Gracewell Healthcare Limited

The Pines

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected The Pines on the 20 and 21 July 2015. The inspection was undertaken because of concerns raised to the Care Quality Commission (CQC) from members of the public.

The Pines is a nursing home providing care and treatment for up to 35 people. On the days of the inspection 31 people were living at the home. The age range of people varied between 60 – 100 years old. Care and treatment was provided to people receiving end of life care, nursing care needs, including mobility needs, long term healthcare needs, diabetes, as well as people living with various stages of dementia.

Accommodation was provided over three floors with stairs connecting all floors along with a lift. All bedrooms provided en-suite facilities and hallways and door frames were wide enough to enable people to freely move around in wheelchairs. The home accommodated a large conservatory which provided a light and airy dining space. Direct access to the local park was also provided and people were seen spending the afternoon in the local park.

The Pines is part of the large corporate provider Gracewell Healthcare. Gracewell Healthcare provides nursing care all over England and has several nursing homes within the local area.

Summary of findings

An acting manager was in post but was not the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Risks to people safety were not always adequately assessed. Choking risk assessments failed to provide clear guidance for staff to follow. Staff members were not consistently aware who required thickened fluids in their drinks, therefore placing people at risk of aspiration. We have identified this as an area of practice that requires improvement.

Staff's level of knowledge was inconsistent and staff were not consistently aware of who was receiving end of life care or who was at risk of/or experiencing pressure damage. Care plans were not always consistent, accurate or fit for purpose. Care plans failed to provide guidance for staff or reflect the level of need people required. We have identified this as an area of practice that requires improvement.

People's medicines were stored safely and in line with legal regulations. People told us they received their medicines on time, however, guidance for the use of 'as required' (PRN) medicines were not available to ensure that these medicines were not administered consistently and only when needed. The management of pain medicines also required improvement. We have identified these as areas of practice that requires improvement.

The requirements of the Mental Capacity Act 2005 (MCA) were not being adhered to. Mental capacity assessments were not completed in line with legal requirements. The care planning process had not given consideration to whether some people may be deprived of the liberty under the Deprivation of Liberty Safeguards (DoLS). We have identified this as an area of practice that requires improvement.

Where people had bed rails in place, documentation did not confirm if they consented to the bed rails or if they were implemented in their best interest to keep them safe. We have identified this as an area of practice that requires improvement.

We received information of concern from a relative, whereby their loved one's dignity was not upheld and significantly impacted upon them. This was subject to an on-going review.

The provider's quality assurance framework was not consistently effective. Concerns had not always been acted upon or action taken. We have identified this as an area of practice that requires improvement.

The provider was committed to the on-going improvement of the home and had sourced additional input to help provide management oversight and address all information of concern. The provider was transparent, honest and dedicated to improving the delivery of care and support.

People spoke highly of the opportunities for social engagement. People commented there was never time to be bored and there was a strong emphasis on providing meaningful activities. The use of technology was engaged in reducing social isolation and enabling people to remain in contact with their families.

Staff members had a firm understanding of people's personal history, likes, dislikes and personality traits. It was clear staff had spent time building rapports with people. Staff interacted with people in a kind and friendly manner and people appeared at ease in the company of staff.

Effective recruitment procedures were in place. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by The Pines and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date. Training schedules confirmed staff's training was up to date and nursing staff received clinical training.

Feedback was regularly sought from people and staff. The provider was committed to acting upon the feedback received and driving improvement. Following feedback from one resident, a nurse call bell system had been implemented and was named in honour of them.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The Pines was not consistently safe. Protocols for when some medicines should be given were not in place, and it was not always clear how people were being supported to manage pain.

Choking risk assessments were not consistently completed or lack sufficient guidance to provide advice to staff members. On-going work was required to management of pressure damage and skin integrity.

Effective recruitment procedures were in place. Risks associated with the safety of the environment and equipment were identified and managed appropriately.

Is the service effective?

Requires Improvement

The Pines was not consistently effective. The Mental Capacity Act 2005 was not being followed and consideration had not been given as to whether people were deprived of their liberty.

Where staff had identified the need for additional training, this was not always acted upon.

Not all staff knew who required specialist foods or why some people needed specialist meals. However, people spoke highly of the food provided and the dining experience was made available. People were served a three course meal with staff providing support whilst encouraging people to be independent with eating and drinking.

Is the service caring?

Requires Improvement

The Pines was not consistently caring. Staff members were not consistently aware who was receiving end of life care. People's end of life wishes had not consistently been recorded.

People had high praise for staff and spoke of staff's caring nature. A dignity champion was in place and staff understood the importance of respecting people's privacy.

Staff members supported people to maintain their personal appearance and people spoke highly of the staff members painting their nails and choosing their outfits for them.

Is the service responsive?

Requires Improvement

The Pines was not consistently responsive. People's records did not always contain consistent information to guide staff on the needs of people.

There was a strong emphasis on providing social engagement and stimulation. The use of technology was used in creative ways to engage and stimulate people.

Summary of findings

A complaints procedure was in place and complaints were responded to in a timely manner.

Is the service well-led?

Requires Improvement

The Pines was not consistently well-led. The home does not currently have a registered manager The quality assurance framework was not consistently effective to identify areas for improvement and action taken.

People spoke highly of the management along with staff. Staff commented management operated an open door policy. Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

The provider was dedicated to making on-going improvements.

The Pines

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.

The inspection took place on the 20 and 21 July 2015. The inspection on the 20 July 2015 took place out of hours from 10.30pm to 01.30am. The Inspectors returned at 08.00am on the 21 July 2015, spending the whole day at the home. The Inspection was carried out by four inspectors over the course of the 20 and 21 July 2015. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were responding quickly to information and concerns that had been raised with us.

During the inspection, we spoke directly with seven people who lived at the home, but we also spent time observing how staff interacted with people. We also spoke with two visiting relatives, six care staff, four registered nurses, the chef, maintenance worker, two regional directors, deputy manager, acting manager, activities coordinator, two Care and Quality Directors and a visiting healthcare professional (Speech and Language Therapist).

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding concerns that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority and Clinical Commissioning Group to obtain their views about the care provided in the home. We looked at areas of the building, including people's bedrooms, the kitchens, bathrooms, and communal lounges.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at eight care plans and relevant risk assessments along with other relevant documentation to support our findings. We also looked at six bed rail risk assessments. We also 'pathway tracked' people living at The Pines. This is when we looked at their care documentation in depth and obtained their views on how they found living at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

The Pines was last inspected in October 2014 where we had no concerns.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person told us, "Of course we're safe, I've no concerns at all." A visiting relative told us they felt confident leaving their loved one in the care of The Pines. Another visiting relative told us, "I think he is safe. I don't like leaving him, but I know he is being well cared for." Although people told us they felt safe, we found examples of care practice which were not always safe.

Older people with health impairments such as dementia and Parkinson's can be at heightened risk of choking. Management of choking and risk minimisation requires risk assessments and input from Speech and Language Therapy. Choking risk assessments were completed which identified whether people were at risk of choking and aspiration. However, where people were identified at risk of choking, the care plan failed to reflect the measures required to manage / reduce the risk. One person's nutrition care plan identified they are at risk of aspiration, however, a choking risk assessment had not been completed. Guidance was not available on the instructions on how to prevent the risk of choking or the measures required to help the person swallow safely. Although nursing staff had a firm understanding of the measures required to prevent the risk of choking, such as ensuring the person is sitting upright when eating and drinking, however, this detail was not recorded in the risk assessments and care plans to ensure they were consistently supported.

Due to the above concerns, in relation to poor record keeping of the management of choking and aspiration, we have therefore identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) 2014.

Medicines were stored safely. Some prescription medicines had legal requirements for their storage, administration, records and disposal. Medicines were stored, recorded and ordered appropriately. The stock levels of medicines were checked on a regular basis and medicines were administered in the presence of two care staff as per good practice guidelines. Only trained nursing staff administered medicines. We spent time observing the lunchtime medicines being administered at lunchtime. Whilst administering medicines, nursing staff preserved the dignity and privacy of the individual. For example, nursing staff discreetly asked people sitting in communal areas if they were happy taking their medicines there. Staff were appropriately trained and regularly had medicine competency checks and confirmed they understood the importance of safe administration and management of medicines.

Medicine Administration Records (MAR) charts confirmed a sample of people were prescribed 'as required' medicines. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. Clear PRN protocols were not in place to ensure that that these medicines were administered consistently and in accordance with any prescribed instructions. One person was prescribed a medicine to treat anxiety. Guidance was not available on how that anxiety presented, any triggers and the steps to take before administering the medicine. Another person was prescribed a strong pain relief as a PRN medicine. The MAR chart recorded that if the person was being administered the PRN medicine on a regular basis to inform the GP. The MAR chart indicated the person was administered the PRN medicine on a regular basis dating back to June 2015; however, the GP had not been informed. Therefore there was the risk of the person receiving the PRN medicine inappropriately.

Management of pain required improvement. For people living with dementia, communication difficulties or people receiving end of life care, they may not be able to verbalise they are in pain or discomfort. Pain care plans were in place but were not robust or consistently completed. One person had a pain care plan in place, however, the care plan failed to reflect the person was prescribed pain relief patches. Information was also not available on whether the person could or how they expressed they were in pain. Concerns were also brought to our attention that the person's pain patch had fallen off. We were informed that the person's pain patch was changed every few days. Nursing staff were unaware of when the pain patch had fallen off and an incident form had not been completed. Therefore there was the risk the person was experiencing pain which had not been identified by staff.

Inadequate management of pain and of PRN medicines, is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) 2014.

Concerns were brought to our attention by a visiting healthcare professional who advised that a person's medicine had not arrived on time and therefore they were

Is the service safe?

without vital medicine for two days. We spoke with the management time regarding the incident and they confirmed a safeguarding concern had been raised and was subject to on-going review.

Management of pressure damage is an integral element of providing care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. We looked at the management of pressure damage throughout the home. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses, regular re-positioning and application of barrier creams. Input from sought from the Tissue Viability Nurse where the person's skin integrity had broken down and nursing staff followed specialised wound care management plans. Care staff had a good awareness of the basic principles to prevent the development of pressure damage. One care staff told us, "We have turning charts in place and people need to be repositioned regularly, air mattresses are in place and we have barrier creams to apply."

During the inspection, the provider had sourced specialist input from registered nurses and directors of care within the organisation and all people were being reviewed for any pressure damage or skin breakdown. We were informed that one person had grade four pressure damage and three people had grade three pressure damage. The turning charts for these people reflected they were regularly re-positioned, however, care staff had been signing that the skin was intact. We brought this to the attention of the regional directors who confirmed they had been holding training with care staff as they identified care staff were not completing the turning charts correctly. Throughout the inspection, we also asked care staff if they could tell us who was subject to skin breakdown. Care staff were not consistently aware who was at high risk and subject to three grade or grade four pressure damage. The sharing of information was therefore inadequate as staff members were not aware who was experiencing skin breakdown. We have identified this as an area of practice that needs improvement.

Many people living at The Pines required the support of an air mattress (inflatable mattress which could protect people from the risk of pressure damage) as they had been assessed as high risk of skin breakdown (pressure ulcers). When receiving care on an air mattress, it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. Settings of the air mattresses were checked daily and recorded confirming the setting matched the person's weight.

People felt there was sufficient numbers of staff on duty. One person told us, "When I press my bell, they come straight away." A visiting relative told us, "A few days ago, I did feel there wasn't enough staff but since then things have improved and there's always staff around." Care staff felt additional staff at night and during the morning could be beneficial but identified they never felt rushed and always delivered care in a timely manner. Throughout the inspection, we found the atmosphere to be calm; staff were present throughout the home and spending one to one time with people.

Staffing levels within nursing homes need to be based on the individual needs of people along with staff skills and competency. Staffing levels consisted of two registered nurses in the morning along with six care staff. One registered nurse in the afternoon along with five care staff and one registered nurse and three care staff at night. Along with maintenance, domestic and kitchen staff. We asked the regional director what systematic approach was in place to determining the staffing levels. Whether a dependency tool was utilised or other mechanisms which could demonstrate how the conclusion that the current staffing levels were based on the individual needs of everyone living at the Pines. The regional director acknowledged that a formal dependency was yet to be implemented but advised staffing levels were regularly reviewed and increased if people were unwell or required additional support. We have therefore identified this as an area of practice that needs improvement.

Training schedules confirmed staff had received safeguarding adults at risk training. Staff members commented they would feel confident in raising a safeguarding concern and challenging bad practice. One staff member told us, "I wouldn't hesitate in using the whistle-blowing policy." Despite staff receiving safeguarding training, we questioned the effectiveness of the training and whether it was embedded into practice. We found incident whereby a staff member was found to be inappropriate towards a person, however, a

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safeguarding concern was not raised. The management team at the Pines also informed us they had raised concerns regarding staff's ability to recognise and speak up about bad practice and they were working with staff members to raise awareness. This has been identified as an area of practice that requires on-going improvement.

Effective recruitment procedures had been followed. Records showed staff had completed an application form and interview and the provider had obtained written references from previous employers. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff. Staff files contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed by The Pines and bank nurses as well all had registration with the Nursing Midwifery Council (NMC) which were up to date.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Moving and handling equipment such as hoists and slings were regularly serviced to ensure they remained safe and fit for purpose. Regular checks on fire-fighting equipment took place alongside weekly fire checks and tests. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. In the event of a fire, grab bags were throughout the home. These had torches and fire equipment in to enable the safe evacuation of the home.

Requires Improvement

Is the service effective?

Our findings

People spoke highly of the staff and felt confident in their skills and abilities. One person told us, "Yes they [staff] all know what to do, I get on very well with them." Another person told us, "The staff are great and well trained." Despite people's high praise for staff, we found care and support was not always delivered effectively.

The Mental Capacity Act 2005 (MCA) is designed to protect and restore power to people who lack capacity to make specific decisions. The philosophy of the legislation is to maximise people's ability to make their own decisions and place them at the heart of the decision making. The MCA 2005 should only be instigated when it is felt the person has an impairment or disturbance of the mind/brain and at a particular time, they may be unable to make a decision. The MCA 2005 is decision specific and it needs to be assessed whether the person can retain, weigh up, understand and communicate the decision. For mental capacity assessments to be completed in line with legal requirements, they must adhere to the code of practice and legislation.

Mental capacity assessments were not completed in line with legal requirements. They were not decision specific nor did they record the decision that was required to be made. Documentation recorded the trigger for the assessment as 'unable to sign care plan agreement or consent to treatment.' Inability to sign a care plan would not consistently constitute a mental capacity assessment to be undertaken. Where people were unable to consent to treatment, the mental capacity assessment failed to record what treatment the person was required to consent to. Documentation consistently recorded that the person did not understand the information, unable to retain the information, cannot weigh up the information and unable to communicate a decision. Information was not available on why the person was unable to understand or weigh up the information. There was no reference to how the information was presented, if the staff member went back at various times of the day or how they empowered the person to understand and weigh up the information. Therefore, we were unable to ascertain how the decision of capacity was reached and what measures were used to empower the person and enable the person to be part of the decision.

Consent forms were in place which considered the person's ability to consent to a physical examination, consulting with other professionals and photographs being taken. However, they were not consistently completed, to record whether the person could consent or not. One person's stated 'unable to sign due to rheumatoid arthritis, dementia and Parkinson's. We were therefore unable to ascertain if the person consented or not. A diagnosis of rheumatoid arthritis, dementia and Parkinson's does not mean an individual is unable to provide consent. A subsequent mental capacity assessment for each decision could not be located; therefore it was not clear if the person was just unable to sign, did not consent or lacked the capacity to make those specific decisions. Nursing staff confirmed the person did lack capacity to make the specific decisions and acknowledged and the documentation did not reflect this.

Observations of care identified that many people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety but do restrict movement. Bed rail risk assessments were in place which considered if the bed rails were necessary or preference and if least restrictive alternatives had been considered. Where people could not consent to bed rails, mental capacity assessments had not been completed. Assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom for example use of bed rails. If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored. One person's bed rails risk assessment documented they had not consented; it was necessary as they became confused and move from side to side. However, no other least restrictive alternatives had been considered. Another person's care plan clearly identified they had expressed their wish not to have bed rails, however, we identified on both days of the inspection that they remained in bed with bed rails in place. Documentation failed to record why the bed rails were being used and no risk assessment was in place. Nursing staff confirmed the person's health had deteriorated and it was for their safety, however, there was no indication that other least restrictive options had been considered.

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Mental capacity assessments were not being completed in line with legal requirements was identified a breach of Regulation of 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

In March 2014, changes were made to Deprivation Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. If someone is subject to continuous supervision and control and not free to leave they may be subject to a deprivation of liberty. On the days of the inspection, we were informed that no one was subject to a DoLS authorisation. However, we identified people who could be subject to DoLS but no consideration had been given to ensure people's rights were being protected. One person was living with dementia, receiving half hourly checks, remained in bed with bed rails in place all day. The person was not free to leave and subject to continuous supervision and control, however, staff had given no consideration as to whether this person was deprived of their liberty or how to empower the person to have choice and control within their life. Training schedules confirmed staff had received training on DoLS but this training had not been embedded into practice and staff lacked understanding of the DoLS process.

The lack of assessing and considering whether people are subject to a DoLS, was identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did however; demonstrate a firm understanding of the concept of consent and gaining consent. One person told us, "We always gain people's consent that they are happy for us to provide care." For people with communication difficulties, staff told us how they used various forms of communication such as picture cards and body language to gain consent. One staff member told us, "One person is unable to talk, however, a nod of their head means yes and if they shake their head that means no. They are always clear in whether they are happy for us to give them a wash or not."

The Pines provided care and support to people living with a swallowing difficulty. For people assessed with swallowing difficulty, the use of thickened fluids when drinking is required to minimise the risk of choking and aspiration. Thickened fluids are easier to swallow; however, the quantity and texture must be appropriate for the individual as otherwise they can place the person at risk of aspiration. We asked staff who required thickened fluids. Staff members clearly told us about two people who required thickened fluids and explained the process in which they made the thickened fluids. However, throughout the inspection, we identified four people who required thickened fluids to safely swallow fluids as assessed by Speech and Language Therapists. Staff were therefore not aware of everyone who required thickened fluids. Therefore, there was the risk people would not receive thickened fluids as staff were not aware who required thickened fluids.

Care and treatment was provided to people living with diabetes. Throughout the inspection, we were informed of four people who were diabetic. Some people controlled their diabetes with medicines, while others were diet controlled. For people living with diabetes, risk assessments were not consistently in place identifying the individual signs and symptoms of high and low blood sugar. Nursing staff had a firm understanding but for care staff this information and guidance was not available. Where people required a diabetic diet, we liaised with the chef to ensure they were aware of those people and how a diabetic diet was provided. The chef was only aware of one person who was diabetic and they told us that they didn't follow a diabetic diet. The chef then liaised with a member of nursing staff to ascertain if they should be providing a diabetic diet to other people and they were informed no one required a diabetic diet. However, the care plan for one person clearly identified they required a diabetic diet. A diabetic diet primarily requires monitoring of sugar levels, however, there was the risk this person was receiving high sugar meals or desserts high in sugar. Daily recording did not reflect what was the person was eating or having for dessert but blood glucose testing identified their blood sugars had remained stable.

Some people's food and drink was monitored and recorded on a daily basis. This was because they had been identified at risk of weight loss or dehydration. Where fluid charts were in place, there was not always a total recorded of how much the person should be drinking. The total amount of fluid received each day was not totalled to ascertain if the total had been met or if staff needed to provide more fluids. Where the need for a special diet had been identified, the rationale was not always recorded. One person's care plan identified they required a puree diet. We were unable to

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locate any input from speech and language therapy or information on how the decision was reached that the person required puree diet. Nursing staff confirmed the person was at risk of aspiration but a choking risk assessment was not in place. Therefore, there was the risk the person was administered a puree diet when it was not required.

Due to the above concerns, in relation to poor management of thickened fluids, diabetes and food and fluid charts, we have identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were concerns about some people's diets, people did speak highly of the food provided. One person told us, "It's lovely food, they make what I like." We spent time observing the lunchtime meal whilst sitting and interacting with people. The dining room was prepared for the lunchtime meal. Tables were laid with table cloths, flowers, napkins and condiments were to hand. The dining room was also decorated with bunting and music was softly playing in the background. The menu was on display for people and people were seen to enjoy a three course meal. Bread was at hand for people to independently eat and butter was available in individual dishes on each table. The atmosphere was calm, relaxing with a social feel. People were engaging with one another while staff provided one to one assistance with people in a discreet yet kind manner. People confirmed they were offered choice at each meal time and could also make requests. One visiting relative told us, "I think the presentation of the food is pleasing, nicely cooked as it should be, with vegetables not overdone."

Staff commented they felt supported and received sufficient training which enabled them to provide effective care to people. Training schedules confirmed staff received an on-going programme of essential training which was updated regularly. Training included pressure care, moving and handling and equality and diversity. Staff spoke highly of the opportunities for training. One staff member told us, "We have a couple of residents who are deaf, so I asked to do a sign language course which has been agreed." People confirmed they felt confident in the skills of staff. One person told us, "The staff are very good and know what they are doing."

Although staff commented they felt supported and received effective training. Records demonstrated that where staff members had specifically identified training themselves and felt they needed additional training, this was not provided. Therefore they were not supported or enabled to develop their level of understanding and deliver a higher quality of care. We have therefore identified this as an area of practice that needs improvement.

Systems to support and develop staff were in place through regular supervisions meetings with the manager, deputy manager and registered nurses. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Regular supervision provides an insight into what the role of the person being supervised entails, the challenges they face and what support they need. It is an aspect of staff support and development. Staff commented they received supervision on a regular basis and found the forum extremely helpful. The nursing staff confirmed they received regular clinical supervision along with clinical training, such as catheter care and end of life care to keep up with their continuing professional development.

People had access to healthcare professionals when required. Each person had a multi-disciplinary care record which included information when GPs, dieticians, SALT and other healthcare professionals had visited and provided guidance and support. A visiting healthcare professional told us, "Staff seemed quite good at contacting me and taking on board my advice." Where people's healthcare needs had deteriorated, advice from healthcare professionals had been sought and external referrals made. One person had deteriorated rapidly and a referral to the specialist palliative care team had been made.

Is the service caring?

Our findings

People spoke highly of the caring nature of staff. One person told us, “They are very kind.” Ladies commented on how staff supported them to maintain their personal appearance which was of great importance to them. Staff demonstrated sound knowledge of people’s likes, dislikes, personality and life history. Although people spoke positively of the care, we identified areas of practice which were not consistently caring.

Feedback from one relative identified serious concerns in which a person’s dignity and well-being was not upheld or respected. Due to the concerns raised and the impact on the person, this concern was subject to an on-going review by the local authority.

Nursing homes play an important role in the care of older people at the end of life. The Pines provided care and support to people who were receiving end of life care. We spent time exploring how dignified care was provided to people at the end of their life. One staff member told us, “Where a person is at the end of life and the family cannot be present, we will provide a member of staff to provide one to one care to ensure someone is with them when they pass away.” We asked staff members who was receiving end of life care. We received various responses and staff members were not consistently aware who was receiving end of life care. Some staff members felt people were receiving end of life care, however, when we checked with nursing staff and management, they confirmed they were not. From talking with nursing staff and management, we identified that care and support was provided to three people receiving end of life.

We looked at care documentation to ascertain what was important to the person at the end of their life. Each person had an advanced care plan and spirituality care plan in place; however these were not consistently completed. One person receiving end of life, their advanced care plan had not been completed. Information was not available on what was important to them and what end of life provisions had been implemented or whether they did not want to share these details We identified that the person was receiving hourly checks (checks to check on their well-being) during the day and half hourly checks at night. Documentation failed to reflect how the decision was reached on the frequency of checks and if the person was happy with it. We asked staff members how it was agreed and decided how often people should be checked upon. Staff members identified they were not sure the frequency of checks were agreed but felt they were sufficient and not too intrusive. However, documentation failed to reflect the preferences of the person and whether hourly checks or half hourly checks were sufficient in meeting the needs of people receiving end of life care.

Due to the above concern, in relation to care plans not reflecting the needs and preference of people’s end of life wishes, we have therefore identified a breach of Regulation of 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 due to.

Staff were observed interacting with people in a friendly manner. We observed one interaction in which humour and laughter was evident. The staff member asked the person if they would like a biscuit with their tea. The person replied what for, when the staff member advised to dip in. The person then asked, why would I do that in which the staff member replied because it tastes nice. The person then replied, “Go on then, but only because it’s you.” Laughter was heard throughout the interaction and the person appeared at ease in the company of the staff member.

People’s independence was promoted. Staff members recognised the importance of enabling people to retain their independence. One staff member told us, “We always encourage people to do as much for themselves as possible.” Staff members told us in depth of one person who was dedicated to retaining their independence and staff members only provided assistance when requested. One staff member told us, “We have one person who likes to wash their own body, it takes them a long time but it’s really important to them and we support them to do this.”

Support was provided in enabling people to maintain their personal appearance. They were supported to dress in the clothes they preferred and in the way they wanted. Ladies had their handbags to hand which provided them with reassurance. One person told us, “We get a choice of what to wear, but there is one carer who I ask for advice on what to wear as she has fantastic taste and chooses me lovely outfits.” Another person told us, “I like matching my nails with my clothes and the carers help me with this, one in particular is really good, she gets me bright coloured nail varnish.” People commented that they were made to feel

Is the service caring?

comfortable at The Pines and to treat The Pines as their own home. People's rooms were personalised with their belongings and memorabilia. With pride, people showed us their photographs and items of importance.

A dignity champion was in post. Led by the dignity in care campaign, a dignity champion provides advice and guidance to other staff members on how to respect people's dignity and ensure the 10 dignity do's are upheld. The dignity champion told us, "We have previously been giving staff members a number of the 10 dignity do's. We may give one staff member in the morning, such as number six which is 'Respect people's right to privacy.' We will then ask the staff member later on how they met that dignity do." Staff members had a good understanding of how to respect people's privacy. One staff member told us, "We will always explain to the person, talk through what we're doing, gain their consent and provide choices." Another staff member told us, "Always gain consent to enter a person's bedroom. When providing personal care, ensure the door is closed and curtains are pulled." As part of the inspection, we undertook an out of hour's inspection, arriving at the home at 10.30pm. Upon arrival, people's curtains were drawn closed, the home was calm and relaxed with some people asleep in bed while others were watching television or listening to music. Staff members commented that most people were subject to nightly hour checks to check on their well-being and to also provide support to re-position. One staff member told us, "We always try and undertake these checks without disturbing the person's privacy as much as possible."

Staff members had a firm understanding and knowledge of people's likes, dislikes and personality traits. It was clear staff had spent time building rapports with people and people looked comfortable in the company of staff. We spent time talking with staff members asking them to talk about people they provide care to. One staff member told us, "One person has a huge interest in aircrafts as they use to design air crafts. There are pictures of the aircrafts they designed throughout the bedroom along with pictures of his wife who he adores, they met when they were young and he talks about always being in love with her." Another person told us, "We have two people who have formed a friendship since moving into the home and it's lovely to see. They sit and spend lunchtime together."

People were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. Mechanisms were also in place to involve people in the running of the home.

Resident meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. Minutes from the last resident meeting held in March 2015 also included relatives participating. Minutes from the last meeting reflected that activities were discussed, how people could be involved in interviewing potential new staff and the menu options

People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting, taking people out and being welcomed by staff.

Requires Improvement

Is the service responsive?

Our findings

People spoke highly of the opportunities for social engagement and activities. One person told us, "We don't get time to get bored here, there's too much going on. There's a lot to do." Dedicated activities co-ordinators were in post who understood the importance of meaningful activities. Despite people's high praise about activities, we found areas of practice which were not consistently responsive.

Each person had a care plan which was personal to them. Each care plan included a 'who am I' sheet. This included important information on the person's likes, dislikes, communication needs, whose important to them and what's important to them. One person's 'who am I' sheet clearly recorded they did not look to be cold; this was then reflected throughout the care plan, advising if they are cold, it can increase their agitation. Care plans covered specific areas of need, including consent, mobility, pain relief, spiritual needs and nutrition. The care plan considered the person's needs, goals and actions required. On a monthly basis, care plans were reviewed for their effectiveness and if the current level of support was meeting the person's needs. However, we found that some care plans were contradictory, despite being reviewed monthly, it was not always clear what level of support people needed. One person's nutrition care plan stated, they required supervision when eating due to high risk of choking. However, subsequent monthly reviews recorded they did not consistently need supervision when eating. We were therefore unsure if the risk of choking had been minimised. We also identified concerns that where a person's needs had increased, a care plan had not been implemented. One person's multi-disciplinary notes recorded they had been found after having a seizure. An anti-convulsing had been prescribed, however, a care plan and risk assessment had not been implemented describing the measures to take if the person was found to be having a seizure, in order to guide staff to know what to do. Another individual's care plan stated they should be drinking 1850mls of fluid per day and for fluid charts to be completed, however, fluid charts were not in place. Nursing staff confirmed the person was now drinking sufficiently and fluid charts were no longer required, but this had not been reflected in the guidance provided for staff in their care plan.

People's records did not always provide clear guidance for staff on the individual needs, this is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People did however comment that they felt involved and aware of their care plan. One person told us, "They do ask me about my care plan, I've spoken about it." Another person told us, "I'm aware of my care plan." Visiting relatives confirmed they were regularly asked about their loved one's history, likes, dislikes and what's important to them.

It is important that older people in nursing homes have the opportunity to take part in activity, including activities of daily living that helps to maintain or improve their health and mental wellbeing. People should be encouraged to take an active role in choosing and defining activities that are meaningful to them. The provider employed a dedicated activities co-ordinator who worked full time and another activity coordinator who worked part time. Both provided meaningful activities and opportunities for social engagement. A weekly activity timetable was displayed which reflected a wide range of activities taking place, these included: gardening and pruning, trips out, massage, arts class, countdown quiz, poetry class, dominoes and news of the world. The activities coordinator expressed compassion and dedication to their role and ensuring people receive activities and social stimulation of importance and meaning to them.

People spoke highly of the activities on offer. One person told us, "We get activities, people come in to do chair yoga and exercises, and there's a man who plays the violin." Another person told us, "They take us out and we get trips over here [the park]." The activities coordinators recognised the importance of ensuring people received fresh air and taking people on regular trips. The provider had a dedicated mini-bus which enabled staff to regularly support people to visit the pier, local parks, garden centres and other places of interest. On the day of the inspection, the weather was warm and we were informed the activity coordinator had taken people out to the local park. We visited the local park and spent time with people. People were enjoying the sunshine whilst sitting eating ice cream. People were supported to be dressed appropriately with sun hats, sun glasses and sun screen.

In order to protect people from social isolation, the activities coordinators regularly spent time with people in

Requires Improvement

Is the service responsive?

their bedrooms, providing one to one interaction. The activities coordinator told us, "In the mornings, we go round and spend time with people who may be unwell; bed bound or prefer to stay in their room. We bring in CDs and music to play. We also have a violinist and pianist who comes in and plays to people in their bedrooms. It's important to keep people company in their bedroom and make them feel included. We also read to people and go through pictures with them." Throughout the inspection, we regularly saw the activities coordinators coming and going from people's bedrooms, providing one to one time. People told us they enjoy and appreciated this one to one time. One person told us, "They come and go through pictures with me."

The use of technology was integrated into providing meaningful activities and to reduce social isolation. The Pines had a computer in the library in which the activities coordinator was supporting people to Skye with their families. For families that lived far alone, this enabled them to have regular contact with their loved one. Hand held computer tablets were utilised as a creative tool for engaging with people. We observed one interaction whereby a person was enquiring about the building next to the home, the activities coordinator sat down next to the person and used the tablet to goggle the building, they then spent time talking about the history of the building. A recent photography exhibition had also taken place. Staff members and the activities coordinator enabled and encouraged people to take pictures. On a recent trip out, the activities coordinators had been supporting people to take photographs with cameras. The photographs were then displayed in an exhibition held at the home.

The Pines was part of the local community. Local volunteers (Friends of the Pines) provided support by taking people out and spending one to one time with people. A coffee morning was held on a monthly basis whereby the local community was invited into the home along with relatives to join people and staff. Alongside a coffee morning, a book reading club had been organised which people and staff could participate in.

People's spiritual needs and beliefs were supported. An ecumenical church service was held on a weekly basis at the home. Alongside this, ministers, priests and reverends also visited the home, providing services along with Holy Communion.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. One person told us, "I'd speak to the nurse in charge or the manager if I had any concerns." When people moved into the home, a copy of the complaints procedure was provided which detailed how to make a formal complaint and the timescales in which the complaint would be acknowledged and addressed. A copy of the complaints policy was also displayed in the entrance hall of the home. Since January 2015, the provider had received five complaints. Information was available on the nature of the complaint, action taken and any learning.

Requires Improvement

Is the service well-led?

Our findings

People spoke highly of management. One person told us, "I think the home is well-managed." Another person told us, "They are very professional." A visiting relative told us, "I think the home is well run and professional." Despite people's high praise about the day to day management, we found some practices did not demonstrate that the home was consistently well-led.

Systems were in place for the monitoring and review of the quality of care, treatment and support provided. Regular audits were being undertaken. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who live at the home. Regular audits were being undertaken and these included care plan audits and medication audits. The regional director also conducted monthly visits whereby monthly audits were completed, assessing the delivery of care and statement. In line with new Care Quality Commission (CQC) methodology, a key line of enquiry audit was taking place which considered how the home was meeting the five key questions, is the service safe, effective, caring, responsive and well-led. We looked at the various audit undertaken since the beginning of the year. The key lines of enquiry audit (March 2015), identified concerns with the recording of care plans, discrepancies within care plans and that care plans required updating and reviewing. The provider had set the date for the end of May 2015 for improvements to be made. The care plan audit undertaken in May 2015 identified on-going concerns with the recording of care plans and that inconsistencies with recording were still present. On the day of the inspection, some care plans were still contradictory and inconsistent despite concerns being identified in March 2015. The regional directors recognised that on-going work was required to the recording of care plans and expressed commitment to making the improvements.

Sharing of information within nursing homes is vital. The delivery of safe and effective care requires all staff members to understand the needs of people, whose at risk and what level of support and input is required to meet people's individual needs. Daily handovers took place to provide staff with the forum to learn the information required to provide safe care that day. However, we raised concerns in relation to the effectiveness of the handovers and the sharing of information. Throughout the inspection, we asked staff members if they could tell us who was receiving end of life care, who required thickened fluids and who was experiencing pressure damage. Staff were not consistently aware of people's needs, despite daily handovers and meetings taking place. We also raised concerns that management had not identified this concern or assessed the effectiveness of the daily handovers. We have identified this as an area of practice that needs improvement.

There were systems and processes in place to consult with people, relatives and staff. The provider sent out a yearly satisfaction survey to people and relatives. This enabled management to monitor people's satisfaction with the service provided. Regular staff meetings were held which provided staff with the forum to air any concerns or raise any discussions. Staff members commented they felt any concerns or suggestions they made were acted upon. The provider was also committed to acting upon feedback received from people. One person had expressed dissatisfaction with the nurse call system and the sound it made. Sadly the person passed away but in honour of them, the provider implemented a new call system which was silent and was named after the person.

There was a clear management structure at The Pines which provided clear lines of responsibility and accountability. An acting manager was providing day to day leadership. A registered manager had not been in post since April 2015. Acting managers have been providing leadership. A deputy manager was in post and regional directors provided on-going support. Staff commented they felt able to approach management and an open door policy was operated.

The Pines had a governing values statement which directed the ethos and vision of the home. The deputy manager told us, "Five values are in place which govern the running of Gracewell care homes, these are: Kindness, Integrity, Trust, Empathy and Respect." The Care and Quality director told us, "The Pines was one of the first care homes opened under the provider of Gracewell. Gracewell (the provider) was started by two brothers whose Mother had poor experience of care whilst residing a care home. They wished to create care homes that were homely and didn't have the atmosphere of a nursing home." The five values were displayed throughout the home and staff members

Requires Improvement

Is the service well-led?

expressed dedication to providing high quality care. One staff member told us, “We provide a good level of care.” Another staff member told us, “I will do everything I can to make sure people get good care.”

The provider was dedicated to recognising good practice and enabling care home managers to keep up to date with good practice, changes in legislation and policy. A Heart and Soul award ceremony was held on a regular basis. This would be when care workers, nursing staff and managers are recognised for their hard work and commitment by colleagues and people living in the nursing homes. Conferences were also held for care home managers to attend where best practice would be discussed whilst providing the forum for learning and sharing to take place.

Following a significant incident, the provider was providing high level input into the Pines. Specialised input was being sourced and management input was being provided twenty four hours a day which meant a regional director was present at the home around the clock. The Care and Quality Director told us, “We want to be transparent, learn, develop and grow. We will not tolerate bad practice.” The provider was committed to making on-going improvements and during the inspection, provided us with service improvement plans and action plans which identified all the areas of shortfalls and what mechanisms were being put into place to address the shortfalls.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA (RA) Regulations 2014 Need for consent** **Regulation 11 HSCA (RA) Regulations 2014 Need for consent. The registered person had not ensured care and treatment of service users must only be provided with the consent of the relevant person. Regulation 11 (1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. Proper and safe management of medicines were not in place. Regulation 12 (2) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment** **Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good Governance** **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance** **The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs.** **Regulation 14 HSCA (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs. The nutritional and hydration needs of service users had not been met. Regulation 14 (1)**