South London Nursing Homes Limited

The Pines Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service responsive?	**Good**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 and 23 December 2015. Some breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to safe care and treatment, consent and person-centred care.

We undertook this focussed inspection to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the breaches found. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Pines Nursing Home on our website at www.cqc.org.uk.

The service had a manager in post who had completed the application to become 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 2008 and associated Regulations about how the service is run.

The Pines Nursing Home is a care home with nursing, providing nursing care and support for up to 50 people. It is located in Putney, in the London Borough of Wandsworth. There were 30 people using the service at the time of our inspection.

At our previous inspection we found that risk assessments and care plans were not always updated when people's needs changed and we found that consent to care and treatment was not always clearly documented.

At this inspection, we found that improvements had been made in all of these areas.

Appropriate checks were in place which helped to identify risks to people and care records showed that risks to people were regularly assessed and managed appropriately.

Specific risk assessments were in place and they were reviewed on a monthly basis. Any high risk areas identified had relevant assessments, care plans, a plan of care to guide staff and other monitoring records which helped to manage the risks to people.

We did see some examples where staff had incorrectly scored some of the risk assessments tools. Although there was minimal impact as the management of the risk was not affected by this.

Mental capacity assessment forms were in place and they were specific to particular areas such as maintaining a safe environment, personal hygiene, manual handling and health promotion. Where people did not have the capacity to consent, best interests care plans were available and best interests meetings

had taken place which helped to ensure their rights were respected.

Records were in place documenting the level of involvement of family members and how often they wished to be involved in care plan reviews and how often they wished to be kept up to date.

Individual preferences questionnaires were completed for people asking them for their preferences in relation to how they liked to be supported, this allowed for a more person centred level of care to take place.

Care records were arranged logically and each identified risk had relevant risk assessments, care plans and plan of care in place. Records were updated monthly.

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

We found that action had been taken to improve the safety of the service.

Risks to people had been identified and they had appropriate plans in place to manage the risk. We found that some risks were not scored correctly however this had minimal impact as the risk management plans remained unchanged.

We received mixed feedback about the response of staff to call bells.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Good

We found that action had been taken to improve the effectiveness of the service.

People's consent to care was recorded appropriately and those that were unable to consent had their rights protected.

Is the service responsive?

Good

We found that action had been taken to improve the responsiveness of the service.

Care plans were laid out logically and reflected people's current support needs to ensure that their individual needs were met appropriately.

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 unannounced comprehensive inspection on 15 November 2016.

This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 17 and 23 December 2015 had been made. We inspected the service against three of the five questions we ask about services: is the service safe? is the service effective? and is the service responsive? This is because the service was not meeting some legal requirements.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses services like this.

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 our inspection we spoke with four people using the service, three relatives and four staff members, including the manager, deputy manager and activities coordinator. We looked at four care plans.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection which took place on 17 and 23 December 2015, we found people were not always protected from avoidable harm as not all risks were adequately mitigated. Risk assessments were not always up to date and there was not always a documented response to changes.

People we spoke with raised concerns about the efficiency of the call bell system and the slow responsiveness of staff.

At this inspection we found that some improvements had been made. The provider was now meeting the regulation.

We still received mixed feedback from people and relatives about the responsiveness of care staff when they used the call bells. Comments included, "[Person] uses the bell in the room and they come", "I use the bell. The dreaded bell doesn't always get answered" and "Not always no."

We saw that call bells were in reach of people and we observed them being responded to in a timely manner.

Some people had call bell care plans in place which included steps to ensure that call bells were accessible and also for staff to carry out hourly checks on them. We checked a sample of charts for people with a call bell care plan and saw these were filled out and coded as to whether the person was asleep, awake or assisted with personal care.

The regional manager confirmed that the call bell system was to be upgraded in March 2017.

Care records showed that risks to people were regularly assessed and managed appropriately. Appropriate checks were in place which helped to identify risks to people.

For example, assessments of daily living skills were completed which highlighted people who were at risk of falls. A falls risk assessment was also completed and reviewed monthly. Those that were identified as being high risk had associated care plans in place. We saw examples of these where there was an identified need, the cause and the desired outcome. The plan of care documented the steps that staff needed to minimise the risks such as maintaining a clutter free environment, ensuring mobility aids were in place and if bedrails or crash mats were needed. A falls booklet was in place for tracking falls.

The provider used assessments of daily living skills that were specific to areas such as moving and handling, manual handling and tissue integrity to determine the level of support people required in these areas.

An assessment of daily living skills for moving and handling was completed determining the level of support needed in this area. These looked at whether people needed support and the level of support needed. People identified as being at high risk had associated risk assessments, care plan and a plan of care in place

in relation to moving and handling which helped to ensure the person had the appropriate level of support.

We observed staff using a hoist to transfer a person. They explained to the person what they were going to do, and spoke with them in a reassuring manner. There were enough staff to support the person and they did so appropriately.

The assessment of daily living skills for tissue integrity identified people at risk of pressure ulcers and there were risk assessments in relation to this such as Malnutrition Universal Screening Tool (MUST), pressure ulcer, falls and moving and handling assessments and a care plan for tissue viability in place.

We saw some examples where staff had incorrectly scored some of the risk assessments tools. There was a MUST and Waterlow assessment for pressure sores which were scored incorrectly. Although there was minimal impact as the associated management plans were the same, there was still a potential risk. We highlighted this to both the regional and home manager.

Although we found that concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

Good

Is the service effective?

Our findings

At our previous inspection which took place on 17 and 23 December 2015, we found people's rights may not have been protected as the provider did not always seek consent for care and support from the relevant person. We found that consent to care and treatment was not always clearly documented.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

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).

One person had an advanced care plan in place, which stated that the person was not to be resuscitated. This had been signed and dated by the person and also by their next of kin and a nurse. They had a Do Not Attempt Resuscitation (DNAR) form in place which had been reviewed and signed by the GP recently.

Mental capacity assessment forms were available. These were specific to particular areas such as maintaining a safe environment, personal hygiene, manual handling and health promotion.

Best interests care plans were in place and these recorded whether people were able to make decisions for themselves or if best interests meetings were needed to ensure their rights were respected.

Best interests meetings had taken place where people did not have capacity to understand decisions and restrictions in place for their safety. A best interests meeting had taken place for a person with bed rails to minimise the risk of them falling following which it had been decided to discontinue with this practice as the person was at risk of climbing over the bed rails. It had been decided that the risk would be managed better by lowering the bed, this decision was taken in consultation with family members and nursing staff.

Where people had a lasting power of attorney (LPA), this was recorded in their care records. A care plan for 'decision by relatives/carers/residents' was in place documenting the level of involvement of family members and how often they wished to be involved in care plan reviews and how often they wished to be kept up to date.

The provider had identified people who they felt were being deprived of their liberty and had submitted DoLS applications to the appropriate authority.

Good

Is the service responsive?

Our findings

At our previous inspection which took place on 17 and 23 December 2015, we found care and treatment did not always meet people's needs. People were at risk of not having their needs met as care plan documentation was not always fully completed or up to date.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

Individual preferences questionnaires were completed for people asking them for their preferences in relation to bedtimes, waking and mealtimes, personal care and their level of involvement in the service. This allowed for a more person centred level of care to take place.

Care records were arranged logically and each identified risk had relevant risk assessments, care plans and plan of care in place. Records were updated monthly and the information in one area matched information in other areas, which was not the case previously. Food and fluid charts were completed appropriately and other records related to monitoring people's health such as turning charts and wound charts were updated regularly with notes and photos including a record of dressing changes.

Evidence was seen in care records that referrals had been made to health professionals and people were being supported well. We saw a dietitian letter dated November 2016 indicating that the nutritional status, weight and BMI of a person under their care was stable and they were being managed well. We also saw a discharge summary from the maximising independence therapy team who had been contacted due to the number of falls for a particular person. There was evidence that the risk was managed, with referrals being made to physiotherapists after falls. An assessment by the specialist dietitian was seen after a referral had been made for a person whose malnutrition decreasing.