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Southdown 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 and 29 November 2016 at which a breach of legal requirement was found in relation to good governance. We found the provider did not have sufficient processes in place to review the quality of all care records and ensure learning from key service data. Following our inspection, the provider told us they would make the necessary improvements by 31 January 2017.

We undertook a focused inspection on the 10 March 2017 to check they now met legal requirements. This report only covers our findings in relation to this inspection. You can read the report from our previous comprehensive and focussed inspections, by selecting the 'all reports' link for 'Southdown Nursing Home' on our website at www.cqc.org.uk.

Southdown Nursing Home provides accommodation, nursing and personal care to up to 28 older people, some of whom have dementia. At the time of our inspection 24 people were using the service.

The service did not require a registered manager, as the provider was an individual provider who also managed the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 this inspection we found the provider had not taken sufficient action to address the breach of regulation identified at our comprehensive inspection on 28 and 29 November 2016 and there remained ineffective processes in place to review and monitor the quality of care records. In addition to the continued breach of legal requirement relating to good governance, we identified people were not protected from the risk of unsafe care and treatment because sufficient processes were not in place to help prevent and manage pressure ulcers.

We found the provider was now in breach of two legal requirements relating to good governance and safe care and treatment. You can see what action we have asked the provider to take in regards to the breach of safe care and treatment at the back of this report. We are considering what action to take in regards to the continued breach of good governance and will report on this when it is complete.

After our comprehensive inspection in November 2016 the service was rated 'good' overall and for four of the key questions, with only the key question 'is the service well-led?' rated 'requires improvement'. However, due to the concerns identified at this inspection the service is now rated 'requires improvement' overall and for the two questions 'is the service safe?' and 'is the service well-led?'.

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

Some aspects of the service were not safe. There were ineffective systems in place to protect people from the risk of developing pressure ulcers and ensure those with pressure ulcers received appropriate treatment to manage their wounds.

Is the service well-led?

Requires Improvement

Some aspects of the service continued to not be well-led. The provider continued to have ineffective processes in place to assess, monitor and improve the quality of care recording and ensure risks to people's safety were mitigated.

Southdown 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 a focused inspection of Southdown Nursing Home on 10 March 2017. This inspection was completed to check that improvements to meet legal requirements planned by the registered provider after our comprehensive inspection on 28 and 29 November 2016 had been made. We inspected the service against two of the five questions we ask about services: is the service safe? And is the service well-led?

The inspection was undertaken by one inspector. Before our inspection we reviewed the information we held about the home, this included the registered provider's action plan which set out the action they would take to meet legal requirements and the statutory notifications received. Statutory notifications provide information about key events that occur at the service.

During the inspection we spoke with three staff members, including the provider, the administrative manager and the nurse on duty. We reviewed care record audits and aspects of six people's care records.

Requires Improvement

Is the service safe?

Our findings

During our checks of care records we found incomplete and inaccurate records relating to the support provided to people to reduce their identified risks of developing pressure ulcers. As a result we looked in more detail at other aspects of care relating to the prevention and management of pressure ulcers.

We looked at the records of two people identified as having pressure ulcers and the records of a third person who may have been at risk of developing these due to a noted change to their skin condition. For these three individuals we saw their pressure ulcer risk assessments had not been updated in response to changes in their skin conditions. We could not find any records that the person's skin condition which was noted as having changed, had been reviewed by a nurse to identify if any additional support was required to protect from further deterioration of their skin. For two people that had pressure ulcers there was a lack of treatment plans available. We were unable to establish from their records how their wounds were being managed, what dressings were being applied and how frequently they were being changed. People's pressure ulcer support plans stated "follow regime for maximum healing", but they did not detail what the regime was that was meant to be followed. Each of these three individuals had pressure relieving mattresses in place, however upon checking, these were not set at the correct setting in line with the person's most recent weight records.

We could not be assured that people were being appropriately protected from the risks of pressure ulcers and receiving appropriate treatment to prevent further skin breakdown. One person's care records had noted their skin condition had significantly declined but due to the lack of records we were unable to establish whether this could have been mitigated.

The provider was in breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection in November 2016 we found the provider had improved the quality of care records audits. However these audits did not fully review the quality and completeness of daily records maintained by staff. Our own checks at the time found these were not completed correctly and did not provide an accurate record of the support provided. We also found whilst the management team had reviewed the process for capturing and recording information about incidents and complaints, they had not implemented their plans to analyse and learn from this data.

At this inspection we found the provider's systems to review and monitor the quality and completeness of care records were still ineffective. Since our comprehensive inspection in November 2016 the provider had audited two people's care records in February 2017. There were no other audits undertaken on the quality of care recording and the provider had no other systems in place to ensure the accuracy of records maintained about people's care. The provider was unable to provide us with a reason as to why these checks had not been undertaken to ensure oversight and scrutiny of the quality of care recording.

We found that care records still did not provide an accurate record of the support people received. The management team told us four people required support to regularly reposition due to the risk of developing pressure ulcers. We checked the repositioning records for these individuals and saw they were not completed accurately and we were unable to evidence that people were being repositioned as frequently as they should be. We identified on one day and two nights no records were maintained of people being supported to reposition. We also identified there were insufficient details in people's care records about how pressure ulcers were being managed and what treatment plans were in place. The management team confirmed there were no checks in place to ensure pressure relieving equipment was accurately set according to people's individual needs.

The food and fluid charts we viewed had limited entries and we saw on one day that people had no food or fluid intake recorded from 3pm on one day until 9am the following day. The records regularly did not record any food or fluid intake after the evening meal until breakfast the following day. We spoke with the managers about this lack of recording and they assured us people did have access to food and drink throughout the day and night but that this was not appropriately documented, and they had not undertaken any checks on the accuracy of the records.

The provider continued to be in breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The provider had improved their processes to learn from key service data. This included analysing complaints to identify any themes or trends and reviewing data submitted to the Clinical Commissioning Group as part of the pan London continuing health care in nursing homes group on the number of infections, pressure ulcers and falls so any trends could be identified for learning to take place.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured service users were protected from the risk of unsafe care and treatment, by effectively assessing the risks to their safety and doing all that is reasonably practicable to mitigate those risks. (Regulation 12 (1) (2) (a) (b)).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person had not ensured effective systems were in place to assess, monitor and improve the quality of care and to assess, monitor and mitigate the risks to service users. They had not ensured accurate and complete records were maintained in regards to service users' care. (Regulation 17 (1) (2) (a) (b) (c)).

The enforcement action we took:

A warning notice was issued.