Care Quality Commission

Paydens (Nursing Homes) Limited

Southdowns Nursing Home

Inspection report

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Ratings

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

Overall summary

We undertook an unannounced inspection of this service on the 07 July and 09 July 2015.

Southdowns Nursing Home provides accommodation, personal and nursing care for up to forty eight people living with dementia and mental health problems. There were 48 people living at the home at the time of our inspection. Accommodation is arranged over two floors and each person had their own bedroom. Access to the each floor is gained by a lift, making all areas of the home accessible to people.

Southdowns Nursing Home is a large detached house in a residential area of St Leonards on Sea, close to public transport, local amenities and some shops.

This service did not have a registered manager in post. The registered manager resigned at the end of March 2015. A registered manager is a person who is 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.

Summary of findings

During this inspection we met the manager who had been in post for three weeks and was in the process of submitting their application to become the registered manager.

We last inspected the home 16 May 2013 and no concerns were identified.

People and visitors spoke positively of the home and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

People's safety was being compromised in a number of areas.

Staffing levels were not sufficient and staff were under pressure to deliver care in a timely fashion. The delegation of staff placed people at risk from accidents and incidents due to lack of supervision in communal areas.

The delivery of care suited staff routine rather than individual choice. Care plans contained information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. However these were not followed. We saw staff make decisions about where people spent their day without consulting the individual. For example, remaining in bed because staff didn't have time to get them up. The lack of meaningful activities for people in their rooms impacted negatively on people's well-being.

Whilst people were mostly complimentary about the food at Southdowns Nursing Home, the dining experience was not a social and enjoyable experience for people. People were not always supported to eat and drink in a safe and dignified manner. The meal delivery was not efficient and we were told by people that they didn't often get a hot meal at lunchtime. We also observed food left in front of people without being offered the support they needed to eat. We also could not be assured that people had sufficient amount of fluids to drink.

Whilst quality assurance systems were in place, We found that shortfalls had not been acted on. Quality assurance systems had not identified the shortfalls we found in the care delivery.

Arrangements for the supervision and appraisal of staff were in place. Although staff supervision took place to discuss specific concerns, regular supervision and appraisals, intended to monitor the training, ongoing development and the competence of staff had lapsed slightly due to a change of management structure.

The deputy manager understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Relevant guidelines were available within the service for all staff to reference. Staff at all levels had an understanding of consent and caring for people without imposing any restrictions. However the staffing levels on the first day of the inspection had impacted on people not being got up as usual and being restricted to their room.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated they had built a rapport with people and people responded to staff with smiles. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Southdowns Nursing Home all had registration with the nursing midwifery council (NMC) which was up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

Southdowns Nursing Home was not safe. Risk assessments were devised and reviewed monthly. However, management of people's individual safety and skin integrity was poor and placed people at risk.

There were not enough staff to meet people's needs. People's individual needs were not met due to staff delegation and numbers.

Medicines were stored safely and people received their medicines when they needed them. However as required medicines protocols were not in place.

People told us they were happy living in the home and they felt safe. Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Inadequate

Southdowns Nursing Home was not consistently effective. Meal times were observed to be solitary and inefficient with food being served to people who were in an inappropriate position or left with their meal untouched in front of them. Senior staff had no oversight of what people ate and drank. No guidance was available on how much people should be eating and drinking to remain healthy.

Visitors spoke positively of care staff, and told us that communication had improved.

Staff received ongoing professional development through regular supervisions, and training.

All staff working had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were consistently recorded in line with legal requirements. Deprivation of Liberty Safeguards (DoLS) had been submitted as required.

Is the service caring?

Inadequate

Southdowns Nursing Home was not consistently caring. People and visitors were positive about the care received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity. People who remained in their bedroom received very little attention.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction with the individual However we also saw that some staff were very kind and thoughtful and when possible gave reassurance to the people they supported.

Summary of findings

Is the service responsive? Southdowns Nursing Home was not consistently responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care. People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated. A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be resolved and investigated.	**Requires improvement**
Is the service well-led? The service was not consistently well led. There was no registered manager in post. People were put at risk because effective systems for reviewing accidents and incidents and implementing management strategies had not been established. Changes to staffing delegation levels had impacted negatively on the care delivery for people. Quality monitoring systems were used to identify areas for improvement but they had not been acted on The management of the home were reactive to situations rather than ensuring the service was proactive in establishing good care. People and staff were encouraged to share their views on the service. Both thought the management arrangements had improved and were now effective and supportive	**Requires improvement**

Care Quality Commission

Southdowns Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 07 and 09 July 2015. This visit was unannounced, which meant the provider and staff did not know we were coming.

Two inspectors, a pharmacist inspector and a specialist dementia advisor with experience of caring for people living with dementia and with complex nursing needs undertook this inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the two floors of the home. We spoke with people and staff, and observed how people were supported during their lunch. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning on the reminiscence Neighbourhood. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, including eight people's care records, six staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation.

Several people had complex dementia and mental health needs and during our inspection, we spoke with 14 people living at the service, three relatives, eight care staff, the activity co-ordinator, two housekeeping staff, two registered nurses, the area manager and the manager.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Southdowns Nursing Home. One person told us, "I have no concerns." Relatives confirmed they felt confident in leaving their loved one in the care of Southdowns Nursing Home. One visiting relative told us, "I think It's a good home, I keep a close eye on things." Another relative said, "I trust staff here." However we found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Peoples' risk assessments did not always reflect their actual needs and some lacked sufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mental capacity, mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. They looked at the identified risk and included a plan of action to promote safe care. However we found that not everyone's health, safety and wellbeing was assessed and protected. For example, bed rails were in place but were not all fitted with bumpers that covered the rails sufficiently to protect people from injury. We saw one person in bed with both their legs through the gap between rails placing them at risk from injury.

We also noted that risk associated with use of pressure relieving equipment and the use of bedrails had not always been assessed and used appropriately. For example, three pressure relieving mattresses were found to be set on the wrong setting on both days. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. We also found bed rails that had been used with pressure relieving mattresses. The risks associated with their use had not been assessed and did not comply with safety guidelines as the space between the mattress and the top of the bed rails were less than that recommended by the health and safety executive. People were therefore at risk from falling. These were discussed immediately with the manager who asked the maintenance team to immediately check the identified beds.

Risk assessments did not include sufficient guidance for care staff to provide safe care and other care plans were not being followed. For example, good skin care involves good management of incontinence and regular change of position. There was guidance for people who stayed in bed to receive two or four hourly position changes and the use of a pressure mattress. However for people sitting in chairs or wheelchairs in communal areas there was no change of position or toilet breaks in their care planning for staff to follow. We identified during the inspection five people had not been assisted to access the toilet or offered a change of position for up to six hours. One person had sat in their room in the same position for approximately five hours including the lunchtime period. The staff told us that they had not had time to go back to offer a change of position or a bathroom visit.

Accidents and incidents had been documented with the immediate actions taken. However there was a lack of follow up or actions taken as a result of accidents and incidents. For people who had fallen and had been unwitnessed by staff there was no record of an investigation or a plan to prevent further falls. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect the person from harm. Therefore there was no learning evidenced from accidents and incidents.

We saw a one person had a number of skin tears that were not reflected in their care documentation. We could not find any completed accident forms for this type of injury. We asked the registered nurse where we could locate the details of the incident. Staff could not find this during our inspection.

We found bedrooms with a call bell system but no call bell leads. This meant that people had no means of calling staff if they required assistance. We spoke with staff and they could not explain why some people who were able to use the call bell facility did not have one. We drew this to the manager's attention immediately. We were told that there was no reason for the call bells not being in place. The lack of a call bell could place people at risk as they would not be able to call for help if they needed it. Risk assessments for the use and safety of call bells were in place. There was no alternative facility offered for those people who could not ring for help.

Personal emergency evacuation plans (PEEPs) were not in place. When we asked for PEEPs we were directed to a typed list which listed people's names, bedroom number and stated whether they could walk /otherwise, or needed horizontal evacuation. This list was found lacking in guidance for safe evacuation. There was no further information to guide staff in the safe evacuation of each person. Staffing levels decrease in the evening and night

Is the service safe?

time and this was not reflected in the evacuation list. Staffing levels especially at night would not be able to respond to the actions detailed, due to the layout of the home and number of staff. This placed people at risk from failed emergency evacuations.

Whilst infection control measures were in place, not all areas were clean and hygienic. There was a daily check of bedrooms, bathrooms and communal areas, where a checklist is completed once all of the area has been cleaned. However we found bumpers that covered bedrails dirty in people's bedrooms. Chairs in bedrooms and communal areas were not clean and stairs and banister rails were grubby with remnants of spilled dried food. In the first floor sluice area dirty commode inserts were seen, a yellow bag for medical waste was on the floor and the bin lid was missing from the black bag bin. The sharps bin was not dated on opening and was full. The bin lid was missing in the toilet on the first floor as was the bin lid in the first floor lounge area. We found that sluice rooms were not included in the cleaning and maintenance checks. We found missing seals around sinks, broken cabinets and unsealed areas of flooring. This posed a cross infection risk. We saw barrier creams and ointments in people's room and it was difficult to read the labels on some of these. Some cream pots when handled were greasy on the outside indicating poor hygiene practices.

The service had electrical hoists to move people and had a selection of different size slings. However the use of slings was not individual and the same slings were used for different people without being cleaned. These issues were potential sources of cross infection and placed people at risk from infection.

The environment was not free of potential risk hazards to people. A first floor unlocked store cupboard was full and untidy with several manual handling slings, foot plates, foot spa, zimmer frame and a bedrail. A ground floor lounge used by staff was unlocked and filled with chairs, quilts, bed tables, dining chairs and an ironing board. An unlocked ground floor bathroom had chair, wheelchairs, and boxes of gloves and aprons stored in it. We saw that there were people walking around in the corridors unsupervised and they were seen opening these doors.. Areas must be maintained in a safe manner and all equipment used must be risk assessed as the people living in this home are unaware of dangers. These issues were potential risks to people's safety and well-being

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

There were not sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Most people required two staff to assist them with all personal hygiene needs, assistance with mobilising, and one staff member to assist or prompt them with their nutritional needs. We were told the provider did not currently use a formal staffing tool to assess required staffing levels for the dependency levels of the people they were delivering care to. The staffing levels were not flexible to meet people's changing needs. Staff told us "No-one is the same two days in a row and it's hard to spend time with our residents in a way that we want, we rush from room to room. We also don't always get our breaks."

We saw that staff were busy throughout the day and that care was not delivered in a timely manner. Personal care to get people up for the day was still being undertaken at midday and this was not always people's individual preference. This meant that people had not had an opportunity to enjoy their morning as they were waiting for staff. On the first floor staff told us the 16 people who lived there were high dependency. They told us four people needed hoisting for all care delivery, four needed two members of staff for all movements with supporting moving aids such as sliding sheets. Eight people needed support with eating and drinking. We saw staff deliver task orientated care as they were continuously rushing from one task to another. Staff did not have time to ask people where they wanted to spend their day, or if they wanted a bath or wanted to go to activities and therefore the care delivered was to suit staff and staffing levels. On the first floor only one of the 16 people living there was taken to the lounge/ dining area for their midday meal. Six people sat in chairs in their room and nine people remained in bed. We asked staff if this was normal and staff told us, "We do not have enough time to get people up and into the lounge for lunch, we usually get more people up." We were also told, "The staffing levels don't give us the time to do the care we should give people, and it's not fair on our residents."

Staff struggled to provide care and to supervise people in communal areas. Staff told us that the staff had recently been reduced in the HDU unit from three care staff to two care staff. They told us the areas of concern were the "High dependency of the residents and that there were residents

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Is the service safe?

who were prone to falls and at risk if we are helping someone in the bathroom or their bedroom." We observed that the lounge was left unsupervised for periods of over thirty minutes (11.40 am -12.10 pm) leaving four people at risk from falls. At lunchtime we saw that they could not assist and support people with their food and drink. Relatives told us that weekends were short staffed and staff were always busy. Another relative told us that "There were not enough staff recently and a staff change around had occurred, which was unsettling." Another relative told me that staff shortages occurred at weekends and that staff were always busy. We looked at past rotas for May and June 2015 and found that there had been just three staff on the HDU which included the two staff allocated to the person who required two staff at all times. This meant that the staffing levels were not sufficient or consistent to meet people's needs. One person said "It depends how many people they have to see to so they cannot come to me quickly."

On the ground floor there were 25 people living there. There were times when we noted that people were walking the corridors without any engagement with staff as staff were busy with other people. One person was entering other people's rooms and distressing people who were in their rooms. This was not managed by staff. Another person was distressed and worried and calling out on a regular basis and we had to find staff to respond to them.

The lower floor had long corridors leading away from the dining and lounge area and some bedrooms were some distance away from where staff spent time and the staff office. People in those rooms were frail people and isolated. Apart from coffee and lunch we saw that these people received very little attention from staff. The staffing numbers and staff delegation were not sufficient to meet people's individual and changing needs.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems for ordering, checking orders received, disposal and administration were in place to manage people's prescribed medicines. Trained nurses administered medicine to people. Any medicine given covertly was against a best interest decision following a capacity assessment.

There was a 'Global' care plan that staff referred to as a quick reference on required person centred care, however this or the main care plans did not contain information to give guidance to staff to manage people's medicines when it was prescribed to be taken only if needed. We recommend that the service considers having guidance on giving medicines prescribed for people to be taken only when needed.

Hand sanitizers were located throughout the home. Soap and towels were available in bathrooms and at sinks. There were colour codes linen skips to ensure that linen was washed at the correct temperature. In the laundry there were two washing machines with a hot wash cycle for soiled items and two driers. All equipment was in working order. We asked the two staff in the laundry about infection control measures and they knew to wear protective clothing and wash items separately.

There was an ample supply of gloves and aprons in areas throughout the home. Staff were aware of infection control measures and the need to wash hands and wear appropriate protective clothing.

Staff received training on safeguarding adults and understood clearly their individual responsibilities to safeguard people. Staff and records confirmed that staff received regular training and recent safeguarding activity in the home had led to greater staff awareness. Staff had recently had a group supervision session on safeguarding people. Staff were able to give us examples of poor or potentially abusive care they may come across working with people at risk. They talked about the steps they would take to respond to allegations or suspicions of abuse. Staff were confident any abuse or poor care practice would be quickly identified and addressed immediately by the senior staff in the home. They knew where the home's policies and procedures were and the contact number for the local authority to report abuse or to gain any advice. One person was at risk from people outside of the home. Guidelines were in place for staff to follow in order to protect this person.

People were protected, as far as possible, by a safe recruitment practice. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults, completed by the provider. Interviews were

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Is the service safe?

undertaken and two staff completed these using an interview proforma. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Inadequate

Is the service effective?

Our findings

People and visitors spoke positively about the home and the care and support provided by the team of staff. Comments included, "I have great faith in the staff," and "Staff are very good and provide good care." One visitor said "They (the staff) manage very well, but sometimes I think it's sometimes disorganised and staff don't always know what's happening."

However, we found that staff at Southdowns Nursing Home did not consistently provide care that was effective.

Whilst people told us the food was 'okay', 'good and tasty', we observed that the lunchtime experience on the first day of the inspection process was very varied on the different floors and again on the HDU. Meal times were not a pleasurable experience for everyone or made to feel like an enjoyable event.

The main dining area and lounge was on the ground floor. A large table seated nine people whilst six other people sat in armchairs in the adjoining lounge area. People were served their meal from a hot trolley by the chef. People seated at the dining table received their meal immediately and enjoyed a meal served at the right temperature. For people in their rooms and sitting in the lounge area we saw that staff took meals to people covered but not everyone received timely assistance. People in their bedrooms were not assisted straight away until all the other people had been served. This meant that for some people the meal had cooled considerably and people did not eat very much.

On the first floor only one person ate in the lounge dining area, Everyone else received their meals in their room. Nine people were assisted to eat from their bed and six from their chairs. Meals arrived in heated trolley already served. Meals for the HDU were transported on an un-heated trolley by a care staff member. The meal service started at 1pm with the last meal served at 2.15pm. We observed that one person was assisted with their meal whilst lying flat in bed, we intervened by finding another member of staff to ensure the person was sat up to ensure their safety. One person was given a normal diet with meat, the care plan indicated that they should receive finger food and had difficulty swallowing meat. We found this person was taking meat out of their mouth and placing this on the side of plate as they could not chew. This person also attempted to eat red cabbage and cauliflower with their fingers. There was no offer of condiments, serviettes or a plate guard. For one person lying on their bed in their room their meal was placed by them on the table at 1.20 pm. At 2.00 pm a senior member of staff encouraged them to sit on a chair to eat their meal. No attempt was made to check if the food was still at an appropriate temperature.

The hot sponge pudding and custard was served at the same time as the main meal. People chose to eat the pudding first and in a couple of cases just the pudding was eaten. This meant the meal was not nutritionally balanced. The person who ate their meal in the lounge had limited company and support. What support was given was given intermittently by different staff. We asked a member of staff for a banana for this person as this is what they said they wanted and this was not provided. We observed staff standing and leaning over bedrails without gaining eye contact or talking with the person. The level of support to enable people to eat well was poor. People did not have a good experience. Staff told us they rushed people to get the work done. The meal service was seen as a task to undertake rather than a social and enjoyable experience.

On HDU the midday meal was brought to the unit at 1.10pm on an unheated trolley. The meals were on different coloured plastic plates with a plastic cover, and a number written on the plastic cover. Plastic cutlery was used throughout. There was no preparation for lunch, no serviettes or condiments were offered. Plate guards were also not offered and we observed that some people experienced difficulty in managing to eat their meal. One person spilt their food down their front whilst struggling to eat with their fingers. Another person was eating using a plastic spoon and fork, the red cabbage and cauliflower was spilt onto the bed table in front of them and the person had little to eat from this meal.

We looked at some of the fluid charts. Food and fluid intake, as well as personal care delivery are recorded on the 'Global Patient Charts'. Each person had a chart to be completed by staff. The charts showed some low fluid intakes, for example, less than 400 mls. Records for food intake were generic, for example, 'all main and all pud' Records on food and fluid intake must be legible, accurate, specific and should the desired amount of intake not be achieved then this should prompt staff to encourage drinks. Many charts showed no entries after 7:00pm. One person had a urinary tract infection, yet there was no prompt to staff to tell them to encourage fluids and what

Inadequate

Is the service effective?

the minimum intake should be in 24 hours. This person only took 500mls in 24 hours on the 06 July 2015 and there was no fluid output recorded. There was no other record of staff monitoring the colour or odour of urinary output that would indicate whether the person was taking enough fluids. For example strong odour and dark colour indicates that not enough fluids are being taken.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had undertaken training on the MCA and Deprivation of Liberty Safeguards (DoLS). Care staff had a basic understanding of mental capacity and informed us how they gained consent from people. Records supported people's consent was gained in a consistent way throughout the home. Most consent forms were well completed and demonstrated that people had been consulted about their care and treatment. However other records were incomplete and there was no evidence how staff had gained consent. For example, people's capacity was assessed routinely following admission, and there was no evidence how decisions were made for three people who lacked capacity to make an informed choice. For example, when bed rails were being used the rationale and discussion to ensure safe and effective use was not clearly documented. One person had bedrails in place, a lowered bed and a 'crash' mat by the side of the bed (to prevent injury on falling).

The senior nursing staff had a good understanding of the MCA and DoLS. They understood their responsibilities in relation to helping people making decisions and were aware any decisions made for people who lacked capacity had to be in their best interests, and would include appropriate representation for the person concerned.. Two people had a DoLS in place and we saw supporting documentation was in place with relevant guidelines for staff within each person's care plan. The deputy manager was also following up the restrictions imposed by key pads on the doors and lifts in the HDU with the local authority to ensure the least restrictive practice was used whilst keeping people safe.

People told us that staff working in the home were trained and looked after them well. One visitor said, "The training covers everything I think, certainly seem competent."

All staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Staff received an induction programme which lasted a month and on-going training support. Newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role. This was confirmed by a member of staff who said, "I was fully supported through the induction process, I am still supported by senior staff I always have someone I can ask for advice, all staff are helpful."

Staff and training records confirmed that a programme of training had been established and staff had undertaken essential training throughout the year. This training included health and safety, infection control, food hygiene safe moving and handling, safeguarding and dementia care. The training programme consisted of both e learning and direct training. Additionally, they said there were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. However some staff members told us that training was needed to help them feel safe and to respond to people with behaviours that challenge. This was raised with the deputy manager as an area for improvement and they confirmed this would be addressed.

Registered nurses were supported to update their nursing skills, qualifications and competencies. One registered nurse told us she had been supported in attending additional training on palliative care this had included specific training on equipment used to administer medicines via a syringe driver. The registered nurses told us that they had the skills to look after the people living in the home and would access training they felt they needed through the home or externally if required. The registered manager told us staff training had been reviewed with an emphasis on providing further specialist training to ensure the needs of people were appropriately responded to.

All staff told us that they felt well supported and felt they could speak to senior staff in the home and that they would be listened to. Staff confirmed that in the past support had not been good. They had not received regular supervision and there had been confusion on what roles and responsibilities staff had been allocated. With recent management changes staff told us the support and clarity on roles had been greatly improved. Most staff had received a recent individual supervision and group

Inadequate

Is the service effective?

supervisions had been recorded. Systems for regular supervision and annual staff appraisal had not been established. This was identified as an area for improvement.

Staff had developed systems for organising work and for communicating information between staff. Each shift began with a handover and staff were allocated people to look after and specific roles. This included either assisting in the lounge areas or supporting people in their own rooms. Staff breaks were also recorded to ensure effective allocation of staff. Handover sheets were used to communicate individual needs and appointments. The staff handover demonstrated that staff were knowledgeable about people and their individual needs. They reminded people of these needs, for example discussion took place about one person refusing medication and this was to be referred the GP for review. Daily records and charts were used to communicate how people's needs were being attended to. We have already identified some shortfalls in the recording of nutrition. However we also saw some other clear instructions for staff to follow such as two hourly checks at night on a person who was unwell, and 30 minute checks on a person who needed closer supervision to prevent falls. These were clearly documented to demonstrate they had been completed.

Records showed that people had regular access to healthcare professionals, such as GPs, chiropodists, opticians and dentists and had attended regular appointments about their health needs.

People and relatives told us that when they needed to see a GP this was arranged in a timely fashion. The service has a contract with a local GP practice who have two regular GPs who attend the home routinely and when requested. One person complimented staff on the way they handled a recent infectious outbreak at the home. They told us, "The way in which staff handled it, was clear and controlled the outbreak from spreading. Staff dealt with it with humour and patience." Staff and records demonstrated that the outbreak was managed in an effective way that promoted people's health. Senior staff sought expert advice and set up strategies to respond to people's needs and to contain the outbreak. All visitors and visiting health professionals were informed on entering the home. Statutory notifications were sent to the relevant organisations informing them of the outbreak.

Inadequate

Is the service caring?

Our findings

People were positive about the care they or their loved one received. One person said, "They are quite kind but they do rush around, everything takes so long." Another said, "I'm left alone a lot, pretty bored." Visitors told us, "They speak to residents, seem respectful and it's keep the place clean, and know how to calm them," and "My husband seems happy enough."

At times staff did interact with people in a caring and respectful manner, but we also observed instances when staff were too busy and did not engage positively with people whilst supporting them. Staff assisted people, but did not ensure their comfort by verbal reassurance or display empathy with people's mental health needs. We saw one person continually walking around the corridor areas and entering other people's rooms without staff intervention or company. We saw other people being asked to wait when they called out for assistance and then we heard them still calling out 30 minutes later.

Staff told us they promoted people's independence and respected their privacy and dignity. Staff greeted people respectfully and used people's preferred names when supporting them. One staff member commented on how they encouraged people to be as independent as possible. However this was not supported by our observations. For example, one person wanted to go for a walk and staff had to refuse the request because they didn't have the time. This meant that the person became distressed and agitated. We were told that people on the first floor had been kept in bed or in their room because staffing levels did not allow the staff the time to meet individual needs. This decision not to get people up and in communal areas was not discussed with people. This meant that staff were not promoting peoples independence to choose whether they remained in bed or if they joined other people in the lounge areas.

The meal service at Southdowns Nursing Home did not ensure that people's dignity was promoted. We observed that people struggled to eat without the necessary support from staff. Food was placed in front of people and left getting cold as people were not able to eat independently. No clothes protectors or serviettes were offered and people remained in stained clothing following the meal.

One person's room had no curtains or window coverings to give them privacy and respect their dignity. We were told this was due to the person pulling them down. No alternatives had been considered. The bedroom was overlooked by a neighbouring house. This had not ensured this person's privacy.

We saw that peoples clothing was not always appropriate. Some clothing was ill fitting and looked uncomfortable whilst other people were dressed in stained clothes following drinks and meals. Staff did not offer a change of clothing or a clothes protector. This had not maintained people's dignity.

Our SOFI identified that on the HDU and on the first floor engagement between staff and the people they supported was generally task driven, for example, assisting them with their lunch and giving them their medicines. Spontaneous engagement was limited, meaningful activities, stimulation and involvement was also very limited. In the lounge there were six people, three of whom had their eyes closed for the majority of the two hour SOFI.

We noted in one bedroom, the television was showing the message 'no video available' and this was the same for one hour without staff intervening. In another bedroom the person was continuously calling out and this lasted for 20 minutes until staff responded to them.

Observations throughout the day identified that staff did not always offer people a choice or listen to what they wanted. People were placed in chairs for long periods without a change of position or being asked if they wanted to sit elsewhere. The television was on in the lounges but people were not asked if that was what they wanted to watch. One person was asking to return to their bedroom but staff told them to stay in the lounge. This had not enabled people to make everyday choices important to them and to meet their identified needs. One member of staff told us, "We can't always do what we should to encourage people to be independent, no time, so we do it for them." We also noted that many rooms had clocks that were set incorrectly and calendars in some rooms stated the wrong date. This did not promote people's independence or autonomy.

People told us they were well cared for. One person told us, "Very nice staff." Another person told us, "I'm happy here." However documentation on when people received oral hygiene, bath or a shower recorded that often people

Inadequate

Is the service caring?

would not receive the care they required. We saw that people could go five days without receiving oral hygiene. The manager informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes we looked at did not always record when an individual received care or if personal care was offered. We could therefore not tell if people received regular support to bath or shower. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. This meant we could not be assured that people's personal hygiene needs were being met. We asked staff if there was a dignity champion on the staff team. Staff were not sure of what a dignity champion was, We were informed later by the manager that there wasn't one at present but this would be discussed and a champion appointed.

The provider had not ensured that people were treated with dignity and respect in ensuring their personal care needs were met consistently. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we did see some staff interacting with people in a kind and compassionate way. When talking to one person who was a little distressed, we saw a staff member sit next to the person and talk to them in a way that had them smiling and agreeing to have a cup of tea." There were staff who had clearly developed rapports with people and people responded to staff with smiles. Staff we spoke with spoke positively of the home and confirmed they enjoyed their work.

Relatives were complementary about the staff saying," The staff are lovely," "Staff are very aware and observe my husband," and "Lovingly cared for." Relatives told us staff were polite. Another relative told us that their loved one had had difficulty settling, but was now settled and seemed happy. This was evident the relative said, as their husband smiled a lot at the staff.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Is the service responsive?

Our findings

People commented they were well looked after by care staff and that the service listened to them. One person said, “I think I get everything I need, no problems really.” A visitor said, “They deal with things quickly.” However, we found Southdowns Nursing Home did not consistently provide care that was responsive to people’s individuality and changing needs in a consistent way.

People’s continence needs were not always managed effectively. Care plans identified when a person was incontinent, but there was no guidance for staff in promoting continence such as taking them to the toilet on waking or prompting then to use the bathroom throughout the day. We asked staff about continence management and they could tell us who was incontinent and who required prompting and assistance. However there was no mention of promotion of continence to prevent incontinence. People’s continence needs can be managed by regular prompting and responding to body language and timings for drinks and meals. This meant staff were not responsive to people’s individual needs.

We saw a person moving round the home using a walking stick. In the mobility care plan it did not reference this, nor did it refer to him walking without shoes or socks. We were told the person refuses the shoes and socks yet the care plan referred to wearing ‘well-fitting shoes’. The care plan had not been updated to reflect the current situation. The falls risk assessment for this person had been completed 8 September 2014. Nine accident forms had been completed for the period 5 June 2015- 4 July 2015 for this person. There was an accident form dated 1 July 2015 referring to an injury the person sustained. The accident form said that the resident was found on the floor and it was unwitnessed. There was no documentation as to the actions taken to prevent a reoccurrence and the family had not been informed. A robust review and update of the falls risk assessment had not been undertaken to prevent further injury occurring.

Activities were available and were held in the main lounge on the ground floor. However there was a general lack of stimulation for people who remained in their room and on HDU. The activities co-ordinator was working hard to introduce more meaningful person centred activities for people. She also said that it is very difficult on her own to ensure everyone had the opportunity for one to one sessions. On the day of the inspection we did not observe any specific activities suitable for people living with dementia on the first floor or on HDU. There were no sensory items for people to touch or feel. We noted that many rooms had clocks that were set incorrectly and calendars in some rooms stated the wrong date.

People were socially isolated. During the morning we found people sitting in lounge areas with the television on, but no other stimulation. Many people were asleep in their chairs. People who remained on bed rest received very little interaction or stimulation. A member of staff told us, “There isn’t enough for people to do, they sleep a lot of the time.” Some bedrooms were un-personalised and sparse with little for people to engage with.

The evidence above demonstrates that delivery of care in Southdowns Nursing Home was not suited to individual people’s preferences and needs. rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People’s care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. The care plans contained details of how to manage and provide person specific care for their individual needs. However as previously identified in the report the care plans were not being followed by staff on the day of the inspection.

Before someone moved into the service, a pre-admission assessment took place. This identified the care and support people required to ensure their safety and care needs could be met in the service. The manager told us everyone was visited prior to any admission. If they felt they did not have enough information to make a decision they requested more. Care staff told us that care and support was personalised and confirmed that, where possible, people were directly involved in their care planning. Where people could not be due to their dementia, family had been involved in providing important information to help care staff with the delivery of people’s care. We saw evidence of this in care plans. One relative said, “They really seemed interested for my input.” The care and support plans contained clear instructions about the needs of the individual. They included information about the needs of each person for example, their communication, nutrition,

Requires improvement

Is the service responsive?

and mobility. Individual risk assessments including falls, nutrition, pressure area care and moving and handling had been completed. These had been reviewed and audits were being completed to monitor the quality of the completed care and support plans.

Complaints were responded to and used to improve the service. The home had a clear complaints procedure that was available to people within the home and from staff if requested. People spoken to said they were able to complain and were listened to. Visitors were also confident that they could make a complaint and it would be responded to. One visitor said "I now have complete faith in staff, they listen and act, before I felt ignored." Another said, "I would not hesitate to talk to a member of staff if I needed to." Records confirmed that complaints received were documented investigated and responded to. For example a concern about the washing of clothing was responded to and resolved to the complainant's satisfaction. Staff practice had also been reviewed to limit the likely hood of a reoccurrence.

Requires improvement

Is the service well-led?

Our findings

People told us they liked living at Southdowns Nursing Home. Visitors said and that although there had been a lot of changes with the members of the management team they were satisfied that the home was being well managed now. One relative said, “I have faith in the staff, bit rocky recently, but much better.” Comments reflected on the approachability of the managers and senior staff working in the home and the belief that they listened to their feedback.

However we found that the service had not fully established good leadership.Accident and incident reports identified that these were not recorded accurately or responded to effectively to reduce risk in the service. Repeated accidents for one person had not been pro-actively managed. Another person’s skin tears had not been documented. Learning from these incidents had not been taken forward. For example the possible need for further training to reduce the number of injuries and implementation of strategies to respond to people when their mobility deteriorated.

We were told by staff that staffing levels had been decreased recently which impacted on direct care delivery. We were told also by staff that the management team had been informed of this but no action had been taken. We raised this with the new management team who said that staffing delegation had been changed but this was to improve the staff knowledge of all the people who lived in Southdowns Nursing Homes. This put people at risk from poor care delivery. On the second day of the inspection we were told that the staff delegation and staffing numbers had been amended. Staff and the rotas confirmed these changes and felt that it had enabled the staff to meet the needs of the people they cared in the way they should.

Staffing levels had impacted negatively on the care people received and potentially put people at risk. These issues are is a breach of Regulation 17 Of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Southdowns Nursing Home had management structures in place that staff were familiar with. This included an area manager, manager, registered nurses and senior care staff. There has been a recent introduction of a deputy manager (RN) to support the manager. There was no registered manager in post. However a manager was appointed in June 2015 and her registration with the CQC was being progressed.

Staff told us that they were clear on who they reported to and had access to the manager and deputy manager if needed. They felt there had been a lack of leadership in the past but was more confident with the current management arrangements. They told us that the changes in the management structure had been positive development, they were more supported. Three staff members when asked if they felt supported said, “Much better we are fully supported.” Staff were aware of the Whistle blowing procedure and said they would use it.

The new management structure had responded positively to a number of concerns raised by anonymous complainants. Staff had been supported through the resulting investigation process and told us they had learnt a great deal from this. The management and staff had been open and honest where problems had arisen and were looking for ways of improving the service further. This proactive response to information was also evident throughout the inspection process where improvements were progressed immediately following identification. For example, the assessment of bedrails where there were concerns around safety, the resetting of bed mattresses where they were incorrect and immediately fixing some environmental concerns. The managers were aware this was a reactive reaction and that they needed to have systems in place to ensure they were pro-active.

Organisational audits were being completed routinely and a new audit based on the CQC requirements completed had identified some shortfalls that were to be addressed. This included the issues identified at this inspection relating to medicine administration and the care plans. A full overview was yet to be concluded and actioned.

Southdowns Nursing Home had clear values and principles established at an organisational level. All staff had a thorough induction programme that covered the organisation’s history and underlying principles, aims and objectives. These were reviewed and discussed within supervision sessions with staff.

The provider sought feedback from people and those who mattered to them in order to improve their service. Meetings were used to update people and families on

Requires improvement

Is the service well-led?

events and works completed in the home and any changes including those of staff. People also used these meetings to talk about the quality of the food and activities in the home. Meetings were minuted and available to view.

Staff meetings were now regularly held to provide a forum for open communication. Staff said meetings were an important part of communication as they could raise ideas, concerns issues and feel supported by the staff team.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that systems or processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider must ensure that there are effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1) (2) (a) (b) (c) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. Regulation 9 (1) (a) (b) (c) 3 (a) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected. Regulation 10 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:
warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b) (e) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met. Regulation 14 (1) (2) (a) (b) (4) (d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Regulation 18 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice