South London Nursing Homes Limited

The Pines Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 17 and 23 December 2015 and was unannounced. The provider knew we would be returning for a second day. At our previous inspection on 30 May 2014 we found the provider was meeting the regulations we inspected.

The Pines Nursing Home is a care home with nursing, providing nursing care and support for up to 50 people. It is located in Putney, in the London Borough of Wandsworth. There were 39 people using the service at the time of our inspection.

There was a registered manager at the service. 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.

People using the service told us that they felt safe living at the home. They told us that staff treated them with respect and were kind. They told us they were very good at managing their personal care needs. However, the

Summary of findings

majority stated that staff did not always engage with them and did not always have time to sit down with them. We saw that staff had a caring attitude towards people but did not always engage with them, aside from when they were delivering personal care or supporting them at lunchtime.

People told us they enjoyed the food at the home and we saw that people were offered choices and a varied menu. The kitchen area was clean and well maintained. Good quality food, including fresh meat was purchased and meals looked appetising.

People did raise some concerns about the length of time it took for staff to respond to their call bells and some staff reported that they felt rushed. However, we found that staffing levels were determined according to dependency tools and stated levels at the home were consistent with accepted guidelines.

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

The provider had robust staff recruitment checks in place and arranged comprehensive induction and ongoing training of staff. Staff had regular supervision but these discussions were not always recorded fully.

People had their healthcare needs met and a GP visited the service every week to see people that were unwell.

The registered manager held regular staff meetings and also carried out a number of audits to monitor the quality of service.

During this inspection we found breaches of Regulations relating to safe care, consent and care planning. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. Risk assessments did not always reflect people's support needs.

People told us they felt safe living at the home and staff had received training, and were familiar with safeguarding procedures.

Staffing levels at the home were calculated using a dependency tool and we saw that staffing levels were consistent. However, people told us that they sometimes had to wait a long time for staff to respond to their call bells. Staff also reported that they felt rushed.

Staff recruitment checks were robust.

Medicines management at the home was safe and regular audits took place.

Is the service effective?

Requires improvement

The service was not effective in some aspects. People's consent was not always recorded.

Although people had their healthcare needs met, nursing staff were not always proactive in their communication with healthcare professionals.

Induction and ongoing training of staff was comprehensive.

People told us they enjoyed the food at the home.

Is the service caring?

Requires improvement

Some aspects of the service were not always caring. Staff interactions with people were limited at times.

People told us that staff were kind and considerate.

Staff respected people's privacy and dignity.

Some aspects of the care plans were person centred.

Is the service responsive?

Requires improvement

The service was not responsive in some aspects. Care plans did not always fully reflect people's individual needs.

A range of activities was on offer at the home.

When complaints were received, the provider responded in a timely manner.

Is the service well-led?

Requires improvement

Aspects of the service were not well led. Audits were competed and feedback sought from people using the service, relatives and staff.

Summary of findings

Some of the audits were not effective in picking up the concerns identified during the inspection.

The registered manager held regular meetings with staff.

A business plan, with identified areas of improvement, was in place.

The Pines Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 17 and 23 December 2015 and was unannounced. The provider knew we would be returning for a second day. This unannounced inspection was undertaken by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses services like this. On this inspection the specialist advisor was a registered nurse.

Before we visited the service we checked the information we held about it, including notifications sent to us informing us of significant events that occurred at the service. The provider also submitted 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.

During the inspection, we spoke with 13 people using the service and five relatives. We spoke with seven care workers, two nurses, the registered manager, a regional manager, the activities co-ordinator, one domestic staff, the chef and the training administrator.

We also spoke with two visiting health professionals on the day of our inspection. We looked at six care records, two staff files and other records related to the management of the service including training records, audits and quality assurance records.

Requires improvement

Is the service safe?

Our findings

People were not always protected from avoidable harm as not all risks were adequately mitigated. All care records that we reviewed contained a pre-admission assessment booklet although these sometimes lacked detailed assessment of needs and risks. Care records contained information on risks such as risk of falls, pain assessment, pressure sore risk and risk of malnutrition. These outlined the identified hazard and the control measures required to minimise the risk. Standard monitoring scales were used to measure the level of risk such as Waterlow (pressure sores) and the Malnutrition Universal Screening Tool (MUST). However, we found that these were not always up to date and there was not always a documented response to changes. For example, the records for one person indicated a weight loss of five kilograms from October to November 2015 but this was not reflected in the updated MUST score. In another person's care plan, the falls risk assessment gave a score of 10 which was a medium-high risk, however the care plan for 'maintaining a safe environment' in the section entitled 'what are my falls risk' it stated the score was 7, a low risk. This showed that staff did not have clear and consistent information about people's healthcare needs and associated risks to their safety and wellbeing.

Where needed, photos of pressure ulcers and body mapping records identified the areas of concern, however in one care record we looked at there was no written information apart from the body mapping on the development of the ulcer and treatment the person was receiving. We asked the GP about this who confirmed he was aware of the ulcer and had prescribed topical medicine. We asked the nurse on duty about this issue and they offered no explanation why this was not included in the person's care records.

There was evidence that the provider was aware of gaps in risk assessments for some people. Letters had been sent to all nurses highlighting concerns around aspects of care planning. The letters stated said there was 'limited information on new admission documentation' and 'people's needs had changed but this had not been reflected in care records'.

One shower/wet room had been newly refurbished. The emergency pull cord was too high to be accessible from the floor. This meant it might be out of reach in the event of a fall.

People we spoke with raised concerns about the efficiency of the call bell system and the slow responsiveness of staff. One person said, "The buzzer doesn't work nine times out of ten. The room numbers don't always show. It's old equipment, it needs updating. If it happens at weekends you have to wait until Monday to get it fixed. I'm terrified it's going to happen at the weekend and I'm left in my room." Other comments included, "Bells don't work properly. They need new ones" and "I press it (the call bell) and they don't come; now sometimes I don't bother." One person told us they needed support in the evenings to go to bed, "I press my buzzer in good time in case I have to wait 30 minutes." Another person explained how on the day of the inspection, they had woken and needed to use the toilet. They pressed the bell but no one came so they went to the toilet by themselves. They told us they found the experience quite daunting.

The above identified issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns about how quickly call bells were being answered had been identified by the provider. This was highlighted in a staff noticeboard in the hallway. The registered manager told us the call bell system was an old system and they did not have any qualitative data to work out how long it was taking staff to answer call bells. The purchasing of a new call bell system had been documented in the business plan for 2016.

Everyone we spoke with told us they thought they were safe from being bullied by the staff and they would complain to the registered manager if they had any concerns. One person said, "I feel safe". One relative alluded to a recent incident regarding their family member and a staff member. They told us they reported it to the registered manager who took it very seriously.

A safeguarding poster was on display on a noticeboard, giving details of who to contact if there were concerns about people's safety. One staff member said, "Safeguarding is to make sure people are safe" and another said, "Safeguarding and whistleblowing is about reporting any concerns you have." All the staff we spoke with were able to provide definitions of different forms of abuse and said they had received training in safeguarding, including the procedure to follow if there was a concern. Staff were aware of their right to whistle blow but not the legal protections afforded to whistle-blowers. Some staff needed

Requires improvement

Is the service safe?

prompting when we asked them about 'whistleblowing' as they had limited understanding of the term, however they did state that they would report any concerns to the office staff.

There was a known issue about thefts within the home, these had all been reported to the local authority and notifications sent in to the Care Quality Commission. We saw that the provider had taken steps to try and identify who was committing the thefts and prevent further thefts but it was still an ongoing concern. The provider had taken action which included carrying out bag checks on staff, locker searches and arranging for the police to visit the home. Letters were sent to relatives each time there was an incident and the issue was discussed in relative and staff meetings. People living at the home including potential new residents were advised of the incidences of theft and were advised not to keep anything of value in their rooms.

We spoke with the registered manager about staffing levels at the home and how they determined the number of staff to be deployed on each shift. She said she used The Royal College of Nursing (RCN) nursing assessment and older people dependency tool for staffing, which was on display in the office. She told us there were eight care workers and two nurses allocated in the morning, seven care workers and two nurses in the afternoon and four care workers and one nurse at night. In addition to this, there were separate kitchen, domestic, administrative staff and two activity co-ordinators. She told us that some nurses had left the service but their positions were being filled. On the first day of our inspection, there were two extra nurses on duty who had recently been recruited and who were on their induction, shadowing more experienced nurses.

All staff we spoke with told us they felt that staffing levels were not always adequate and the number of people that needed help with personal care in the morning meant that they felt stretched with respect to their workload. Some of the comments from staff included, "We do try and find five minutes with people, but it is difficult sometimes." People using the service told us, 'I feel sorry for them (staff) because they've not got enough staff, they are always apologising for being rushed."

We looked at staff rotas from the period 03/10/2015 to 11/12/2015. During this period there were always two or sometimes three nurses and eight or nine care workers on during the day. At night there was always one nurse and four care workers. We did see that on 12 occasions between 03/10/2015 and 06/11/2015 there was an agency nurse used during the night, this was due to annual leave or staff sickness.

Staff recruitment procedures were robust. On 06/10/2015 the service received a visit from the Home Office immigration team. We saw confirmation that there were 'excellent records and that all staff's right to work documents were up to date'. The administrator carried out a personnel file audit in December 2015 and we saw that all the employees including domestic and kitchen staff had criminal records checks and all the nurses had current registration with the Nursing and Midwifery Council (NMC).

We observed nurses administering medicines both in the morning and the afternoon. This was undertaken using the correct procedure, checking the date of the drug expiry, the amount people had, the route it should be given and checking the photo on the medicine administration record to ensure it matched the person receiving the medicine. However this took a long time, the morning medicine round not finishing until 11.10am. This meant that there was a potential risk that there was not sufficient time between medicines administration rounds. We asked the nurse about this, they said this did not happen as they would check people's individual medicines requirements. When we observed the afternoon medicine administration this was confirmed. We also spoke with the registered and regional manager about the time taken for the medicines round, they told us that this had been raised with the GP with regards to a full medication review for all people. The registered manager carried out a weekly medicines audit which consisted of checking the expiry dates of the medicines, photos of people on the medicines charts and allergies. Nurses ensured that people were happy to take their medicines and clearly gained oral consent before administering it.

Requires improvement

Is the service effective?

Our findings

People rights may not have been protected as the provider did not always seek consent for care and support from the relevant person. We found that consent to care and treatment was not always clearly documented. Care files contained a care plan/advance decision form check list which was signed by the person and/or relatives to indicate consent and whether they wished to be informed of changes to care planning. However, there was no indication of agreement to care plans which were not signed and no further evidence of any involvement, or input to care planning or reviews. There were no signed consent form for the use of bedrails or best interests decisions in the case of one person who lacked the capacity to make this decision.

Care files contained a red sticker on the spine to indicate a Do Not Attempt Resuscitation (DNAR) decision for easy reference. DNAR forms were present in the records that we saw, however these were not always completed fully. Forms were signed and dated by the GP and we saw evidence that in some cases forms were correctly completed and there was evidenced discussion with people who had capacity to make decisions. In other cases, the records were not fully completed. In one example, it indicated that the person did not have capacity and in their advance care plan decision there was no evidence of discussion with relatives. The DNAR did not reference consultation with the next of kin or discuss the capacity of the person. In another record, a person had a financial care plan in place which recorded that there was a lasting power of attorney (LPA) for property and affairs but there was no record to evidence that the LPA had been seen by a member of staff. This care plan was not signed by the LPA or the person using the service. This person also had an advanced care plan in place. Relatives had been involved in this and this was signed by a staff member but not by the person using the service. This person had a best interests decision care plan which was signed but not dated and stated that the person's family members could make decisions in relation to property and affairs and personal welfare, which was not consistent with what had been recorded in the financial care plan.

We found the above issues to be a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that there were three people on a DoLS and a further two applications had been submitted where it was felt restrictions were in place for people who did not have the capacity to consent to these. We looked at the authorisations and saw evidence that the provider had applied for renewals for those people whose DoLS authorisations were about to expire.

Staff said they had received training in MCA and DoLS. They were able to explain some aspects of the Act including best interests meetings and the requirement for capacity assessments and DoLS. One staff member said, "Mental Capacity (Act) is used when a resident cannot decide, they have to be offered a choice and we have to involve their family member."

There was a training co-coordinator who worked full time at the service who was responsible for arranging training for all staff and worked alongside a regional trainer. She also delivered moving and handling training herself and was currently completing a train the trainer course in dementia. She told us "I have had the opportunity to move up and do something else, I'm happy." Other staff said, "My colleagues are very supportive."

All new care workers completed induction training based on the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life, to provide the introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Each new staff member was required to complete a Care Certificate Completion Record

Is the service effective?

within three months of starting and the training administrator completed a 'colleague competency observation record' in which they assessed the competency of new staff. We spoke with a new staff member who told us they felt well supported and could ask for help if required.

Nurses completed additional induction training relevant to their role and they completed a nursing assessment workbook, ideally within one month of joining. This included being observed for good moving and handling knowledge and techniques, medicines administration, use of syringe driver, catheterisation, venepuncture and dressings. The registered manager was aware of the requirement put in place by the Nursing and Midwifery Council for nurses to revalidate their registration every three years. The provider had already begun to implement some steps to ensure their nurses would be supported in this process.

All staff had access to an online training portal to manage their training requirements. Some of the comments from staff included, "We have training on a regular basis, [the training co-ordinator] is very helpful." Staff confirmed that they received regular mandatory training updates to ensure that their skills were current. This included training in moving and handling, safeguarding, infection control, health and safety, the MCA and DoLS, food hygiene and dementia. We reviewed a training matrix for staff and saw that training records were up to date.

Some concerns had been raised about the quality of the nursing care delivered to people using the service, we saw evidence that the registered manager was aware of this. Nursing staff were supervised every month and we saw that where concerns had been identified about care planning, nurses this had been addressed by the registered manager with the individual nurses concerned.

Care workers' supervision records indicated they were supervised but not as regularly as nurses. In some instances we saw that both nurses and care workers did not always sign their agreement to the content of the supervision records. The recording sheet for supervisions was a checklist of items that was discussed but did not give any detail about the discussions that took place or record the views of the supervisee. There was also a lack of detail in relation to any action points assigned to staff or the supervisor to follow up. This meant the provider could not comprehensively demonstrate how they supported staff to develop their practice.

Most of the people we spoke with enjoyed their lunch. Comments included, "The food is pretty good", "On the whole the food is quite good but there's not enough seasoning and too much chicken", "Not enough fresh fruit but they are freshly cooked meals", "Food is very good, but my only complaint; sometimes it's cold by the time it gets to my room. However I tell them and they take it and reheat it" and "The food is good, first class. One of the best things about this place." One person told us they were offered a side salad every evening and fruit at breakfast.

We observed lunchtime in the dining room, where care workers supported people that needed help with their meal. People were treated with respect; those who preferred to have meals in their own room were able to. One person said, "I sometimes have my dinner here or in the dining room." Care workers ensured food and appropriate amounts of fluids were within reach of people. People who asked for changes to their meal were listened to.

We asked the chef if any people had special dietary needs. They said there were some people who had a 'soft' or 'puree diet' but did not initially identify any people who were diabetic, although we saw that people with diabetes or those that required a soft diet were identified on a noticeboard in the kitchen or on the menu plan that was kept in the kitchen.

People's preferences were also recorded and guidelines such as an 'eatwell plate' and dysphagia texture descriptions were kept by the chef in the office so they could refer to them if needed. The kitchen was clean and well maintained. There were separate sinks for washing, colour coded preparation boards and staff wore appropriate clothing. The dry store and the fridge/freezers were well stocked with food, and food that had been opened was labelled. The chef told us that all meat was bought fresh, apart from fish which was bought frozen.

One person using the service told us, "Health wise, I'm fine." We spoke with visiting health professionals about people's healthcare needs. The GP indicated that the service was not always effective. They gave us previous examples when called by the staff to review a person, nurses had not

Requires improvement

Is the service effective?

always undertaken basic observations such as temperature or blood pressure prior to the home visit. Other occasions included not being notified early enough when people reported they were feeling unwell. We also spoke to a member of the local NHS Speech and Language Therapy (SALT) team who said that staff at the home were fairly receptive to advice and generally followed recommendations and guidance. However they indicated that communication was not always effective although this was usually dealt with when the issue was raised with senior staff.

We raised these concerns with the registered manager during the inspection and she acknowledged that this was an area that could be improved. She had already identified this and taken steps to try and improve practices. For example, more frequent supervision of nurses, observations and highlighting areas of care records that needed updating.

We reviewed one person who was a diabetic and saw they were given insulin in the morning after the nurses had undertaken blood sugar monitoring, post breakfast. When staff were asked about a diabetic person's diet they said they gave them soft food such as yogurt. We checked the care records and we saw that a diabetic diet was clearly identified but the pictorial chart in the care plan included non-sugar free custard as a food option. This person's fluid and food chart did not indicate that they were on a diabetic diet. This meant the person could potentially have been given an unsuitable dessert in error.

People were weighed regularly to monitor if people were losing weight. We asked care workers what they would do if a person had lost their appetite or was losing weight, they said they would let a nurse know. Visits from healthcare professionals were recorded in care plans. A GP visited the home every week to review people at the request of the nurses.

Requires improvement

Is the service caring?

Our findings

All of the people we spoke with said the staff were kind and they were respected but no-one had any time to sit and chat. Comments from people included, "The staff are kind", "The carers are very nice and well meaning", "They're always in a rush. They have to feed a lot of people so they haven't really got time", "Staff are kind and respectful but have no time to talk, never enough time. I ring if I have problems but some days I don't see anyone much", "I would like a bit more interest in me" and "They don't really sit down and talk to me."

We did not observe a lot of one to one contact between staff and people in their rooms apart from physical care and assistance at meal times. We saw examples of both good and poor care.

Care workers did see to people's wishes in a caring way, they cleared away the used plates and liaised with the kitchen staff for more napkins and checked when the kitchen staff were ready to bring dessert. After the dessert was served they went around offering everyone tea or coffee. There was a gentle, unhurried pace to this lunch time.

We saw examples of staff acting in a caring manner towards people using the service. They spoke to people in a manner which was of an equal. Staff displayed kind and gentle mannerisms, for example touching and speaking gently. They listened to people and showed genuine interest in what they spoke about. They remained calm when people presented with behaviour that challenged. In one instance, a care worker gave a person some time alone and then re-approached them which appeared to be effective and the person was less agitated on the second approach. Staff listened to people's views, they were not condescending or patronising and treated each person as an individual. For example, one person wished to sit at the front entrance of the home in their outdoor clothes and this was accommodated.

However, few staff made attempts to engage with or converse with people either in communal areas or with individuals in their rooms, except when delivering personal care or assisting with meals and on occasion even this was limited. We saw a care worker supporting a person during lunch and did so slowly and with kindness, repeatedly stroking the person's arm but at no time did they engage in conversation with them. They talked to the other care worker in the room and another person sitting at the table, but not the person they were supporting. Another care worker placed a bowl of grapefruit in front of some people, without a word of greeting. Then they placed bowls of soup in front of other people without a word of greeting or saying the flavour of the soup.

Staff always knocked on people's doors, whether this was during lunch, administering medicines or providing personal care. Staff said they always respected privacy and dignity by ensuring that people's choices were respected and closing doors when delivering personal care. We observed care staff encouraging independence both physically and verbally, encouraging those who could walk with a Zimmer frame to do so this.

All care staff wore uniform and name badges so it was possible to identify who they were and their designation. People's bedrooms were clean and personalised with individual belongings, plants and pictures. All communal areas and bathrooms were clean and odour free. The home was undergoing redecoration but was clean, bright and well-appointed with good quality furnishings. One person said, "They come and clean my room, a marvellous man does the washing." There were three communal showers available for 39 people living at the home. The only communal bathroom was out of service at the time of our inspection. Individual bedrooms had en-suite toilets and some had baths.

Care plans contained person centred information on preferences and routines but it was not always possible to tell from daily records or monthly evaluations whether the care delivered reflected personal choices. There was evidence of information about people's personal history and background in care files. Care files contained a 'Life History'/Biography. This gave some information on background, family and past employment but the information was sometimes difficult to find.

Each day, a person at the home was designated the 'Resident of the day'. This meant that their room was deep cleaned and their care plans were reviewed.

Care records contained a preference checklist which was a checklist with preferences for daily routines (rising/bed times), preferred names, gender of care worker for personal care, personal care preferences, door shut/open and where meals taken. Staff told us that they were familiar with the

Requires improvement

Is the service caring?

needs of people and were able to clearly explain the routines and characteristics of different people living at the home. However, apart from daily observation records staff rarely accessed care plans as these were updated by nurses, although they said that they could access them if needed.

Requires improvement

Is the service responsive?

Our findings

People were at risk of not having their needs met as care plan documentation was not always fully completed or up to date. The care plans were kept in a locked cupboard and care workers had limited access to them, only a nurse held the keys on the shift. This impeded access to information, which at times was not updated and could potentially impact on the responsiveness of the staff to people's needs. Care records seen were ordered in a similar way but we found that they were not always well maintained and in some cases there was contradictory, inconsistent and missing information.

Files were difficult to navigate which meant it was difficult to locate relevant information on a particular topic. Care plans and daily records were mostly handwritten, legibility was varied but often so poor that it was not possible to read the information recorded.

Some information was filed across different parts of the file and did not always match and some care plans did not always correctly record important information. For example, Do Not Attempt Resuscitation (DNAR) forms were not always reflected in End Of Life (EOL) care plans and in one care record there was information indicating a Lasting Power of Attorney had been appointed but this was filed in the communication care plan rather than the section on advance decisions. In another file the EOL care plan contained weight and nutritional monitoring records, which were ordinarily filed in another section of the care plan. This could have caused confusion for agency nurses and visiting healthcare professionals. Input from health care professionals was not always being updated in the relevant care plan. Each care record had a front cover containing people's date of birth, date of admission and also a section for any allergies. In two records, this listed current medicines instead of allergies. In one record, the person was recorded as diabetic but the eating and drinking care plan was blank.

There was little evidence of overall reviews of care plans or input from relatives beyond the care decision form in care files. Care records contained a letter inviting relatives to a review of care but no further evidence was seen to demonstrate whether relatives had responded or whether a review had taken place. Monthly evaluations were completed by nursing staff for each care plan. These tended to be generic, did not contain always contain adequate detail and commonly said 'care plan continues' or 'no changes' and did not always document progress or changes. For example, one person had an indwelling catheter which had been changed several times over a short period of time. There was no indication in the care plan or the monthly evaluation that gave the reasons for this. When questioned, staff were able to tell us that the catheter had been changed as it had fallen out, but this was not recorded. Another person using the service had a history of depression, but in the 'social/emotional' care plan the monthly evaluation simply recorded 'had a chat, relatives visited'. There was no information on the person's mood or emotional well-being. This meant that it was not possible to determine whether the care plan reflected current needs beyond the monthly evaluations provided by the nursing staff which lacked detail. They did not always reflect a person's current status or in some cases were out of date.

We found the above issues to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On admission to the nursing home, staff completed a short care plan to be completed within 24 hours of admission; however these were not always done in time. The registered manager held a debrief meeting with staff whenever there was a new admission to the home during which people were introduced and their needs were identified, for example if they had any underlying health conditions, their mobility, communication needs, how much support they required with personal care, and moving and handling.

Care records contained admission details, advance decisions/DNARs, health correspondence, a pre-admission form, consent forms and preference checklist , a care plan decision form, care plans and risk assessments for each different aspect of care including an assessment of daily living/identified need, desired outcomes and care action required.

Daily records of care delivered were maintained by care staff for each shift and these were kept in a separate file. The previous month's daily records were transferred to individual care files. We inspected samples of daily records and also the daily records file. All records seen were up to date and most contained a suitable amount of relevant detail on each person. Daily records were signed off by nursing staff. However records were handwritten and

Is the service responsive?

frequently illegible, making it difficult to access information on progress which could represent a risk to people if problems or changes to health were not properly documented. Although staff were up to date and well informed about people this may not be the case if temporary or new staff were on shift.

The activities co-ordinator said that group activities were organised in the communal lounge in the mornings and in a smaller activities room in the afternoon. They also organised external entertainers weekly such as musicians and singers and other occasional entertainment of interest such as visits from Therapaws (animal/dog visits) and Zoolab (exotic animals/reptiles). Trips and outings were also arranged, on the day of our visit some people were being taken to see Christmas lights in the West End of London.

People said they enjoyed the activities that were organised. Many of the people we spoke with were looking forward to going out to see the Christmas lights. People also spoke positively about the external activities arranged within the home. One person said about the Zoolab activity, "People woke up, they came alive, they smiled when normally they just sat in their chairs and slept."

We observed the activity co-ordinator with some people in the lounge playing bingo. There was little interaction between people and no other care staff were present at the session. The activities coordinator reported that care workers were not involved in supporting organised activities at the home, as they were busy completing tasks and therefore did not spend time talking to people or interacting socially. This meant that people were reliant on the presence of activities coordinators for this aspect of life at the home. They also said there was not enough time to have one to one time with people who preferred to stay in their rooms, so this aspect of the job was limited. The registered manager told us that a second activities co-ordinator had been recruited which she hoped would address this.

There was a weekly schedule of organised activities in the home and this was displayed in the reception area and in people's rooms. People said there were often activities in the lounge which they attended and enjoyed as it was an opportunity for meeting up with other people. An activities log was kept by the activities co-ordinator which consisted on an 'engagement booklet' for each person to record participation in activities. However the records we reviewed were superficial with no information documented on people's mood or response, only whether they had been present. All of the records were out of date, the activities co-ordinator said that the information was kept in her diary but had not been transferred.

One person told us that recently the lift had broken down and they were trapped in their room, so they missed a social gathering which their son had come to the home to attend with them. They complained and they were moved to a room on the first floor which does not rely on the main lift as there is a chair lift.

People were given information on how to raise concerns and complaints when they first came to use the service. A copy of the complaints procedure was kept in people's rooms. We reviewed the complaints that had been received in the past year. There had been six recorded complaints, these had been responded to quickly and assigned to the registered or regional manager to investigate. Some of the complaints had been upheld, however the full documentation was not available in all the complaints that we saw to review.

Requires improvement

Is the service well-led?

Our findings

Staff we spoke with said that they felt well supported by senior staff and management. All claimed that the registered manager was always accessible to discuss issues and concerns. All were positive about the culture at the home which was open and inclusive. There had been a number of staff that had left the home within the past year, including some nurses. At the time of our inspection, the home was without a deputy manager. A peripatetic manager was in place, supporting the registered manager and providing input from a clinical perspective.

We asked staff how the morale was amongst the staff and the responses were, "Everybody gets on okay", "We try and support each other, help one another" and "We try hard." The provider also carried out surveys of the staff to get an understating of how they were feeling. We reviewed the surveys that were held in September and November 2015. Some of the areas that staff felt the service could improve upon were communication and a lack of leadership among the nursing staff. We noted that 34% of respondents said they 'only sometimes or never' felt part of a team and 49 % 'only sometimes or never' felt recognised. However, staff were positive about the induction and training, access to policies and understanding of their roles.

Staff reported that there were regular staff meetings at which issues could be raised and concerns discussed and that there was good two-way communication between staff and management. We saw evidence that a number of meetings were held. The registered manager held a 10 minute meeting every morning attended by a representative from each department, for example domestic, kitchen, care workers, nurses and administrative. We sat in on this meeting on the first day of our inspection; topics of discussion included any incidents/accidents, nursing care, admissions, housekeeping, resident of the day, kitchen, and maintenance. Other meetings included residents, relatives, heads of department, and general staff meetings. Although these were held regularly, we found that the minutes did not always clearly record details of what had been discussed, just the agenda item. It was therefore difficult to have an understanding of the views of the attendees. There was also a lack of action points that were followed up at subsequent meetings.

People using the service were also consulted on their views of the service. We reviewed the results of the feedback survey which took place in April 2015. There were 11 responses received, and there was an overall satisfaction score of 81%.

The registered manager carried out a number of audits, including an unannounced night audit tool. The last one which was carried out on 14/11/2015 and looked at whether the environment was clean, if staff were wearing correct uniform and carrying out their checks and updating records. She also carried out an observation during different settings such as lunch and during an activity. We saw where improvements were identified; when applicable, these were passed onto the staff in question. Other audits included weekly medicine audits, bed rail checks, room temperature checks and mattress checks and an infection control and health and safety audits.

All care files seen contained a care plan audit check list, scoring different elements from one to 10, although it contained limited useful detail. The auditing arrangements for care plans were not always effective or accurate. For example, one file had not had weights and MUST scores updated since April 2015 but the audit form rated this section as a 10.

The provider had recently introduced a new clinical management system for recording and reporting of clinical governance. This system had been in place at the home since April 2015 and a plan was in place to record all incidents/accidents, complaints, compliments, Meticillin-Resistant Staphylococcus Aureus (MRSA) and other infections, falls, wounds, safeguarding, notifications and other records. The expected benefit of this electronic system was that themes and trends could be identified from it. We were shown the system and saw that some data had already started to be inputted into the system and it was set up so that any recorded events could be linked back to a specific person and reports could be run to identify when and where incidents were occurring, to try and mitigate against them in future.

The provider had a business plan for 2016 which we reviewed. In it, areas of improvement had been identified some of which the provider had started to action. This included the renovation of parts of the home which was taking place at the time of our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person. Regulation 11 (1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not assess or effectively mitigate the risks to the health and safety of service users in relation to care or treatment. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not always appropriate and meet service users' needs. Regulation 9 (1) (a)(b).