South London Nursing Homes Limited

The Pines Nursing Home

Inspection report

104 West Hill
Putney
London
SW15 2UQ

Tel: 02088771951
Website: www.caringhomes.org

Date of inspection visit:
04 July 2017
10 July 2017

Date of publication:
20 September 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 and 10 July 2017 and was unannounced.

The first day of the inspection was unannounced, the provider knew we would be returning for a second day.

The Pines Nursing Home is a care home with nursing, providing support for up to 50 people. It is located in Putney, in the London Borough of Wandsworth. There were 34 people living in the home at the time of our inspection.

A comprehensive inspection was carried out on 17 and 23 December 2015 during which breaches of regulation were found in relation to safe care and treatment, consent and person centred care. We then carried out a focussed inspection on 15 November 2016 at which time the provider had met their action plan in response to the breaches found, however we did not improve the overall rating at this inspection as improvements needed to be sustained over a period of time.

There was a registered manager at the service. 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.

People and their relatives were satisfied with the service. They said they felt safe in the presence of care workers. They told us that care workers respected their choices and allowed them freedom and that privacy and dignity was respected. They gave us examples where care workers had demonstrated these qualities. They also said the food at the home was good and we found that people received appropriate support in this regard.

Records showed that the provider had involved family members, friends and health professionals in best interest meetings for people who had been assessed as not having the mental capacity to make certain decisions about their care and support. Where it was felt that people were being deprived of their liberty, the provider complied with the Deprivation of Liberty Safeguards (DoLS).

People received their medicines in a timely manner and staff completed Medicine Administration Record (MAR) charts appropriately. Regular audits also took place which helped to ensure medicines practice was safe. However, we saw that some bottles and creams were being used past their recommended shelf life from when they had been opened. Some people had their medicines crushed before taking them, we found that although authorisation from the GP were held in people's records, there was no evidence that the pharmacist had approved the crushing of medicines. This was highlighted to the registered manager who sought this authorisation immediately.

Standard risk assessments to monitor people at risk of malnutrition, falls and skin integrity were in place and reviewed regularly. If any areas indicated a high risk there was an associated care plan in place to manage the risk.

Each person was allocated a named nurse. The process of nursing care was clear and comprehensive and comprised of a thorough assessment, planning, implementation of care plan and monthly evaluation. Records showed involvement of people, their relatives and health care professionals. People's healthcare needs were met by the provider. Care records included people's medical histories and observations. Daily record charts documenting any visits from doctors, nurses, and any other professionals were maintained.

Care workers were familiar with safeguarding procedures and the steps they would take to protect people that were at risk of harm or abuse. They told us that they felt supported and praised the quality of the training they received. Records showed they received regular training and supervision.

We found that staff recruitment procedures were not always robust. Although staff files included completed application forms, references, proof of identity and address and criminal background checks, we saw some examples where gaps in employment history were not explored and some references were not verified. We have made a recommendation to the provider regarding the use of more robust recruitment procedures.

The provider had systems in place to monitor the quality of service. These included monthly reports from a regional manager, mealtime observations form the registered manager and audits such as infection control and medicines.

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 safe in all aspects.

Recruitment procedures were not always robust, some references were not verified. There were sufficient numbers of staff on each shift to meet people's needs.

People were supported to take their medicines in an appropriate manner. However, we saw that some creams and bottles were in use past their recommended use by date from when they had been opened.

People told us they felt safe living in the home. Care workers were familiar with safeguarding procedures.

Standard risk assessments were completed for people and care plans were in place where an area of high risk was identified. These were reviewed regularly.

Is the service effective?

Good

The service was effective.

Care workers completed an induction which was based on the Care Certificate. Staff were offered regular training opportunities.

People's consent was taken and their care plans developed with their agreement. Where people did not have the capacity to consent the provider worked in line with the Mental Capacity Act 2005 (MCA).

Care plans were in place to manage people's health support needs. Daily record charts documenting any visits from doctors, nurses, any professionals were maintained.

Is the service caring?

Good

The service was caring.

People said that care workers were friendly and respected their privacy.

People had their personal care needs met in a timely manner and care workers updated records appropriately.

Is the service responsive?

Good

The service was responsive.

Records showed involvement of people, the relatives and health care professionals. Each person was allocated a named nurse.

Each care plan had an identified need, a plan of action to manage the need and the steps that staff needed to take to support the person.

Complaints were responded to in a timely manner. Investigation reports and email trails were retained as evidence of investigations.

Is the service well-led?

Good

The service was well-led.

The feedback from people and staff was that the service was good.

Staff told us they felt supported and the registered manager was a positive influence.

A number of quality assurance checks such as meal time observations, monthly regional manager reports and infection control audits took place on a regular basis.

The Pines 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. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook this comprehensive inspection on 4 and 10 July 2017.

The inspection was carried out by one inspector, a specialist advisor who was a registered nurse and an Expert by Experience with experience of older people services on the first day and one inspector on the second day.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection we spoke with six people using the service, three relatives and one friend of a person using the service. We spoke with four staff, the registered manager and the training coordinator. We looked at seven care records, medicine administration record (MAR) charts, staff records, training records, complaints and audits related to the management of the service. We also observed a medicines round.

Requires Improvement

Is the service safe?

Our findings

Staff told us when they applied for their post they were interviewed, had to submit two references and also had police checks. Nurses had valid registrations with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK.

We reviewed some staff files for evidence of recruitment checks. Staff files contained people's application forms and their CV's along with their contracts and evidence of identity and right to work in the UK. They also contained Disclosure Barring Service (DBS) checks. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

We found there was some inconsistency with the recruitment checks. In one file, there were two references but one reference did not give a start or end date. In another file, one reference did not have a company stamp on it and it came from a personal rather than a company email.

We raised these discrepancies with the manager at the time of the inspection.

We recommend the provider seeks advice from a reputable source about robust recruitment checks.

We found there were no opening dates on two medicine bottles. This issue had been identified in a pharmacist audit in January 2017. On two bottles the medicines were still in use after the recommended use by dates of opening. This did not have a major impact as it was given on a PRN basis ('when necessary' from the Latin "pro re nata") and the person did not need it frequently. We highlighted this to the nurses during the inspection who took immediate action and disposed of the medicine and ordered new ones.

PRN protocols were completed appropriately for people, identifying the person, the doses and frequency over 24 hours, and the reasons for administration. However, we found that staff were not familiar with the pain assessment tool and its use. The pain assessment tool was not always used appropriately and effectively. One record showed that the pain was '0' when PRN analgesia was administered. We raised this with the registered manager during the inspection who emailed us confirmation after the inspection that pain management training had been arranged for staff.

People were supported to have their medicines as prescribed. Each medicine profile had a recent photograph of the person to help identify people. A staff nurse was available on each shift to ensure people had their medicines at the times they required them and the right dose. We observed people receiving their medicine on time at lunch. During the medicine round the nurse wore a 'Do not disturb' tabard in order to avoid distraction, and thus potentially avoiding any medicine errors. People's medicine administration record (MAR) charts were signed as appropriate and updated.

People told us that they received their medicine regularly and on time. One person said, "They bring it in and

I take it myself". Another said, "They bring my medicines to me every day."

The home had robust system in place for the ordering and disposal of medication, the pharmacist also did a six monthly audit. Medicines were kept in a locked clinic room in locked trolleys and cupboards. They keys were kept by the nurses. There was good management of stock. Controlled drugs were stored and dispensed appropriately and were checked weekly. The controlled drugs register was completed appropriately by two nurses when medicine was dispensed. Drugs that required storage in the fridge were kept in the fridge. The fridge temperature and the room temperature were recorded daily.

Staff completed medicine audits monthly which helped to ensure that people received their medicine as prescribed. The MAR charts and the monthly audits showed that there had been no incidents of missed doses and there were no gaps in the records we saw. Staff told us that they had medication management training and competency training, all the nurses had recently undergone a competency test.

One person told us, "There are enough staff around and I have not had to ring my buzzer to call them." Other comments included, "Yes seems to be enough", and "Always seem to be someone there when you want someone." People also told us that staff were quick to respond when they used their call bells. They said, "Takes them a couple of minutes", "The longest I've had to wait is 5 minutes", "Up until now I have not used the emergency button" and "Only happened once and they came in seconds." One relative expressed that they complained about the call bells and were told the system was being upgraded. We confirmed this with the registered manager during the inspection.

During the inspection we found there were sufficient numbers of staff available to meet people's needs.

Staff also told us that they felt there were enough of them on shift to support people appropriately. One staff member told said, "Staffing levels are increased if additional support is required for people. For example, on Fridays and Mondays we have three nurses because of the GP round and taking people's blood on Mondays."

At the time of the inspection, there were 34 people using the service. The registered manager told us there were eight care workers and two nurses allocated to the morning shift between 08:00 and 14:00, six care workers and two nurses between 14:00 and 20:00 and four care workers and one nurse between 20:00 and 08:00. In addition to this, the registered manger and deputy manager were on shift between 09:00 and 17:00 in addition to a separate domestic and kitchen team.

We reviewed the staff rotas between 22 April 2017 and 07 July 2017.

We saw that staff levels were as stated by the registered manager, however there were 15 separate occasions where care workers had worked a continuous 24 hour shift. The registered manager told us this was due to last minute cancellation and they were not able to get anyone from the bank team to cover. We sought reassurances from the registered manager that care workers who had worked a 24 hour shift were given sufficient breaks. We saw meeting minutes that showed the registered manager discussed these shifts with the relevant care workers. The minutes showed the care workers were happy with the arrangements and the number breaks they were getting. The provider also ensured that care workers who worked a 24 hour shift got at least get two days off during that week. We confirmed this in the rotas that we saw.

People told us they felt safe in the presence of staff, "I've not had any trouble with any of them" and "They have all been kind to me even the cleaner."

Staff explained how they would recognise the different types of abuse and neglect which could occur in a care setting. They were able to explain the actions they would take in accordance with the provider's adult safeguarding procedures to protect people from harm. Staff understood how to act as 'whistle-blowers' and report concern outside the home if their managers did not take action to keep people safe.

Training records showed that up to date safeguarding training had been provided for staff.

Risks to people were identified with plans in place to manage them. Risk assessments were updated regularly and when people's needs changed. Staff were aware about individual risks to people. Guidance for staff ensured that people were kept safe.

One area of the care plan was called 'safe and enabling environment'. This contained risk assessments and care plans related to keeping people safe. For example, there were falls risk assessments which were reviewed monthly. Those people that were identified at high risk had a falls booklet which was uses to track and analyse falls, to potentially identify any trends.

There was a care plan in place for call bells and those that were not able to use them, these care plans stipulated the frequency that care workers were required to attend people's rooms to check if they needed assistance.

People were protected from the risk of developing pressure ulcers. A person's record specified they should be supported to turn over in bed to relieve pressure on their skin. They were supported to do so every three hours and also transferred to a chair. They were also nursed on an air mattress. Staff had signed a number of charts to demonstrate that they had done the necessary checks. The staff had also involved the expert help of the Tissue Viability Nurse. Each person also had a comprehensive booklet which guided people to the elements of care and progress. The records showed that the wound had healed.

The Malnutrition Universal Screening Tool (MUST) calculator used for establishing nutritional risk MUST tool was used to assess people with the risk of malnutrition. This was updated on a monthly basis.

Records showed that staff undertook regular checks at night and day to ensure people had support when they required it. For example, records showed that a person been identified at risk of falls was supported to use the toilet regularly to ensure the person continued to maintain their independence and felt safe.

Good

Is the service effective?

Our findings

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Care records contained mental capacity assessments where it was felt that people did not have the capacity to understand decisions related to their care.

Do Not Attempt CPR (DNACPR) records were in place for people. Where people did not have capacity to understand these decisions fully, decisions to not resuscitate were taken by a clinician in consultation with people's next of kin. Where people did have capacity, these decisions were taken in consultation with them. Advanced care plans were in place for people who had capacity.

Records showed that the provider had involved family members, friends and health professionals in best interest meetings for people who had been assessed as not having the mental capacity to make certain decisions about their care and support. Where it was felt that people were being deprived of their liberty, the provider complied with the Deprivation of Liberty Safeguards (DoLS). Records showed that DoLS applications had been appropriately made to the local authority when people were subject to restrictions to their freedom, for their own safety.

There were some people using the service whose medicines were crushed before they took them. This was due to taste and difficulty swallowing. Where people had the capacity to consent to this, we spoke with them and they told us they were happy with this arrangement. Their views were recorded in their care plans and these decisions were reviewed monthly. For those that were not able to consent, these decisions were taken in their best interests in discussions with the GP, nursing staff and next of kin.

However, we found that although authorisation from the GP were held in people's records, there was no evidence that the pharmacist had approved the crushing of medicines.

The provider's policy stated 'If a person is having difficulty swallowing their medication, or wishes them to be administered other than whole capsules or tablets, this should be discussed with the person's GP who may review the medication, be able to prescribe more appropriate formulations or consider referral to a speech and language therapist for further assessment. Tablets must not be crushed or capsules opened unless the advice of a pharmacist has been sought to ensure that the pharmaceutical properties of the medication are not altered and that it is safe to administer the medication in this way. The method of administering the medication should be documented and the approval of the GP obtained. A written protocol must be developed which is specific for that person. The advice of a pharmacist must be obtained,

as for people with swallowing difficulties, regarding the appropriate administration of the medication.'

We highlighted this to the registered manager who acted immediately and sought the necessary approval from the pharmacist and showed this to us after the inspection.

We spoke with the training coordinator regarding induction training for new staff and ongoing training for existing staff.

Staff praised the quality of the training they received, telling us it was very thorough. Comments included, "The training is really good", "[The training coordinator] is always offering training" and "Training has improved so practice has improved", "The last training I went on was about the Gold Standards Framework [GSF], we learnt about dignity in death, how to speak to the family." The nurses told us that they had training relevant to their practice in order to enable them to practice safely and effectively. One nurse told us, "I had training in medication management, basic life support, mental capacity act, moving and handling. I also have regular clinical supervision by the deputy manager."

New starters completed the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

New starters were expected to complete the Care Certificate within three months of joining and thereafter were provided with mandatory training at regular intervals.

The training matrix showed that the provider was ensuring that its staff were offered regular training and were taking up the training opportunities on offer. The number of staff that were current with the mandatory training was above 89% in all instances. Mandatory training included, manual handling, people moving, safeguarding, health and safety, first aid awareness and emergency first aid amongst others.

We saw records of supervision for both nurses and care workers. These were held with their line managers. The nurses also told me that they supervised the care workers. The nurses told me that the assistant manager also monitored the take up of training courses to ensure that staff had up to date knowledge and skills in relation to people's needs.

Records showed that people had regular health checks and were discussed with the GP who visited weekly. People were also referred to a variety of health care professionals relevant to their care needs. People were referred to dietitian and speech and language therapists where appropriate. People's weights were monitored according to their clinical needs. A staff member told us, "I am supported by visiting professionals like the occupational therapist and the tissue viability nurse."

Care plans were in place to manage people's health support needs. For example, there was a seizures care plan in place which was created after a person had a seizure. This included a seizure protocol, an agreed action plan and timescales for calling the GP in the event of another seizure. There were also care plans in place to deal with low blood sugar level. People with diabetes had their blood sugar taken regularly.

Daily record charts documenting any visits from doctors, nurses, any professionals were maintained. A GP visited weekly and reviewed people's medication.

We asked people and their relatives about the food in the home. They said, "It's been pretty good", "Yes, I get

a choice", "Very good", "More than enough", "You have a choice the day before", and "Food is terrific best thing about the place." They also told us they received appropriate support with their meals.

We carried out an observation during lunch. People asked what was for lunch and were given the two main choices and were offered water, juice and wine. We saw people taking bones out of their mouths after eating the fish starter. We raised this with the registered manager during the inspection who confirmed afterwards they had spoken with the catering company about this as they were contracted to supply boneless fish to them.

There was a four week rolling menu at the service. The chef manager was aware which people were on a modified diet, such as soft or pureed as opposed to those on a normal diet. Records showed that people's preferences in terms of food were recorded and acted upon. People's preferences were on display for example those that liked a particular dessert or drink with their meals.

The kitchen was clean and the provider followed recommended infection control practices such as separate sinks for hand washing and preparing food. Opened food that was refrigerated was labelled with the date it had been prepared and when it was to be used by. Fridge and freezer temperatures were taken daily and cooked food was temperature probed before service.

Good

Is the service caring?

Our findings

People told us the care workers were friendly, "The staff are kind and show me a lot of respect. They really care", "The nurses don't have time to talk to me the carers occasionally come in and talk 5-10 minutes", "They are lovely I can't fault anything here", "Very nice" and "Everyone is kind they come and see you in the morning about how you are."

They also told us that care workers respected their choices and allowed them freedom, "Yes, I get up when I like and go to bed when I want", "They come in to wake me up for breakfast at 08:00, apart from that pretty good and they don't disturb me" and "I get up every morning at 07:30."

There was a calm atmosphere in the home. Staff went by their task in a calm and relaxed manner. When giving medication, staff knocked on the door and asked permission before going into people's room. People were asked if they were comfortable, were not rushed and asked politely whether they would like a drink.

People said their privacy and dignity was respected, "They knock on the door before they come in", "Because I'm bed bound I have to rely on them to clean me up, I think they respect my privacy" and "Everybody knocks [before coming in]."

People had their personal care needs met in a timely manner and care workers updated records appropriately. For example, by the afternoon, records were updated with the care and support that people received that day as written in their care plan. One person had their personal care attended to, was supported to have their breakfast, lunch and medicine on time. Their room was cleaned and they were seen reading a book and talking to other people in the lounge after lunch before going to bed for a rest.

Staff respected people's wishes at lunch, asking people if they needed help and if they said no they respected their wishes. Another person was being supported to eat and the care worker engaged with them, asked if they wanted more and when the person said 'no thank you' they stopped immediately and removed the plate. We saw one or two examples of care that was not always appropriate which we highlighted to the registered manager at the time of the inspection. At lunch, one person had their serviette tucked into their blouse without asking them. Another staff asked a person if they could cut their food up and before they could answer took the cutlery out of their hand and commenced cutting. The registered manager took our feedback on board and took immediate action, speaking to the care workers involved and highlighting this to them.

The provider was going through their reaccreditation for the Gold Standards Framework (GSF) at the time of our inspection. The GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life.

Good

Is the service responsive?

Our findings

Records showed that people had preadmission assessments prior to admission. However we found that some preadmission forms where not completed thoroughly, for example details about people's preferences were missing.

Each person was allocated a named nurse. The process of nursing care was clear and comprehensive and comprised of a thorough assessment, planning, implementation of care plan and monthly evaluation. Records showed involvement of people, their relatives and health care professionals.

The care plans had clear goals and were written in the words of the person and also respected the person's wishes. For example, one care plan read 'I prefer to have a shower once a week and a wash every morning. I need one staff to help me with my personal care.' The daily notes showed that these preferences were being followed and the person was receiving a daily wash, a weekly shower and was being assisted by a staff. Another person with 'challenging behaviour' had care plans which gave staff details how to support this person and the medicines they were to be given. The MAR chart for this person showed that they received the medicine when they asked for it. This had led to a reduction in incidents of behaviour that challenged. Care records showed that people were involved in their care and the provider acted upon their wishes.

Each care plan had an identified need, a plan of action to manage the need and the steps that staff needed to take to support the person. Care plans were updated every month, with staff noting how they were meeting the care plans and any changes to people's support needs.

Although people were not always familiar with the term 'care plan', they told us they were involved in their care and relatives said the provider kept them informed and involved. One person said, "They keep [my family member] informed, everything that happens."

An activities timetable was on display in the main hallway, this included musical bingo, reminiscence sessions, beauty therapy, pet therapy and floor games. On the first day of the inspection, pet therapy was taking place and people who stayed in their rooms were also given a chance to take part in this and the animals were taken into their rooms if they wanted.

We observed one activity where the activity co-ordinator encouraged people to use a pump to blow up a balloon and they played hitting the balloon. The activity co-ordinator called out people's names and aimed the balloon at them. People really engaged and chatted throughout this activity. One person said, "I'm an avid reader they have a large book place."

People told us they had not needed to raise a complaint. One person told us, "I would complain first to the nurse, talk to them first and see how far it goes." Other comments included, "If I want to complain I would complain", "I think I would talk to the nurse" and "Anyone of these ladies will help me."

There had been three recorded complaints since our last inspection. These had all been responded to in a

timely manner to the satisfaction of the complainants. Investigation reports and email trails were retained as evidence of investigations.

Good

Is the service well-led?

Our findings

People told us they felt the service was good. "This is my world they help me with anything I want", "It's improved since the new manager has been here", "Yes whatever you speak to them [staff], we get on extremely well" and "I don't think they [staff] can do anything better for me."

The feedback we received from staff about the management and leadership of the home was good. Staff told us they worked well together, they said "We are very supportive of each other" and "We have a very good and hardworking team, there is good communication within the home."

The registered manager had been in post for nine months and the staff team said he had a positive impact on the service. Comments included, "He is somebody who is on the shop floor and shows a keen interest in people's care, the staff. He has an open door policy and you can see him without an appointment. He is very positive. He is good for this place", "The manager listens", "There has been an improvement in a number of areas since the manager has been in post. We have a more stable workforce" and "He deals with people fairly. He is a good leader and is well liked by everybody.

Staff meetings were held with different departments such as the nursing team, general staff and heads of departments. Issues discussed included health and safety, training, timekeeping, going over policies and discussing issues such as medicines practice and the GSF. One staff member said, "The manager meets with the staff at least monthly and listens to our concerns and acts on them."

The provider had systems in place to monitor the quality of service and drive improvements.

A record of incidents and accidents were kept, these included a summary of all the incidents that had taken place and individual records. These were completed appropriately with details of the action taken and signed off by the registered manager.

The regional manager visited the home every week and completed monthly reports. We reviewed the reports from April, May and June 2017. These were based around whether the service was safe, effective, caring, responsive and well led. As part of this a sample of records were checked and a number of areas were looked at such as infection control, medicines, complaints, care planning, tissue viability and nutrition. These visits also included observations of medicines and dining experiences. Feedback from these visits were passed onto the registered manager to follow up with the relevant staff.

The registered manager or deputy carried out meal time monitoring on a monthly basis looking at the dining experience of people using the service seeing if they were given enough assistance, choice, offered extra helpings, alternate choices and enough water.

Health and safety and infection control audits were carried out by he registered manager looking at a wide range of areas. Where shortfalls had been identified, these were tasked to people to follow up.