

Pentlow Nursing Home Limited

Pentlow Nursing Home

Inspection report

59-63 Summerdown Road
Eastbourne
East Sussex
BN20 8DQ

Tel: 01323722245

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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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Pentlow Nursing Home provides facilities and services for up to 60 older people who require personal or nursing care, for long term and for short periods to cover family holidays or times of ill health. People's nursing and support needs varied, some were living with complex nursing needs, including end of life care, diabetes, stroke, heart conditions and Parkinson's disease.

Many people needed support with their personal care, eating and drinking and mobility. Some were living with a dementia and memory loss and required support with this, along with their physical care needs. Pentlow Nursing Home is based over two neighbouring buildings called Pentlow and Summerdown.

This inspection took place on 30 August and 7 September 2017 and was unannounced. At the time of this inspection 40 people were living at the service, 12 in Summerdown and 32 in Pentlow.

The service did not have a registered manager. However, the appointed manager was working in the service and their application for registration was being processed by the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection undertaken on the 8 and 9 June 2016 the home was rated 'Requires Improvement' overall. This was because we found some areas of practice that needed to improve. At this inspection some areas had improved, including the safety of the premises, however we found further and ongoing areas that require improvement.

The management of medicines did not always provide clear records to ensure medicines were given safely and in a consistent way. There were no records to identify when and how prescribed topical creams were administered and medicines given 'as required' did not always have clear guidelines for staff to follow. When 'as required' medicines were administered the amount and time was not always recorded.

Agency staff were relied on as part of the regular staff provision. Although there was a basic induction sheet completed, staff had not received training on specific care and practice related to the service they were working in. The operations manager and appointed manager advised that further induction training was to be provided, which would be tailored to the agency staff's needs.

The care documentation and records did not always provide staff with the information and guidelines to provide person centred care. Care plans did not cover specific health care needs and therefore did not ensure these needs were responded to in a consistent and appropriate way. Other records were not completed consistently to ensure responsive care. For example, the handover sheets used to share key information between staff were not accurate.

The quality monitoring systems did not always establish best practice or identify all areas for improvement. The provider had not established systems that identified and responded to poor record keeping, the management of reported incidents, the submission of required notifications, and a lack of person centred care planning.

People were happy with the care they received and they appreciated and told us they liked the regular staff that cared for them. Staff were kind and attentive and demonstrated a caring approach to people.

Staff employed by the service had a good understanding of safeguarding procedures and knew what actions to take if they believed people were at risk of abuse. Recruitment records showed there were systems which ensured as far as possible staff were suitable and safe to work with people living in the service. Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Senior staff had an understanding of DoLS and what may constitute a deprivation of liberty and followed correct procedures to protect people's rights.

Staff employed by the service were provided with a full induction and training programme which supported them to meet the needs of people. Staffing arrangements ensured staff worked in such numbers, that people's needs were responded to in a timely fashion. The registered nurses attended additional training to update and ensure their nursing competency.

Staff monitored people's nutritional needs and responded to them. Preferences and specific diets were provided. People were supported to take part in a range of activities maintain their own friendships and relationships with whoever they wanted to.

Feedback was regularly sought from people, relatives and staff. People were encouraged to share their views on a daily basis and satisfaction surveys were used to improve the service. People were given information on how to make a complaint and said they were comfortable to raise a concern or complaint if need be.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4). You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not safe.

Guidelines and records relating to some medicines were not clear and did not ensure all medicines were administered safely and in a consistent way.

People told us they were happy living in the service and felt safe. Regular staff employed directly by the service had received training on how to safeguard people from abuse and were clear about how to respond to any allegation of abuse.

There were enough staff on duty to meet people's care needs. Appropriate checks were undertaken to ensure suitable staff were employed to work at the service.

The environment and equipment was well maintained to ensure safety. Risk assessments were used to assess potential risks and staff responded to these.

Requires Improvement ●

Is the service effective?

Some aspects of the service were not effective.

Staff were trained and supported to deliver care in a way that responded to people's needs. However, agency staff who formed a vital and regular part of the work force had not received any training to support them in this role.

Staff had an understanding of the Mental Capacity Act 2005 and DoLS and the need to involve appropriate people, such as relatives and professionals, in the decision making process.

Staff ensured people had access to external healthcare professionals, such as the GP and specialist nurses as necessary and had established good links with local community resources.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences.

Requires Improvement ●

Is the service caring?

Good ●

The service was caring.

People were supported by kind and caring staff. Relatives were made to feel welcome and encouraged to stay as long as they wished.

Everyone was positive about the care provided by all the regular staff.

People were encouraged to make their own choices and had their privacy and dignity respected.

Is the service responsive?

The service was not always responsive.

Accurate records had not been maintained to ensure that people got individual and person centred care.

There was a comprehensive and personalised activity programme which people enjoyed participating in as they wished.

Complaints had been investigated and actions documented.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Quality monitoring systems did not always establish best practice or identify all areas for improvement.

The appointed manager was committed to developing the service and establishing good standards within the service.

People were confident that they were listened to and had their views taken into account.

Requires Improvement ●

Pentlow 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

The first day of inspection took place on 30 August 2017 and was unannounced. The inspection team consisted of two inspectors and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection took place on 7 September 2017 and the registered manager was advised of this visit.

Before our inspection we reviewed the information we held about the service. We considered information we had been given, including telephone contacts, share your experience forms which are generated when people contact us online, safeguarding alerts 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. The provider completed 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.

Before the inspection we spoke with the local authority who commissioned care for people from the service. During the inspection we talked with 12 people who used the service and five visitors. We spoke with various staff members including the operations manager, the activities co-ordinator, the chef, two registered nurses, the training and quality manager, the maintenance person and three care staff. Following the inspection, we spoke with two specialist nurses who visit the service and a social care professional.

We spent time observing staff providing care for people in areas throughout the home and observed people having lunch in the dining room. We used the Short Observational Framework for Inspection (SOFI) during the second day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a variety of documents, which included four people's care plans and associated risk and

individual need assessments. We looked at four staff recruitment files, and records of staff training and supervision. We viewed medicine records, policies and procedures, systems for recording complaints, accidents and incidents and quality assurance records.

Is the service safe?

Our findings

People told us they felt safe living at Pentlow Nursing Home. They told us they were secure and fire precautions were in place to respond to any fire risks. People said they were well looked after, with staff available to attend to their needs. People's comments included, "Yes I feel safe here, I don't have any problems, there is good fire safety," "I do feel safe, the staff, security and fire safety make me feel safe, I would speak to the manager, or write to Pentlow if I was worried," "Very safe living here, I feel quite safe from the world here, bells are answered quickly," and "I feel safe, the people around me make me feel safe." Relatives were also positive about people's safety. They told us staff were in regular contact with them and had addressed safety issues around mobility. One relative told us, "He is safe now and he uses a wheelchair now. Staff let me know if he is unwell or in hospital."

At the last inspection on 8 and 9 June 2016 we asked the provider to make improvements to the PRN guidelines for individual medicine administration and to records relating to the administration of topical creams. At this inspection improvements had not been made. The service had changed its supplying pharmacist in May 2017 recognising further improvements were required.

Systems and procedures did not ensure all medicines were administered safely and in a consistent way. The service had a medicine policy and procedure, but this did not cover all areas of safe medicine administration, including the use of skin creams. We found there was no system for staff to follow and record how and when skin creams were given. The provider could not demonstrate that skin creams were given to people in a consistent way, or in accordance with prescriptions. For example, one person was prescribed two skin creams which were recorded on the Medicine Administration Chart (MAR) chart, but there was no record of when or if they had been administered. Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example, if they were experiencing anxiety or pain. We found that some people did not have individual PRN guidelines for staff to follow. These should provide guidance for staff about why the person may require their medicine and when it should be given. In addition we found staff were not recording the amount of medicine administered, or the time of administration. This meant staff may not be supported to administer all medicines in a consistent and safe way. This is particularly important when the service has new and agency staff. The appointed manager was aware that the PRN guidelines needed to be updated and reviewed to ensure they were available and record keeping needed to demonstrate clearly when and what amount of medicine was administered. MAR charts reviewed indicated some records were not accurate. We found one record that indicated that a double dose of medicine had been given and another record that indicated two medicines had not been given without any reason for the omission recorded. Staff were not able to explain why the omission had not been authorised or discussed with a GP. These issues were identified to the appointed manager for her to investigate and address.

The lack of safe and consistent practice for medicine administration was a breach of 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Storage facilities for medicines were appropriate and well managed. For example, medicine rooms were

locked and the drug trollies were secured in these rooms when not in use. Medicines were only administered by registered nurses and an allocated nurse was designated the task of ordering and checking medicines once delivered back from the pharmacy. Stock checks were completed on medicines that required additional security and each medicine room had its temperature monitored, to ensure these rooms did not become too hot. High temperatures can lead to medicines not being effective. Practice observed during the inspection confirmed staff administered medicines on an individual basis.

Staffing arrangements included separate staffing for each of the buildings. This included a registered nurse allocated to each covering the 24 hours. In order to maintain the staffing numbers and skill mix the service relied on agency staff. This had been an ongoing situation and compounded recently with three registered nurses giving their notice in. As far as possible regular agency staff were used to ensure people were supported by staff who were familiar to them, and understood their individual needs. People recognised the need for agency staff and knew and liked some that came regularly. However, they expressed a wish to be looked after by regular staff who they preferred and were able to attend to their needs quickly. People's comments included, "Some staff I like, a lot of casual staff who don't know what they are doing half the time, sometimes they answer the bell quickly, I have to have someone help me to get up, so I ring the bell when I am ready," "On the whole the permanent staff are fine, agency staff are not the same. Several staff are leaving which is unsettling. They answer the call bell as quickly as they can," and "On the whole I like the staff, the best carer has been off for 6 months. Not enough regular staff, practically halved. Agency staff some are good, some are not." The operations and appointed manager told us recruitment was progressing they were aware of the challenges of using agency staff. They advised that admissions to the service were being monitored to ensure staff were able to cope with any new admission to the service.

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the service. Checks included the completion of application forms a record of interviews, confirmation of identity, references and a disclosure and barring check (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. There were systems in place to ensure staff working as registered nurses had a current registration with the Nursing and Midwifery Council (NMC) which confirmed their right to practice as a registered nurse.

Regular staff employed directly by the service received training on safeguarding adults and understood their individual responsibilities to safeguard people. Staff told us they were confident in the reporting any safeguarding concerns. Care staff told us they would raise directly with the registered nurses on duty. The regular registered nurses were able to describe the safeguarding procedures to follow to ensure any risks were removed and referred to the appropriate authorities. However, an agency registered nurse was not clear on the procedures to follow and this was raised with the appointed manager for her to address. The appointed manager worked with the local authority when any safeguarding alert was raised. This had included a recent concern raised about another service and the care provided there.

The provider had established systems to promote a safe and clean environment at Pentlow Nursing Home. Systems to ensure the security of the service were in place with all visitors entering a reception area and signing a visitor's book before entering the service. Health and safety checks and general maintenance were established and completed routinely by the maintenance person. Emergency procedures and contingency plans were established for staff to follow and use. This included the use of sister homes for safe accommodation within the local area. There was an 'on call' system to provide advice and guidance from senior staff from within the organisation. A fire risk assessment had been completed and fire equipment was checked and maintained. Emergency information was accessible in the front entrance of the service and staff knew what to do in the event of a fire. This information included Personal Emergency Evacuation Plans

(PEEPs) used to direct staff and emergency services on safe evacuation of people from the service in the event of an emergency.

The computer system used includes a number of risk assessments to provide an individual overview of risk. These included risks associated with nutrition, skin and eating. Risks identified were responded to, for example, people at risk of skin damage had specialist equipment including mattresses and cushions. These were checked daily to ensure they were set correctly and to ensure they provided the best support to people at risk.

Is the service effective?

Our findings

People told us staff responded to their individual needs and felt the regular staff understood how to look after them well. Comments included, "Regular staff know and understand me, and they discuss my care with me. Some casual staff do not know my needs, but they all promote my independence," and, "On the whole the staff know me, though the staff are chopping and changing a lot at the moment which is difficult. I am quite independent and therefore control a lot of the decisions about my care." Relatives were satisfied that staff worked hard to meet people's needs.

The service used both agency care staff and registered nurses. The service relied on agency staff to maintain the service provision. We were shown an induction sheet that they completed. This was basic and for one agency registered nurse working in the service had not been completed. There was limited time and introduction for staff to understand the care needs of people and the care plan system. This was identified as an area requiring improvement. The operations manager and appointed manager advised that with the push to use more regular agency staff, a more in depth induction programme was to be implemented along with additional training on the computerised care plan system. This would include a medicine competency assessment for registered nurses, as currently they were reliant on any training and competency assessments completed by the supplying agencies.

The provider was committed to establishing a structured learning and development schedule for the staff they employed. The service had employed a new training and quality manager who had reviewed the essential training programme and introduced a full induction programme for new staff to complete. This induction included formalised training based on the 'Care Certificate', along with a tailored shadowing period within the service attached to a senior member of staff. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. Staff who had completed this induction training were positive about the programme and how it had prepared them for their role in the service.

A programme of essential training for all staff was in place and staff had completed essential training throughout the year. This training was co-ordinated by training and quality manager who ensured staff completed the required training. They also completed competency checks on staff whilst working in the service to ensure training completed was transferred into practice. The training programme was varied and reflected the needs of people living in the service. It included training on health and safety, infection control, food hygiene, dementia awareness, mental capacity and DoLS, safe moving and handling and safeguarding.

Staff told us that the training had improved and had given them the opportunity to develop. The provider was also providing additional training to staff who were taking on allocated lead roles within the service which included infection control, and nutrition and hydration champions. One care staff member told us they being supported to take up a more senior role in the service. Two other staff told us they were up to date with their training and looking forward to 'virtual dementia' training that had been arranged. The registered nurses were supported to update their nursing skills and competencies. For example, one registered nurse had recently completed an update on taking bloods safely. The registered nurses were also

supported in the training they were required to undertake to maintain their registration with the Nursing and Midwifery Council.

Staff were supported and received guidance in order to fulfil their allocated roles. Regular supervision meetings and annual appraisals were completed. These gave staff the opportunity to discuss individual learning and development needs. Staff told us they found the regular supervisions helpful and supportive.

Staff had completed training on the Mental Capacity Act (MCA) and DoLS. Staff told us they always asked for consent before providing any care. The MCA 2005 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. Mental capacity assessments were completed and when people were not able to make specific decisions, staff worked in accordance with the Mental Capacity Act (MCA). The appointed manager had ensured an application had been made to the local authority for DoLS when appropriate. These had been recorded and included in people's individual care plans. Applications were monitored and followed up with the DoLS assessment team to ensure they were progressed as soon as possible. These safeguards ensure any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm.

People felt the food was good there were choices and their preferences were responded to with a daily menu to choose from. They could eat their meals where they wanted to and attractive dining rooms were available for people to use. One person said, "The food is very good, not a lot of choice, but we get enough and plenty of drinks." Another said, "I have a special diet, they cater for it, not a lot of choice, more than enough to eat, there's plenty to drink. I go to the dining room sometimes especially on a Sunday." Staff knew individual preferences that were important to people. For example, one person had a particular drink with her lunch and evening meal, this was always provided at the correct time to ensure her dining experience was as she wanted.

People were supported to have enough to eat and drink. Staff were available to support and encourage people to eat both in the dining rooms and in people's own rooms. Staff were not rushed and gave people time to eat at their own speed with the correct approach being used.

For example, one person had specific care needs that included the use of a straw and intervals between each sip. This was followed by staff in a sensitive manner.

People's nutritional needs had been assessed and reviewed and staff had a good knowledge of people's dietary needs. The chef was aware of these and was involved in discussions with staff, professionals and families on how best to meet them. They took a genuine interest in ensuring the appropriate provision that met people's individual needs. They said, "I often go to the dining room. This is their home, so whatever they need, it's our responsibility to provide it. Everybody is special, but some we have to be extra careful with." One person was on a complex diet and the chef had a dedicated folder to provide guidance to them and other staff on meeting this. For example, it recorded risk foods that should be avoided. When people lost weight or had difficulty in eating and swallowing, staff referred to appropriate professionals for advice as necessary. Additional support and monitoring was put in place and recommended changes to food and drinks were implemented. For example, one person had nutritional supplements prescribed by the GP.

People were supported to maintain good health and received on-going healthcare support. People said they were supported to have medical advice when they needed it and said they could see a GP whenever they wanted to. One person told us, "I have been to a dentist, and a doctor comes to see me often as I have

bad legs." Staff worked closely with health and social care professionals and promoted timely and effective access. They followed recommendations and advice given. For example, staff sought advice from specialist nurses on a skin injury which was not healing, caused by an insect bite.

Is the service caring?

Our findings

People received care and support from staff who were kind and caring in their every day care and contact with people. People told us all staff were very caring in their approach responding to their wishes and listening to how they wanted to be looked after. One person said, "They treat me in a kind and caring manner." Relatives were complimentary about the staff approach and said, "Staff are caring and lovely, go out of their way to help people, they always respect his dignity and privacy." Another relative said, "Staff are very caring, they put a notice on the door when they are treating him."

The SOFI and general observations showed interactions between staff and people were pleasant and polite. Staff asked people what they wanted, listened to what people said and acted on what they were told. For example, one person was looking for staff attention, a staff member recognised they wanted to be attended to and asked them if they wanted anything. This gave the person the opportunity to ask for the toilet discreetly. Staff were polite and courteous in their contact with people. Staff demonstrated their concern for people's well-being and safety and attended to them with a genuine caring approach. General conversations between people and staff at all levels were meaningful and reflected a respect for people as individuals. For example, housekeeping staff had long conversations with people asking them for a suitable time to return to finish cleaning a particular area of their room. This indicated a positive approach with engagement, consultation and responding to people's choices.

The service encouraged people to maintain relationships with their friends and families and to make new friends with people living in the service. People were introduced to each other and staff supported people to spend time together, in this way genuine friendships were formed within the service. Visitors were able to come to the service at any reasonable time, and stay as long as they wished. Visitors told us they were welcomed and always offered a drink. Beverages and cakes were available at the front entrance of the buildings, and people and visitors were able to help themselves. Staff engaged with visitors in a positive way and supported them to join in the communal activities in the lounge, or have private time together. One person told us, "I can have private time with my son if I wish, staff help me go to my room."

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. One person told us they had regular visits from their church and felt her spiritual needs were respected by staff. Another person told us, "We have a church service every week conducted by the activity staff, a priest comes once a month for communion."

People told us they felt that's staff always respected and supported them in maintaining their privacy and dignity. Relatives were also positive about the approach of staff. One told us, "The staff are attentive and kind, day and night. I am reassured with the obvious provision for people's privacy and dignity. Staff close doors, or use screens and call people by the name they want to be known by." Staff thought about how to promote people's privacy and dignity on an individual basis. For example, one person had regular appointments and in order to maintain their privacy staff had arranged for him to leave the service by a

private exit. People's bedrooms were seen as their own personal area and private to them, with staff only entering with permission. Privacy signs were used on the doors to prevent any disturbance when people were receiving care or had chosen not to be disturbed. Visiting professionals told us staff were mindful of people's privacy and ensured any consultations were completed in private. People's rooms were individual and contained items that were important to people. This included pictures and photographs to make rooms look more homely. Many people preferred to spend their time in the privacy of their own rooms. Staff responded to this choice and visited them regularly to ensure they did not become isolated.

Is the service responsive?

Our findings

People and their representatives were involved in deciding how people's care was provided, they told us that they had discussed their needs with staff and that these had been reviewed. People told us they believed staff knew and understood them, some people had been living in the service for several years and had established how their care was delivered and the routines they liked to have in place.

Despite this positive feedback, we found the care documentation used did not provide staff with the information and guidelines to provide person centred care. For example, people living with diabetes did not have specific care plans to describe how their related healthcare needs were to be responded to. This meant staff had not planned the care of people taking account of recommended guidelines. The provider could therefore not be assured that people living with diabetes were being provided with the best care possible in a person centred way. We also found some inconsistencies in the care provided. The monitoring of blood glucose levels were not completed in a regular and consistent way. For one person, they were completed three times a day and sometimes just once a day. There were no guidelines within individual care plans for staff to follow when responding to the results of blood tests. Staff spoken with did not know what range of blood sugar levels were appropriate for each person living with diabetes. One person had their medicine omitted following a low blood glucose result. The rationale for this omission was not documented within the care plan. The handover sheet used to share key information between staff was not accurate in all areas. For example, it recorded one person had a broken area on their foot, when this was not the case.

Care records were not always accurate and staff understanding of specific care needs did not ensure all services were organised to ensure people's needs were met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new computer system had been introduced in June 2017 that included an individual iPod for care staff to input care information. Training on the system was provided to staff when implemented. However, the system has not been embedded into practice and we were told further training for all staff was to be progressed to ensure the system can be used effectively.

People told us they had been consulted on how they wished to have their care and support provided. People and their relatives said their individual choices had been taken into account when care was planned and given. For example, a number of people chose to spend most of their time in their own rooms preferring their own company. Staff ensured people had their call bells and were checked and spoken to on a regular basis, to ensure their physical and emotional needs were attended to. Therefore, people choosing to stay in their rooms were not isolated and could call for help if required.

A range of activities were provided throughout the service and tailored to meet people's individual needs. These were mostly provided centrally within Pentlow lounge or in the attractive gardens. The provision of meaningful activity and entertainment was given a priority within the service, with allocated activity staff employed. People's past life, interests and hobbies were assessed for staff to arrange and provide suitable variety to people living in the service. People chose to attend the functions and entertainment as they

wished. The Pentlow lounge was used as a central area for meeting and general social interaction. Staff facilitated games and discussions communally promoting a general positive conversation. For example, the daily newspapers were discussed with people taking an interest in world events and being able to discuss them with other interested people.

The activity staff were seen as vital team member working alongside the care staff and the management team to promote people's general and emotional well-being. The activity programme was varied and people were provided with a copy to inform their individual choice. For example, some people were enjoying a massage which was a new activity recently provided on request. One person told us they found this 'really beneficial.' Staff used birthdays and other family events like anniversaries as a celebration for people and a party. People enjoyed the trips arranged outside of the service on the mini bus, which were provided twice a week. These had included trips to local areas of interest and sight-seeing trips, for instance along the seafront, or to the lighthouse. People and their relatives were positive about the activity, entertainment and social interaction promoted within Pentlow Nursing Home. Comments included, "I go to some activities, very good choice, we had a singer yesterday, he was very good," "I do the activities, I love them and a good choice, I have been out in the mini bus as well," and "I enjoy the activities very much." One relative said, "He enjoys the activities very much, Elvis is coming tomorrow."

There was a complaints policy and procedure available to people to use, this gave accurate information on who to contact if not satisfied with internal investigations and resolution. A copy of this was displayed in the service and held within the brochure information. People and relatives told us they were able and comfortable to raise a complaint if they needed to. They believed any concerns raised were, or would be listened to and responded to. People said, "I would go to the manager with a complaint," and "I would go to the new manager with any complaint, she listens and acts, she is very good." A relative told us, "I have never had to make a complaint, but the manager would listen to me." We saw evidence that complaints that had been raised in the past had been documented and responded to appropriately.

Is the service well-led?

Our findings

People and relatives were positive about the management of the service. People told us they were happy living at Pentlow Nursing Home. They were confident that the appointed manager was re-organising the service to address areas that needed attention. For example, recruitment was progressing to address the ongoing high use of agency staff. They knew who the appointed manager was, who had introduced herself and changes within a 'residents meeting.' People and relatives told us she was approachable and willing to listen. One person said, "The manager is quite new, she needs a bit of time to settle in to be fair. I go to the residents meetings, they are definitely useful. No concerns really, I could not manage on my own. This home is as good as any I hear about."

Whilst feedback about the management was positive, we found the leadership of the service was not effective in all areas. There had been four changes to the manager of the service over the past 18 months. The new appointed manager took up post in May 2017 and confirmed their commitment to the service and organisation.

At the last inspection on 8 and 9 June 2016 we asked the provider to make improvements that ensured the agency staff working in the service had the required competencies. That accidents were reviewed and audited to identify themes and trends. Those quality systems were improved to identify areas for improvement. At this inspection the quality monitoring and improvement systems had not addressed all these areas.

Management systems that included quality monitoring had not always ensured safe and best practice was followed in all areas. The provider had not established systems that identified and responded to poor record keeping, the management of reported incidents, the submission of required notifications, and a lack of person centred care planning. For example, records relating to medicines were not always accurate and did not evidence best practice was followed, or that prescribed medicines were always administered. Accidents and incidents reported were not used to identify areas for improvement. For example, incidents identified relating to medicines were not reviewed in a way to identify any themes or trends. Accident reports did not always include a review by a senior member of staff to ensure suitable action was taken in response and to minimise any risk. Care plans were lacking in information, assessment and guidelines for staff to follow to ensure person centred care. The provider had not ensured areas raised within the last two inspection reports had not been fully addressed and improvements noted at last inspection were not embedded into practice and continued.

The lack of quality review and monitoring is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations in a timely fashion. This was discussed with the appointed manager and operations manager on the first day of the inspection. The operations manager reviewed all significant events within the service over the past six months and ensured appropriate notifications were sent as a

priority. Following the inspection the appointed manager ensured all required notifications were sent accordingly.

This lack of appropriate notification is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

There was a clear management structure in place at Pentlow Nursing Home that staff understood. There were identified roles within the service and a new deputy manager had been recruited to support the appointed manager. Staff were aware of the line of accountability and who to contact in the event of any emergency. There was an operations manager who was also available as part of the management team. On call arrangements that ensured advice and guidance was available every day and night if required. This was covered by senior staff within the service and the organisation including managers from other local services. Staff knew about the whistleblowing procedure and how to contact external agencies if they needed to.

Staff understood management changes came with some disruption and changes to practice. This had caused some disruption and a hope for stability in the future. One staff member said, "It's been hard with the number of changes in managers. We are hoping things will settle now." Another said, "There's been so many changes recently including another manager. They have different styles and approach things differently". The appointed manager and operations manager used a service improvement plan to monitor and record planned improvements, these were reviewed at the appointed manager's supervisions. One staff member said, "The new manager has a clear vision for the home, has high standards, has a clear focus and is clear on what needs to be achieved." The appointed manager held regular staff meetings and used these to thank staff and to motivate them to continue planned improvements. For example, the housekeeping staff had been praised for improvements made in the level of cleaning accomplished. The values of the organisation and service were also discussed at team meetings and used to underpin the care provided.

The provider sought feedback from people and those who mattered to them in order to enhance their service. This was facilitated through regular meetings satisfaction surveys and regular contact with people and their relatives. During the inspection people were talking about a meeting to be held with the appointed manager in the communal lounge. They were motivated to attend and interested in what was going to be discussed. Meetings were used to update people on planned events and other activities, changes in staff and any works to be completed to the premises. People were encouraged to talk about other issues including the quality of food and care. Feedback from satisfaction surveys were used to plan improvements through action plans shared with the management team and heads of departments. For example, on-going refurbishment to toilets and bathrooms was progressed through maintenance staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations in a timely fashion
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care documentation used did not provide staff with the information and guidelines to provide person centred care.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and procedures did not ensure all medicines were administered safely and in a consistent way.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Management systems that included quality monitoring had not always ensured safe and best practice was followed in all areas. The provider had not established systems that identified and responded to poor record keeping, the management of reported

incidents, the submission of required notifications, and a lack of person centred care planning.