Homerton University Hospital NHS Foundation Trust

Mary Seacole Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was conducted on 5, 7, 14 and 30 June 2017. The first day of the inspection was unannounced and we advised the provider of our intention to return on the second and third day. The fourth day of the inspection was an announced visit to meet with the registered manager, as he was on authorised leave on the earlier inspection dates.

Mary Seacole Nursing Home is a purpose built 50 bedded NHS care home with nursing, which provides accommodation for people who require permanent or respite nursing care. This includes care and support for people who are living with dementia and people with end of life care needs. The premises are arranged over three floors, with the second floor used for administrative areas. The ground floor and first floor provide single occupancy bedrooms with ensuite facilities, communal dining rooms, lounge areas, adapted bathrooms, an activity room, a relaxation room for people using the service and two passenger lifts. There is a seven bedded transitional neurological rehabilitation unit for people who have had a neurological injury or have been diagnosed with a long term neurological condition, which offers dedicated areas for people to develop and improve upon their independent living skills. Facilities include a laundry room, a therapeutic exercise room, a communal lounge and an adapted kitchen. There are landscaped gardens and a terrace at the rear of the premises for use by people on all of the units, and the building is within short walking distance of local shops, cafés and other amenities. At the time of the inspection 44 people were using the service; 38 people were receiving permanent or respite nursing and six people were using the transitional neurological rehabilitation unit.

There was a registered manager in post, who has managed the service for several years. 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 previous inspection in April 2016 the service was rated as 'Requires Improvement'. There were no breaches of Regulations; however we had made three recommendations to the provider. We had recommended that improvements were made to address the storage temperature for medicines and address the lack of clinical guidance for staff to assess people's pain. It was recommended that the provider implemented a supplementary system to enable staff to quickly access Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) information and that the provider sought guidance from a reputable source about how to put in place person centred care planning that reflected people's wishes and interests. At this inspection we found that the provider had taken appropriate actions to fully address all three recommendations.

There were sufficient staff deployed to provide people with the care and support they needed. Clear systems were in place to make sure that staff were recruited in a safe way.

Assessments were in place to identify potential and actual risks that could harm people, restrict their independence and impact on their safety and wellbeing. Information about how to manage these risks was contained in people's care plans.

Staff had received safeguarding training and knew what actions to take to protect people from the risk of abuse. This included a good understanding of the provider's whistleblowing policy in regards to raising any concerns about the conduct of the service.

Training, supervision and support was provided so that staff could confidently undertake their roles and responsibilities. There had been a positive focus on training to understand and meet the needs of people living with dementia and this training was highly regarded by staff for its usefulness .

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is necessary to restrict their freedom in some way, to protect themselves or others. The provider understood its responsibilities and ensured that people's rights were protected.

People were provided with a healthy diet that met their medical needs and particular cultural needs. Staff provided sensitively delivered support at mealtimes and chatted pleasantly with people to enhance their enjoyment of communal dining.

Care plans showed that people's health care needs were properly assessed and suitable guidance was in place to support people to meet their needs. People were supported to access a wide range of health care professionals and the referral process worked efficiently as staff were part of the same NHS trust.

The provider had implemented an easily recognisable system so that staff had written information and an easily accessible second indicator in regards to whether people were subject to Do Not Attempt Cardio Pulmonary Resuscitation. People using the service and their relatives where applicable had been asked for their views for how they wished to be supported for urgent care and end of life care.

People and relatives told us staff were considerate, conscientious and friendly. We observed positive interactions between people and staff throughout the inspection.

People's privacy during personal care was maintained, although we have discussed the use of 'Do Not Disturb' signs for specific circumstances when people are being supported with their hygiene care in bathrooms designated for communal use.

The provider made sure that people and their representatives were issued with useful information about how the service operated, which included information about how to make a complaint and receive independent support during the process.

Actions had been taken to improve how the service assessed people's social care needs and gathered relevant information about their interests, hobbies and aspirations. However, this work was in progress at the time of the inspection. The standard of support for people to engage in fulfilling activities had significantly improved and we saw how people were now able to access different musical and creative entertainments and pastimes.

The provider had suitable systems for investigating complaints and where necessary, learning from

complaints had taken place. People's views about the quality of the service and how to make improvements were sought through a variety of methods, which included surveys, questionnaires, meetings, and informal chats with the registered manager and other senior nurses.

People using the service and their relatives informed us that they liked how the service was managed. The registered manager provided a visible and approachable style of leadership and he monitored the quality of the service during his time spent on the units. Additional quality monitoring was undertaken through clinical audits and monitoring visits by the senior management team based at the Homerton University Hospital NHS Foundation Trust.

The unit lead for the transitional neurological rehabilitation unit demonstrated a 'hands-on' managerial style, with a good emphasis on working with people, their families, the staff team and other health and social care professionals. The unit had defined clinical and other quality assurance systems to evaluate its performance and gather people's feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were safely managed. This included measures to ensure correct storage temperatures and the use of clinical assessment tools to identify and address people's pain management requirements.

Sufficient staff were rostered and improved methods were in place to ensure nursing and care staff were effectively deployed within the premises. Thorough recruitment practices were followed.

Staff knew how to protect people from the risk of abuse and how to report any concerns.

Is the service effective?

Good

The service was effective.

Staff received relevant training, support and supervision to assist them to understand and meet people's needs.

Mental capacity assessments had been carried out in accordance with the Mental Capacity Act 2005 (MCA) and staff understood how to protect people's rights.

People were offered choices at mealtimes and given the support they required to meet their eating and drinking needs.

Healthcare needs were met by staff at the service, who worked in partnership with a range of professional healthcare colleagues.

Is the service caring?

Good

The service was caring.

People and relatives regarded staff as kind and caring.

People's privacy during personal care was promoted.

Informative guidance was given to people when they began

using the service.

People's wishes for their future medical care and end of life care were established and respected.

Is the service responsive?

Good

The service was responsive.

People's health, care and support needs were assessed and reviewed.

Systems were in place to develop person-centred care and some progress had been attained.

People were offered a range of meaningful activities.

People's views were actively sought and any complaints were appropriately managed.

Is the service well-led?

Good

The service was well-led.

Relatives expressed that the service benefitted from a visible and helpful management team.

Staff reported they felt supported and enthused by positive changes.

There were good auditing and monitoring arrangements in place to continuously develop the service.

The provider encouraged people and relatives to contribute their ideas to improve the quality of the service.

Mary Seacole 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. The 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 service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 5, 7, 14 and 30 June 2017 and was unannounced on the first day. We informed the provider about our planned return on the subsequent three days. Prior to the inspection we reviewed information we held about the service which included the previous inspection report and the 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. We also looked at any notifications of significant incidents we had received. Notifications are events the provider is required by law to inform us about.

The inspection team consisted of two adult social care inspectors. During the inspection we spoke with nine people who use the service, five relatives and 14 members of staff. This included four care staff, two registered staff nurses, three senior registered nurses, the activities organiser, a visiting health care professional, the divisional head of nursing, the rehabilitation unit service lead, an allied health professional consultant, the head of healthcare compliance and the registered manager. Some people who use the service were not able to tell us their views and experiences due to their health care needs, so we used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who could not talk with us. Feedback was given at the end of the third day to a small team of senior clinical and managerial staff from the provider. Following the inspection visits we spoke by telephone with five relatives of people who use the service and the provider's lead nurse for dementia care.

During the inspection we checked the safety and suitability of the premises and looked at a range of documents, which included seven care plans and staff records for training, development, appraisal, supervision and recruitment. We also checked policies and procedures, audits, minutes for separate meetings for relatives and staff, health and safety records, medicine administration records and the storage arrangements for prescribed medicines.

Good

Is the service safe?

Our findings

At the previous inspection we had found that medicines were stored securely and there were records of daily room and fridge temperatures monitoring. However we had noted that the room temperature was consistently above most medicine manufacturers' storage recommendations, which meant that some medicines were potentially at risk of changing their composition or deteriorating due to unsafe storage conditions. The provider had informed us that they were aware of this concern and were looking at systems to address this. At this inspection we found that air conditioning equipment had been installed in order to ensure that medicines were consistently maintained at a safe temperature, which was demonstrated in the daily records for the room temperature.

At the previous inspection we had noted that although nursing staff had described to us how they assessed if people who were not able to verbally communicate were experiencing pain, there was no evidence to demonstrate the use of a recognised pain assessment tool. This had meant the provider could not demonstrate that people's pain was appropriately assessed and managed. At this inspection we found that the provider had implemented the use of the Abbey Pain Scale, which assesses the nature and level of pain for people with dementia and other cognitive impairments.

We checked controlled drugs (CD) for the ground floor unit for older people and balances were found to match that recorded in the CD register, apart from one entry. The senior staff nurse demonstrated that this was a clerical error that did not impact on people's safety, and reported this finding to their line manager. Medicine administration records (MAR) were clearly written and accurately maintained. Records showed that staff who administered medicines had received training and attended regular updates as part of their annual mandatory training. Regular medicines audits were conducted by registered nurses who worked at the service in addition to other audits undertaken by senior managers based at the Homerton University Hospital NHS Foundation Trust. The provider had systems in place to safely support people who were able to administer their own medicines, although this tended to be more applicable to the transitional neurological rehabilitation unit where people were being supported to regain independent living skills.

At the previous inspection we had found that although there were sufficient staff deployed, staff were not visibly available on two separate occasions during an afternoon. This had meant that staff would have been unaware if people who were unable to use the call bell needed assistance. The registered manager had informed us that he would prompt staff about the need to comply with the provider's procedures in regards to ensuring that at least one member of staff was visibly available at all times.

At this inspection we noted that staff were visible in communal areas and people's requests for assistance were responded to in a timely manner. The divisional head of nursing informed us that there had been difficulties in ensuring sufficient staff on the first day of the inspection, which was due to pre-booked bank staff having not turned up to cover for permanent staff attending a one day training course. We looked at the rota for a four week period and noted that ordinarily the service was staffed in line with the planned number and skill mix of staff. People and relatives told us that staff appeared busy and their duties appeared demanding but they did not have any concerns about unsatisfactory staffing levels. One relative told us they

had experienced difficulties accessing the care home during the evenings and weekends, as the front reception desk was not staffed outside of peak business hours. We had previously discussed this issue with the registered manager and there was a protocol in place to minimise any inconvenience. The provider informed us that the reception desk is staffed from Monday to Friday up until 20:00, and at the weekends up until 16:00. When the reception staff is on leave, a nominated healthcare assistant answers the door buzzer.

The provider demonstrated that careful practices were used to ensure that people were supported by safely recruited staff, with appropriate skills and experience for their roles and responsibilities. During this inspection we looked at the staff recruitment files for four members of the nursing and care staff team. We found that there was evidence of the required recruitment checks, for example at least two references, proof of identity and proof of eligibility to work in the UK. Any gaps in employment had been examined to make sure prospective employees were suitable to work with people using the service. We were provided with evidence to demonstrate that Disclosure and Barring Service (DBS) checks had been completed before staff were permitted to commence employment at the service. The Disclosure and Barring Service provides criminal record checks and a barring function to help employers make safer recruitment decisions. The provider kept up to date records for practising nurses to show that they had current registration with the Nursing and Midwifery Council (NMC). Registered nurses informed us that the provider had given them information and advice about how to complete the revalidation process. Revalidation is the new process that all nurses and midwives need to undertake every three years to remain fit to practice.

Care plans contained risk assessments to address specific risks in relation to people's health, wellbeing and safety. For example, risk assessments identified whether people were susceptible to malnutrition, falls or acquiring pressure ulcers. Actions to mitigate these risks had been determined so that people received appropriate care to promote their safety and welfare. We had noted at the previous inspection that risk assessments were focussed on practical safety as we had not seen any risk assessments in regards to people's needs due to their behaviour or vulnerability. Discussions with the registered manager and the dementia lead nurse evidenced that a range of measures had been implemented to achieve a more holistic approach to care planning and the development of accompanying risk assessments. This included staff training and the introduction of new documentation that explored people's social history, interests, emotional needs and behaviours.

People using the service and/or their relatives told us they felt safe living at the service. Comments included, "The staff are very kind, I feel safe" and "We have no concerns at all about [family member's] safety. [Our family member] has one of us with [him/her] every day and we see how the staff treat not just [our family member] but other residents too. They are all nice and some of them are exceptionally nice." At the previous inspection we had spoken with two members of staff about their responsibilities in relation to safeguarding. We had noted that although they were clear about their responsibilities they were unsure about who they could contact outside of the service if they wished to report any concerns about the conduct of a colleague or line manager. Both staff had told us they had been given this information by the provider but could not recall it. At this inspection we noted that all of the staff we spoke with demonstrated a thorough understanding of safeguarding and whistleblowing. This is the term used when a worker passes on information concerning wrongdoings. Records evidenced that staff received safeguarding training and the provider's handbook for employees contained information about how to raise any concerns within the trust and externally.

The provider ensured that suitable actions were undertaken to safely maintain the premises and equipment, so that people, visitors and staff were protected from unnecessary harm. Records showed that the cleaning contractor conducted regular audits to monitor the cleanliness of the environment and up to date certificates were in place to demonstrate that appropriate health and safety checks took place. This

included the testing of fire alarms, emergency lighting and portable electrical appliances, and maintenance of the lifts. We observed that staff correctly adhered to the use of personal protective equipment such as disposable gloves and aprons when required and the provider carried out infection control audits.

Good

Is the service effective?

Our findings

At the previous inspection the registered manager had informed us they were using a paperless system for documenting if people were not for attempted cardiopulmonary resuscitation. The information had been computerised, in line with the practice at the Homerton University Hospital NHS Foundation Trust (HUHFT). We had been informed that staff were aware of people's individual status and this information was also known to the London Ambulance Service, who had access to these records in their vehicles. We had observed during a handover between day and night staff that clear information was communicated so that people received the right care in the event of an emergency. However, a member of staff had told us that not all staff were sufficiently computer literate to access Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) information quickly. We had recommended that the provider implemented a supplementary system to enable staff to quickly access DNACPR information.

At this inspection we found that a clear system had been implemented on each unit, which was understood by registered nurses and health care assistants. This meant the staff team could correctly respond to people's needs in the event of a cardiopulmonary arrest.

People using the service told us that staff understood and met their needs. We received complimentary comments from people using the service and relatives. As the provider operated different types of service at the location, people and relatives had different expectations in terms of how they wished to be supported by staff. People who used the respite unit and the transitional neurological rehabilitation unit told us they were pleased with how the provider was meeting their needs during their stay at the service. Comments included, "I like it here, [my relative] is my carer so being here gives [him/her] a break for a week or two and I like the company" and "I think I am making good progress and going home is now realistic. I get goals every week from the physiotherapist, new exercises and support to do more things independently. My walking is improving."

At the previous inspection we had noted that staff had started to receive formal supervision sessions. At this inspection we found that although one to one supervisions were not yet taking place as regularly as the registered manager had planned, the supervision notes we looked at showed that detailed discussions took place to support staff with their practice, training and development. The three senior staff nurses at the service informed us that they had been booked in to attend supervision training so that they could support the registered manager to carry out the supervision programme. We also looked at a sample of annual appraisals and saw that the appraisal system was used to positively support staff to evaluate their own performance and engage in their ongoing professional development.

Records showed that staff were supported to attend mandatory training which included fire safety, infection control, health and safety, and moving and positioning people. At the previous inspection the registered manager informed us about his plans to expand upon the kind of training that staff received to develop their skills to effectively meet the needs of older people with physical and/or cognitive frailties. At this inspection we found that the training programme had significantly improved and was now tailored to address people's needs. This included a creative syllabus for enabling staff to develop their knowledge of how to support

people living with dementia. A staff member described this course of different training days as being "incredible, I learnt so much and I want to do more training" and another staff member stated "It's amongst the best training I have ever done. We put on goggles that let us see how dementia changes people's vision and perception. I didn't know how it [dementia] could affect mobility and safety."

The registered manager, registered nurses and other staff based at Mary Seacole Nursing Home had opportunities to attend training with colleagues working in the acute services and community services at HUHFT and to participate in meetings and developmental opportunities in different professional settings. This enabled staff to broaden their perspective and share their knowledge in a wider professional setting.

The staff working on the transitional neurological rehabilitation unit undertook mandatory training and their own schedule of training that was relevant to the needs of people undertaking the rehabilitation programme. This included specific training for staff employed as rehabilitation assistants, which was provided by the multi-disciplinary team of healthcare professionals who worked with them on the unit. This team included physiotherapists, occupational therapists, speech and language therapists (SALT) and a psychologist.

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.

We looked at whether the provider was working in line with the principles of the MCA, and we observed that the provider was meeting the requirements of the MCA. Staff had received training about the MCA and informed us about how they supported people to make daily decisions and choices, wherever possible. Capacity assessments were completed as required and staff described individual circumstances when decisions were made using best interest's procedures.

The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager was aware of his responsibilities in making an application to the supervisory body (local authority) if a person assessed as lacking mental capacity was potentially being deprived of their liberty. We noted that the provider ensured that the conditions of authorisation were appropriately adhered to for DoLS authorisations that were in place.

People remarked that the food was pleasant and they were offered choices. We noted that people could order food that broadly reflected some of their cultural preferences. One person told us that they liked the curries and a relative told us that they brought in food that their family member liked as the provider's non-British cuisine choices were limited. The relative stated that the care staff were helpful and supported their family member to have their own food when they were not able to visit at mealtimes. We observed that some people were supported to have specific diets to meet their healthcare needs, for example enriched options were available for people who were at risk of weight loss and food could be prepared at different consistencies including fork mashable or pureed. People's nutritional and hydration needs were assessed by healthcare professionals including registered nurses, dietitians and SALTs, and individual guidance about how to meet these needs was recorded in their care plans. People's weights were monitored so that actions could be taken to address any concerns.

At the previous inspection some of our observations indicated that people were not consistently assisted in accordance with the provider's standards for care and support at mealtimes. For example we had observed one member of staff who was assisting a person with their meal was standing over the person whilst supporting them and staff talked quite loudly amongst themselves. At this inspection we observed that people were supported at lunchtime in a sensitive manner. Staff gently encouraged people where necessary and there was a cheerful and relaxed atmosphere in the communal dining areas. People could choose to eat in their bedrooms when they wished and some people were always supported to eat in their bedrooms due to healthcare reasons.

The care plans we looked at showed that people's healthcare needs were understood and met. The service benefitted from being part of an NHS foundation trust, which meant that people using the service could be referred to healthcare professionals within HUHFT as required. A consultant from the hospital visited the care home once a week, in addition to the twice weekly visits from a local GP. People's healthcare records showed they were seen by a range of healthcare professionals that included occupational therapists, podiatrists, dentists and specialist nurses, for example tissue viability nurses. People using the service and relatives told us they had confidence in the service as they felt it was part of their local hospital, so there was an existing sense of familiarity and continuity of healthcare provision when they chose the service.

Good

Is the service caring?

Our findings

At the previous inspection we had made some observations that demonstrated that some staff were not always caring in their approach. For example we had observed that two wheelchairs that did not belong to a person had been stored in their ensuite bathroom, which meant they had not been able to access the sink to wash their hands. We had also overheard a member of staff make insensitive comments in a communal area.

At this inspection we observed that people received their care and support in a respectful manner that promoted their dignity and wellbeing. People told us they were happy with how staff spoke with them, "[Staff member] is a very helpful [person]. [He/she] is gentle and will try to sort out any problems" and "They are nice, there might be the odd one that isn't very friendly but I get on with the regular ones." Relatives commented, "They work hard to make sure everyone is alright, we are grateful, it takes dedication to look after people" and "I can only say they are a lovely group of people. They are so patient, [my family member] is happy with them, there are a few that look after [my family member] who are fantastic. [Staff member] is a diamond." We saw that people were relaxed when they spoke with staff and there were cheerful interactions.

People and their representatives were given an information booklet, which provided helpful information about either living at the service permanently or staying for a shorter period. This included guidance about how to access hairdressing and chaplaincy services. Staff told us that the service had links with local faith representatives such as imams, rabbis and priests, who could be contacted to provide people with spiritual support in line with people's wishes. A relative told us that during an important religious festival staff were flexible about the visiting times, as they took into account that relatives wanted to be with a family member for as long as possible to follow their religious and cultural traditions. The information booklet provided details about how to make a complaint, and the provider's procedures for managing complaints. People were given the contact details for the Patient Advice and Liaison Service (PALS) based at the Homerton University Hospital NHS Foundation Trust. This is a free service that enables people to discuss any concerns about their NHS service with someone independent of their care team.

People and relatives told us that staff consulted with them when they moved into the service about whether they wished to be supported with their personal care by staff of their own gender, and their choices were respected. We saw that staff knocked on people's bedroom doors before entering and ensured that doors were closed when they were providing people with personal care. However, we noted that another person could mistakenly walk into a communal bathroom when someone was being assisted to have a bath or shower. The divisional head of nursing confirmed that doors were not locked for appropriate health and safety reasons, for example if a person became unwell and additional staff were summoned to provide support. We were advised that the service could use 'Do Not Disturb' signs to help prevent this from occurring. The provider had a discrete pictorial system in place (a small picture of a flower) to remind staff and other individuals that a person was living with dementia and needed care and support that took into account their individual needs.

At the previous inspection we had been informed that the service was working with the trust's lead nurse for dementia care in order to develop compassionate services for people with dementia. This had included plans to create reminiscence focussed areas within the premises and introduce Namaste care. This is a life-enhancing programme for people living with advanced dementia in care homes and other settings. It includes gentle interventions such as hand massage. At this inspection we noted that the Namaste care programme had commenced and the provider was working in partnership with a local hospice in order to deliver aspects of this care. The registered manager told us that four members of the staff team had received training about Namaste and the eventual aim was for all care staff to learn the principles of this approach so that it could be seamlessly integrated into the service's daily care for people. This showed that the provider implemented innovative methods to promote an empathetic and kind culture within the service.

The provider enabled people to access 'Coordinate My Care' so that their wishes could be identified and respected. This is a NHS clinical service sharing information between healthcare providers, coordinating care, and recording people's wishes about how they would like to be cared for. It allows healthcare professionals to electronically record people's wishes to ensure their personalised urgent needs care plan is available at all times to those who care for them. The records we looked at showed that plans were in place to make sure people were not given medical care that they did not want and their wishes for their end of life care were identified.

Good

Is the service responsive?

Our findings

At the previous inspection we had noted that care plans on the nursing care units were very task led and there was little mention of people's preferences and likes and dislikes, in order to meet people's individual needs. We had found that some care plans did not have biographical information to support care planning, particularly where people had dementia and were not in a position to advise staff about their earlier life, social interests and former occupation. The registered manager had told us that the provider had recruited a new activities organiser who would review and improve the quality of people's social information. We had recommended that the provider sought guidance from a reputable source about how to implement person-centred care planning that reflected people's wishes and interests.

At this inspection we found that the provider had made some advancement and this had been achieved with the implementation of person-centred care planning. The provider had introduced 'This Is Me' documents. (This is a simple form developed by the Alzheimer's Society for people receiving professional care and living with dementia or experiencing delirium or other communication difficulties). During the inspection we observed that one person appeared distressed and agitated during lunchtime. We asked the senior staff about how the person was supported at these times and were advised that their 'This Is Me' booklet provided guidance for staff. We checked this document with the senior staff team and found that it was blank. However, staff were aware of the importance of using 'This Is Me' and were working towards its full completion.

The care plans we looked at addressed people's healthcare needs and were up to date. There was clear documentation in place to show how staff were supporting people with complex needs, for example people who had acquired pressure ulcers which had led to hospital admission and then a placement at the care home. Staff completed daily records to evidence how they met people's needs. The format for recording the daily notes linked to people's individual care plans, which ensured that important information was documented about people's identified needs.

At the previous inspection we had noted that activities were taking place but were at times sporadic as the service was waiting for the newly appointed activities organiser to start work. We had looked at photographs which showed that entertainments and seasonal events took place, for example summer barbecues and visits from singers and musicians. At this inspection we found that the activities organiser had made a significant impact on the quality and choice of activities. We checked the monthly activities programme and records for the past four months and noted that people were participating in new ventures within the service and in the wider community. We spoke with a person who took part in a number of the activities and they were very positive about the improvements to their social life. The provider had secured the services of a community dance company that delivers dance workshops aimed at children, young people and older adults with and without physical and learning disabilities. This had been funded for 30 weeks and was drawing to an end at the time of the inspection. We received very positive comments from people using the service and their relatives who had participated in the sessions. One relative wrote to the provider, "The atmosphere was brilliant, professional, enthusiastic, charming to all and sundry. I can't speak highly enough of them." The dance company tutors had provided care staff with a training session and the registered

manager told us that he hoped staff would apply some of the straightforward ideas they had learnt when carrying out daily activities for people.

The activities organiser told us about activities and entertainments that had taken place since the previous inspection. The service had developed links with a local museum, which had resulted in four people attending a tea party at the museum and one person attended a weekly gardening group. There was a greater focus on arts and crafts as this reflected the activities organiser's professional background and more music groups visited the service, for example an orchestra, a steel band and a piano singing trio. These changes had created a more stimulating and enjoyable environment for people who use the service, and staff commented that these changes had made their roles more interesting too.

People and their relatives where applicable, told us that staff provided a positive level of responsive care and support to assist them to meet their goals on the transitional neurological unit. At the previous inspection we had noted that the local Clinical Commissioning Group (CCG) planned to commission an ongoing service for a further two years. At this inspection the unit's clinical lead informed us that due to the success of the service in achieving positive outcomes for people and meeting key performance indicators, the CCG had commissioned the service on a permanent basis since April 2017. Since the previous inspection the provider had made further investments in the unit, for example the kitchen had been adapted so that all areas were comfortably accessible for people using a wheelchair.

One person using the service told us, "I was over at the Homerton Hospital for about six weeks before I came here. I was told about this unit by [staff member at the hospital] and staff here are very helpful." A relative said, "Because it is small I find it very good, people don't get left behind here. They [staff] are very caring, even on a Sunday there is someone to talk to. The staff have been telling me [how to support my family member's specific needs]. They will stay a bit longer to talk to me, even if they are on their way out they will give relatives extra time. There is good continuity here and they are professionals, I can see it."

Care plans were well structured and comprehensive, with clearly defined goals and information about how to support people to meet their goals. People were asked to complete a questionnaire about their interests, culture, values and aspirations so that the care planning process was tailored to their needs and wishes. People using the service confirmed that they contributed their views during care planning review sessions, which took place approximately once a fortnight. The facilities on the unit ensured that people had their own bedroom and ensuite toilet, and there were therapeutic areas for occupational therapy, exercises and sessions to regain domestic skills.

People using the service and their relatives were provided with information about how to make a complaint. There had been no complaints received for the transitional neurological unit since the previous inspection. We looked at the complaints received by the registered manager of the nursing care units and noted that people and/or relatives received a comprehensive and balanced response. The registered manager highlighted any learning points for the future, so that whenever possible complaints and concerns could be used to drive improvements in the quality of care and support.

Good

Is the service well-led?

Our findings

At the previous inspection we spoke with the provider about the system used for informing the Care Quality Commission (CQC) about significant occurrences at the service, such as safeguarding concerns and any incidents or events that impacted on the safe delivery of care. These are known as notifications and providers are required by law to promptly inform the CQC. We had acknowledged that this information was shared by the provider through the use of a reporting system used by NHS trusts, which involved information being sent to CQC on a weekly or fortnightly basis. However, this system meant that there could be delays with key information reaching the adult social care inspector for Mary Seacole Nursing Home, particularly in the event of a safeguarding notification which must be sent 'without delay'. The provider had informed us that they would implement a system to inform us of any notifications that needed to be promptly shared to ensure the safety of people who use the service. This system was now in place and no concerns were identified in regards to how the provider kept us informed.

People using the service and their relatives told us they thought the service was well managed. They reported that the registered manager maintained a visible presence at the premises, and was regarded as approachable and responsive. One person and two relatives also mentioned one of the senior staff nurses as being a good person to speak with if a minor concern needed to be addressed, "[Senior staff nurse] will listen to whatever little niggle you might have and do something there and then to put the matter right, [he/she] is ever so helpful no matter how busy things seem."

Staff told us they felt supported by the registered manager and thought that the initiatives put in place since the previous inspection had boosted the team's morale as well as achieving positive outcomes for people and their representatives. This included the programme of dementia training and other training that was specific to the needs of staff working within the care home, such as an essential skills training course for healthcare assistants, which was delivered by a university provider. We also received positive views about the leadership provided to staff working on the transitional neurological rehabilitation unit.

The registered manager had been awarded a leadership and travel scholarship grant from the London Network for Nurses and Midwives (LNNM), via the Florence Nightingale Foundation. He told us about how this award had been used to develop the quality of care at Mary Seacole Nursing Home, which included visits to prestigious overseas facilities for older people living with dementia and physical frailties. We looked at the provider's plans to create a dementia friendly environment at the service, which had been developed by the registered manager, the trust's dementia care lead and other professionals. The plans included a sensory garden and more signage in and around the premises to support people living with dementia to retain their social and functioning skills for as long as possible. The registered manager and the trust's dementia care lead were also involved in a dementia alliance with other NHS trusts, so that good practice could be shared through each trust making presentations to the other organisations within this grouping.

The unit lead for the transitional neurological rehabilitation unit told us that the unit worked in accordance with the British Society of Rehabilitation Medicine (BSRM), Stroke National Standards and other expert guidelines. The unit submitted its outcome data to a national database, which enabled benchmarking.

The provider actively sought people's views through the use of questionnaires and surveys. Relatives and friends of people who use the service were invited to attend meetings held by the 'Friends of Mary Seacole Nursing Home' to gain their views about the quality of the service and their support to achieve improvements. We looked at the minutes for meetings held since the previous inspection and noted that the group also provided peer support for relatives and friends and an opportunity for the families of people who had passed away to retain their links with the service.

Audits and monitoring visits were used by the provider to assess the quality of the service and make ongoing improvements. We looked at a broad selection of audits that covered areas including the safety of the premises, management of medicines, prevention of falls and pressure ulcers, and the effectiveness of infection control and cross contamination practices. The monitoring visits were known as 'rounding visits' and were conducted by a team of clinical leaders from the Homerton University Hospital NHS Foundation Trust. The outcomes of the audits and monitoring visits had been analysed so that the provider could judge whether improvements had been achieved in relation to issues raised in the previous CQC inspection report.