copy of the most recent questionnaire to fill in. The registered manager invited the relatives and friends of people who used the service to attend the 'Friends of Mary Seacole Nursing Home' meetings in order to gain their views about the quality of the service and their support to achieve improvements. We noted that there were planned dates scheduled for future meetings in 2016.

We spoke with the provider about the system used for informing the Care Quality Commission (CQC) about significant occurrences at the service, such as safeguarding concerns and any incidents or events that impacted on the safe delivery of care. These are known as notifications and providers are required by law to promptly inform the CQC. We acknowledged that this information was shared by the provider through the

use of a reporting system used by NHS trusts, which involved information being sent to CQC on a weekly or fortnightly basis. However, this system meant that there could be delays with key information reaching the inspector for Mary Seacole Nursing Home, particularly in the event of a safeguarding notification which must be sent 'without delay'. The provider informed us that they would implement a system to inform us of any notifications that need to be promptly shared to ensure the safety of people who use the service.