Homerton University Hospital NHS Foundation Trust

Mary Seacole Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 1, 2 and 3 September 2015. The first day of the inspection was unannounced and we informed the registered manager we were returning on the subsequent days. At our previous inspection on 9 September 2013 we found the provider was meeting regulations in relation to the outcomes we inspected.

Mary Seacole Nursing Home is a purpose built 50 bedded NHS care home with nursing, which provides accommodation for people who require permanent or respite nursing care. This includes people who are living with dementia. The premises is arranged over two floors and provides single occupancy bedrooms with ensuite facilities, communal dining rooms, lounge areas, adapted bathrooms, an activity room and two passenger lifts. There is a seven bedded transitional neurological rehabilitation unit for people who have had a neurological injury or have been diagnosed with a long term neurological condition, which provides dedicated areas for people to develop and improve upon their independent living skills, including a laundry room, a therapeutic exercise room and a kitchen. There are landscaped gardens and a terrace at the rear for use by people on all of the units and the premises is within short walking distance of local shops, cafés and other

Summary of findings

amenities. At the time of the inspection the rehabilitation unit was at full occupancy and there were seven vacancies in the units for permanent and respite nursing care.

There was a registered manager in post, who has managed the service for several years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The system for managing medicines was not as safe as it should have been. People were supported to meet their nutritional and hydration needs, although some of our observations showed that staff were stretched and very busy at meal times.

There were not always enough staff to meet people's needs, including their needs for social stimulation. People and relatives told us they did not think there were enough staff on duty and staff were always very busy. People had access to visiting health care professionals including a consultant geriatrician, GP service, occupational therapists and physiotherapists. The provider was working towards improving people's access to more frequent podiatry.

An activities programme was in place, and the service arranged entertainments and events. Despite this, there was little evidence of how people who were bedbound or did not frequently come out of their bedrooms were supported to receive social stimulation.

A safe and rigorous system of staff recruitment was demonstrated, whch helped to protect people from the risk of being cared for by unsuitable staff. However, we found there were not always enough staff to meet people's needs. People and relatives told us they did not think there were enough staff on duty and staff were always very busy. Records showed staff were supported with training, group meetings and an annual appraisal. However, one-to-one formal supervision was not in place.

Measures were in place to protect people from the risk of abuse. Staff had received training and understood how to identify and report any concerns to the registered manager.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. Staff understood the legal requirements of MCA and were in the process of making DoLS applications to the authorising body.

Staff spoke with people in a respectful manner, however, some people's dignity had not been fully maintained by inappropriate bedroom curtains that did not close properly.

Care plans identified people's needs, which were regularly reviewed and up to date. However, we found limited information about how the service met the needs of people living with dementia. A range of risk assessments had been completed for people, which covered areas of daily life including falls prevention, nutrition and pressure area care. We found that risk assessments had not been carried out for the use of mobile armchairs, which we observed staff experience difficulty with manoeuvring.

The registered manager was described as having an open, supportive and approachable management style. People and their representatives knew how to make complaints and told us they were confident that complaints were taken seriously. There were systems in place to monitor the quality of the service and there was evidence that learning took place from audits, complaints and other feedback from people, their relatives and stakeholders. However, the significant shortfalls found in relation to staffing arrangements and medicines management had not been identified or addressed by the quality monitoring system in place.

We have made a recommendation to the provider regarding the use of mobile armcahirs within the service.

We found three breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 in relation to staffing levels, staff supervision and medicines. You can see what actions we asked the provider to take at the back of the main 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

The service was not safe.

Appropriate arrangements were not in place for the safe management of medicines, although the provider began addressing issues of concern during the inspection.

There was not always enough staff to provide people with individual support required to meet their needs.

Staff understood how to safeguard people from the risk of abuse.

There were robust recruitment procedures in place and people were protected by good infection control measures.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were supported with training, group discussions and an appraisal system, but there was no programme of support and development through individual one-to-one supervision meetings.

Mental capacity assessments had taken place in accordance with the Mental Capacity Act 2005 and staff understood their responsibilities in relation to this legislation.

People were provided with a well balanced diet and were supported to meet their nutritional needs. Their health care needs were identified and addressed.

Is the service caring?

Good

The service was not always caring.

Staff interacted kindly with people and we received some positive comments about how people were cared for.

People's privacy was not always maintained due to inappropriate bedroom curtains.

Although activities took place, we observed that some people appeared isolated in their bedrooms and lacked social stimulation.

Is the service responsive?

Requires improvement

The service was not always responsive.

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

However, we found the care plans did not always reflect people's changing needs.

Summary of findings

People and their relatives felt complaints were welcomed and taken seriously. Complaints were fully investigated but the documentation was incomplete and needed more recorded information.

Is the service well-led?

Requires improvement

The service was not always well-led.

The registered manager was described as being approachable and supportive.

There were some robust systems for monitoring the quality of care, including specialist work to reduce the incidences of pressure sores. However, the internal monitoring of medicines and staffing arrangements had not identified issues detected at the inspection.

The provider sought people's views and used their feedback to make improvements.

Mary Seacole Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 1, 2 and 3 September 2015 and was unannounced on the first day. Before the inspection the provider completed a Provider Information Return (PIR) sent by the Care Quality Commission. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR during and after the inspection. We also reviewed other information we held about the service before the inspection.

The inspection team comprised two adult social care inspectors on each day, a specialist professional advisor for two days, and a pharmacist advisor and an expert by experience for one day. The specialist professional advisor was a registered nurse who had experience in caring for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Throughout the three days we spoke with 14 people who used the service, eight visitors, eight care staff, one rehab staff, four staff nurses, the rehabilitation unit service lead, an allied healthcare practitioner neuro-rehabilitation consultant, a consultant geriatrician and the registered manager. We gave feedback at the end of the inspection to senior management staff from the provider.

During the inspection we looked at the environment and checked the quality of the accommodation provided to people. We looked at a range of documents including eight care plans, five staff recruitments folders, staff training records, and other information relating to the safety and management of the service. We spoke with a local GP who provided a twice weekly visiting service and we contacted Healthwatch Hackney, who carried out an 'enter and view' visit in August 2015. This is an independent consumer champion that gathers and represents the views of the public in regards to health and social care services.

Inadequate

Is the service safe?

Our findings

We checked the systems for the receipt, storage, administration and disposal of medicines. We looked at medicines practices within the units for permanent and respite nursing care but did not carry out any checks on the transitional neurological rehabilitation unit. We noted some aspects of the management of medicines were not as safe as they should have been.

We looked at a sample of MAR charts and saw that medicines had not been signed for six people on a specific date and time in July 2015. There were two further examples of medicines not being signed for on other dates.

A staff nurse working on one of the ground floor units explained to us that medicines were stored in individual pods within people's bedrooms or in a locked trolley within a medicines room, if the pods were not in service. There were two separate storage rooms for medicines on the ground floor but we did not find evidence that the room temperatures were monitored on a daily basis. The thermometer on the wall in one of the room's read at approximately 28 degrees centigrade, which was above most medicine manufacturers' storage recommendations. We did not find any evidence of temperature monitoring in the bedroom medicines pods. This meant medicines were at potential risk of changing their composition or deteriorating due to unsafe storage conditions.

The staff nurse showed us how they had properly recorded the medicines that needed to go for waste collection and stored these medicines in a separate trolley. However, we found medicines that had been discarded into an open returns medicines bin, instead of a tamper free container within a locked cupboard. We showed this to the staff nurse so that safe and appropriate action could be taken.

We checked controlled drugs on the ground floor units and balances were found to match the recorded numbers in the controlled drug register (CDR). However we noted an entry in the CDR for a person who returned home in August 2015 with controlled drugs, which had been signed by a registered nurse but not counter-signed by a second registered nurse. This practice was not in accordance with the provider's medicines policy and procedure in relation to controlled drugs being transferred to another setting, which was in place to ensure a clear audit trail and to prevent the risk of medicines being misappropriated.

On the first floor, we found the medicines fridge and the controlled drugs (CD) cupboard were stored in a general office where the door was left open and the office was left unattended for periods of time. Although the fridge and CD cupboard were locked, the access to the general office increased the potential risk of attempted theft of prescribed medicines. Records showed the medicines fridge temperature was monitored daily and remained within recommended temperatures. The fridge housed an excess stock of approximately 40 insulin pens that had not been required for some months as the person they were prescribed for had been switched to a different type of insulin. Medicine no longer required should be disposed of safely via the provider's waste contract to reduce the risk of it being wrongly administered.

Some MAR charts had new medicines or medicinal products transcribed (copied from a script) on them by a registered nurse; however, the new medicines on the MAR charts had not been signed off by a registered prescriber. This was not in accordance with the provider's policy and reputable guidance (the Nursing and Midwifery Council Standards for medicines management). For example, the MAR chart for one person had transcribed additions for three different medicines but had not been signed by the registered nurse who added these items or signed off by the GP who visited twice weekly.

Another hand transcribed MAR chart was for a person who had been admitted for respite care and was prescribed several medicines, which included a medicine for the management of a specific medical condition. The person had brought in their medicines in a compliance aid prepared by their own pharmacist in the community. The prescription labels on the compliance aid showed the person had been prescribed two tablets in the morning, two tablets in the afternoon and one at night. This information had been transcribed without the signature of the staff nurse completing the MAR chart and had not been signed off by the GP. The information had then been crossed out and altered to one tablet in the morning and one in the afternoon. A staff nurse told us this action had been taken in accordance with an instruction from the person's next of kin and they could not provide any correspondence from a doctor or healthcare professional to demonstrate the change to the prescribed dosage had been recommended by the prescriber, or any checks had been made by the provider with the prescriber. The provider informed us the following day that the error had

been made by the person's own community pharmacist and verification of the correct prescribed dosage was recorded at the time in the person's file by the provider's consultant geriatrician.

We also noted that a member of the nursing staff had signed for the administration of a night time dose of this medicine but it was still in the medicines compliance aid.

A third handwritten MAR chart had been in use since 25/08/2015 with no signature for the registered nurse who had completed it, and it had not been signed off by a GP. One medicine appeared to have been initially written as 10mg once a day with a line crossing through the evening dose. The MAR chart had then been altered for the medicine to be given in the evening and staff nurses were now signing over the chart with a line through it. The incorrect use of transcribing procedures placed people at risk of receiving medicines which did not accurately match the prescriber's instructions.

We asked the staff nurse how frequently they had medicine training updates. The staff nurse told us they did not think they had attended this training for approximately five years and thought it would be useful. The provider informed us that 10 out of 12 registered nurses were up to date with their mandatory clinical training, which included medicines management. The registered manager told us there were plans for staff to update their clinical skills, including medicines management, as part of a short secondment to the Homerton Hospital. We were informed that medicines and medicine administration record (MAR) charts were supplied by a community pharmacy, which did not conduct audits, as this responsibility was held by a medicines safety lead nurse employed by the provider. Audits took place every three months and we were shown copies of recent audits.

Accompanied by the staff nurse in charge on the first floor, we reviewed the storage and application of prescribed creams to support people's skin integrity. We found some of the creams had been opened for longer than six months and some others did not state the dates of opening, or no longer had labels attached. There was no formal record of creams being applied as MAR charts remained blank. For example, one person's care plan for pressure area care stated that staff 'ensure creams are applied to sacral areas and leg', however their MAR chart was found to be left unsigned for these items. This meant we were unable to ascertain if prescribed creams were applied in line with the prescriber's intention and the guidelines within people's care plans.

We observed that one person was still receiving a medicine that had expired on 23 August 2015 and another person was written up for a medicine once a day, although the staff nurse in charge told us it this was incorrect and should be given only when required. There were more examples of transcribed medicines recorded on MAR charts, without the signature of a staff nurse and signed off by a GP. Another MAR chart showed a person had gone home for social leave on two separate occasions, however there was no written record of their medicines having left the premises or being booked back in.

The staff nurse in charge showed us medicines stored in the trolley. We found a medicine dispensed in November 2014 which had a three month shelf life once opened. There was no date of opening visible as the label was partially detached from the bottle; therefore we could not determine if the medicine was in date. There was another medicine dispensed in June 2014, with no date of opening recorded on the label and was in current use. This medicine must be disposed of 30 days after opening, hence we could not establish if it had expired or not. These observations meant people may have been at risk of receiving medicines that had expired and were no longer as effective due to loss of potency.

We discussed our findings with the provider at the end of the second day of the inspection. On the third day of the inspection we were presented with the provider's investigation of the issues we raised and an action plan for improvement, which were comprehensive and detailed.

These findings evidenced a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014.

We received mixed views about the staffing levels, with some relatives and staff stating there were not always enough staff around to meet people's needs, and staff were over stretched. One relative said, "They are massively understaffed, especially at the weekends. When I visit, I hear people calling out for attention and assistance. Staff do not have the time to do anything beyond offering basic care." Another relative told us "There are definitely not enough staff here, that is one of the poor things about Mary Seacole Nursing Home." They also said, "Everyone is

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usually in their room; how can staff check everyone?" A third relative told us they were happy with the care provided for their family member and rated the service "eight out of ten" and a fourth relative commented, "[My family member] is always clean and tidy no matter what time I visit. [He/she] needed consistency of care and they are getting it." Three other relatives told us they were not happy with the staffing levels and thought the lack of staff made the care appear task orientated instead of person-centred.

Healthwatch Hackney informed us they received comments from relatives that a few people were not always supported to get out of bed due to staff shortages, and three relatives told us the same. We discussed this with the registered manager, who told us people got up daily unless they were acutely unwell, or experiencing increased frailty and discomfort on a particular day due to their health care needs. We also received information from relatives that some people did not receive personal care (showering and bathing) at a frequency that met their wishes. The registered manager told us that most people had requested a weekly bath or shower, although he was aware of one person who had two showers a week in accordance with their specified request.

We spoke with the registered manager about the staffing levels and looked at a sample of staffing rotas for the past month. The staffing ratio during the daytime (8am to 8pm) was ordinarily set at one member of staff for every four people. He told us there were systems in place to monitor whether staffing levels at the service attained the levels agreed by the provider and these were reviewed on a daily basis. The registered manager was responsible for the completion of a 'monthly safer staffing report' which compared the actual staffing level to the planned staffing level. We were informed the staffing levels varied based on people's needs and activities taking place within the service, such as people's review meetings. We asked about the use of an established tool for determining staffing levels and were told that this had been tried, but it was found to be too clinical and did not reflect the social care needs of people.

At the time of the inspection, there was one staff nurse and three health care assistants allocated to the ground floor nursing units, and one staff nurse and seven health care assistants allocated to the second floor. One of the health care assistants on the first floor was providing one-to-one care, which showed the provider had arrangements in place to meet people's specific more complex dependency needs. On the first day of the inspection a health care assistant booked to work on the ground floor did not turn up and their absence made the unit appear busy and short staffed. In the afternoon we saw that three members of staff were needed in order to support a person who required a dressing changed. We walked around the unit several times and could not find a visible member of staff. The provider had implemented a policy that all personal care was delivered by two members of staff at all times, following a very serious incident in 2013, which impacted upon staff availability.

Staff demonstrated they were aware of the importance of people's social and emotional well-being, but we found practical tasks took precedence for them. For example, one member of staff took a person to the lounge and left them sitting in front of the television. We asked if that particular television programme was the person's preferred choice and whether they would have any company, since there was no one else in the lounge. We were told "They just like to be out of their room and I don't have the time to stay with them. I have others to assist who are in their rooms." Another staff member told us, "A lot of the job is about just doing things. There is not enough time to sit and talk with people. I will often spend my break sitting and chatting, it is the only time." We subsequently noticed on several occasions how people were sitting in lounges areas without any staff engagement.

We observed how people were being supported and cared for at lunchtime on the first day of the inspection. Some people required support with eating. In one of the dining rooms where we did some of our observations, there were two people who required full assistance to eat. There was just one member of staff available to assist, which meant that one person waited 35 minutes before another member of staff came to assist them with eating their lunch. We asked the member of care staff whether this delay was usual and they said "it all depends on whether people are finished in their rooms, then staff can come to help in the dining room. We are very busy here." The support on offer was varied, one health care assistant engaged well, explained what was on the plate and chatted, whilst the other health care assistant did not offer any explanation about the food or make an attempt to engage with the

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person whom they were assisting. We observed on different units for nursing care that lunch time stretched over several hours and the care plans did not identify if some people chose to have a late lunch.

We spoke with the registered manager about these observations and discussed whether staffing levels needed to be improved in order to enable people to have their lunch at a time that met their individual preference. The staffing levels did not demonstrate how people's needs were met beyond their personal care needs, for example, how people were supported to leave the building to access local amenities and take part in regular activities.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no concerns received from people who used the neuro-rehabilitation unit in relation to staffing levels. The unit appeared well staffed and people were full of praise about the staff. We saw that people received support and from a range of healthcare professionals including staff nurses, physiotherapists, occupational therapists and psychologists. The provider had introduced a 'rehabilitation worker' role and these staff had been trained to support people with elements of their rehabilitation programme.

We looked at staff recruitment records for five staff members and found safe practices were in place to protect people using the service. The staff records showed that prospective staff completed an application form, which was checked for any gaps in employment, education and/or training not accounted for. Two references were sought, including one from the applicant's most recent employer, proof of identity and proof of eligibility to work in the UK. Disclosure and Barring Service (DBS) checks had been completed before a candidate was permitted to commence employment. The Disclosure and Barring Service provides criminal record checks and barring functions to help employers make safer recruitment decisions. We also saw evidence to demonstrate the provider checked that any practicing nurses had current registration with the Nursing and Midwifery Council. The registered manager confirmed that he was seeking to recruit new staff nurses. Interviews had been held a few weeks before the inspection and did not result in the appointment of suitable staff, so the recruitment drive was taking place again.

The registered manager told us that relatives asked if they could contribute questions for staff interviews which we saw in the minutes for a meeting for the relatives group, known as the Friends of Mary Seacole Nursing Home. The registered manager said a question devised by a relative about how staff demonstrated caring values was now being used for the recruitment of new staff and the relative had joined a recent interview panel.

Most of the people we spoke with told us they felt safe and protected from harm. Three people said they preferred the service in comparison to other care settings they had experienced. One person told us, "I am very fond of the staff, they treat me respectfully." Another person told us, "In the main I feel safe with the staff." They explained this remark by informing us they had made a complaint about the attitude of one staff member, which they felt the registered manager appropriately dealt with. One relative we spoke with told us, "My [family member] is safe only when their regular carers are on duty. I do not think those who do not know my relative could handle them safely." Another relative said, "I feel my family member is safe here. They can shout and complain if they are unhappy with someone."

A relative told us about an incident which occurred a couple of days before the inspection, in which a person using the service appeared to have received inappropriate personal care which did not take into account their wishes. The relative told us they had discussed their concerns with the registered manager but did not want to make a formal complaint. We thought the concern could potentially constitute a safeguarding allegation and discussed it with the registered manager. He confirmed the same view and had begun interviewing staff to establish further relevant information.

We spoke with a member of the care staff about safeguarding. Whilst they told us, "It has been a long time since I remember having had training in safeguarding vulnerable adults" they demonstrated an understanding of the types of abuse that could occur, the signs they would look for and what they would do if they thought someone was at risk of abuse, including who they would report any safeguarding concerns to. They said, "I report everything to the nurse."

Inadequate

Is the service safe?

Staff working in the neuro-rehabilitation unit had identified safeguarding concerns that a person was potentially at risk of abuse from a visitor. Records showed they took appropriate action to ensure the person's safety.

We spoke with the registered manager about how safeguarding notifications, and other notifications, were reported to the Care Quality Commission (CQC). At present, these notifications were being recorded on a system used by NHS trusts and sent fortnightly to the CQC. The registered manager stated they would contact the inspector about any future safeguarding allegations so that the information was received promptly.

There were risk assessments in place in the care plans we looked at, including risk assessments for falls, manual handling and use of bed safety sides. We observed that a member of the care staff followed the written guidance in order to maintain a person's safety. Whilst these risk assessments were reviewed each month, we noted there was nothing to indicate how this review was done or what was taken into consideration, since the only comment written each month was 'no change'.

We observed the transfer of three people from the dining area to the lounge whilst seated in their mobile armchairs. The armchairs appeared to be difficult to manoeuvre, their width made it a tight fit to get through the lounge door and there appeared to be a potential risk of people getting their arms or legs caught whilst being pushed. A health care assistant told us the chairs "have a mind of their own' and were "like supermarket trolleys". However no injury/ incident was actually witnessed and our review of accidents and incidents in the past six months confirmed there had not been any accidents related to these armchairs.

We discussed our observation with the registered manager who told us that occupational therapists had been consulted about the use of and safety of the armchairs, and risk assessments were in place within people's care plans. We looked at the care plans for two people on the first floor who used these chairs and could not find applicable risk assessments. We spoke with the staff nurse on duty, who was unaware of any specific risk assessments having been carried out.

Staff informed us that a hoist ordinarily used on the first floor was broken and they temporarily had two hoists to use for up to 28 people. This situation appeared to restrict staff members' ability to effectively plan their support for people and impacted upon how they met people's care needs within a reasonable timescale. We spoke with the registered manager who provided confirmation that arrangements were in place for the repair of the broken hoist.

We recommend the provider seek good practice guidance about the safe use of these mobile armchairs.

Requires improvement

Is the service effective?

Our findings

People using the rehabilitation unit spoke positively about their experiences of using the service. They told us they had benefited from the rehabilitation programme and were looking forward to returning home. One person living permanently at the service said, "Four years ago I couldn't move at all. I had no independence. Now I can go out shopping and go to a day centre."

A relative told us, "[my family member] is settled here. I don't want them going anywhere else." Another relative said, "I have put many hours and lots of effort into making this placement work. I feel I have to be constantly on the case to make sure it continues to work for my [family member]."

We spoke with staff about training, supervision and annual appraisals. One staff member told us they never had one to one supervision and described how there was a monthly staff meeting during which, "The manager listens to our points of view." When asked, they did not know whether they had ever had an annual appraisal. Other staff told us they attended training regularly and found it useful.

The registered manager told us they did not have a system in place for one to one formal supervision of staff. Records showed that staff attended monthly meetings, which were used as an opportunity to have general discussions about training and development, and update staff about new policies and procedures. We were told that the provider had focused upon staff training and other forms of staff support, for example counselling and psychology sessions, following a serious event at the service in 2013. The registered manager told us the plan was to commence one to one supervision sessions.

This finding evidenced a breach of Regulation 18 Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the records for training that staff attended within the service in the past 12 months. It included dementia awareness, catheter care, moving and positioning people, fire safety in relation to the service, the use of ski pads for evacuating people from the premises and the use of pressure relieving equipment to protect people from the risk of pressure ulcers. The minutes for the training sessions showed that where possible the registered manager attended, which promoted the importance of training and development for all staff. We noted that two registered nurses were studying for bachelor degrees, the registered manager was studying for a master's degree and three members of the care staff had progressed to access courses for health care degrees, which indicated there was a culture where professional and personal development was encouraged.

We viewed a copy of the staff training matrix, which was last updated 23 July 2015.

Training was available on-line and through classroom sessions. Staff were responsible for arranging and completing their own training but the registered manager was notified by the provider's central learning and development team if staff had not attained their required training. The registered manager told us he addressed gaps in training or overdue refresher training directly with staff in appraisals. The training matrix showed that staff attended mandatory training including fire safety, infection control and clinical governance.

The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff demonstrated a clear understanding of the MCA and DoLS. They said that most people using the service had capacity to make some decisions about their own care and treatment, "this could be very small, for example, what colour top to wear, but there is always a way to help them make choices." We saw that capacity assessments were completed and retained in people's care files. We noted an authorisation for DoLS was in place, granted by the local authority and saw that the conditions of the authorisation were being followed.

The registered manager was aware of his responsibilities in making an application to the supervisory body (local authority) if a person assessed as lacking mental capacity was potentially being deprived of their liberty. The provider had started sending DoLS applications to the supervisory body in December 2014. The registered manager told us that prior to this date the provider had drawn up a system to prioritise applications, based upon the needs and vulnerability of people using the service so that there was a focused and structured approach in place to refer people.

People using the rehabilitation unit told us the food was good and explained how they participated in food preparation, cooking and washing up as part of their rehabilitation programme.

Requires improvement

Is the service effective?

One person said, "The food is really nice" and another person told us, "You can always get tea and coffee. They don't hurry you at meal times." We observed that when we arrived on the unit at approximately 10.30am some people were finishing their breakfast and there was a relaxed ambience in the dining area.

People's cultural food choices were respected. One person told us they ordered in a lunchtime takeaway once a week and they had a Chinese takeaway that day. Another person liked food that reflected their culture and said their friends sometimes brought in food treats, although they also ordered the type of food they liked from the provider's menu. A person living on one of the ground floor units told us they liked Caribbean food and confirmed there were Caribbean choices on the menu. A visitor to the home was heard to say that they were going out to buy their family member fish and chips from the local chip shop. A staff member said this was something the person particularly liked and it was encouraged. Some relatives brought in homemade meals such as culturally specific dishes, which people said "always tasted better" than similar items on the menu. Staff told us there used to be a cooked breakfast offered and they knew that some people would appreciate this choice being reinstated.

We asked staff on the nursing care units how people made choices and were shown a large brochure, from which choices could be made. They told us, "We show them the brochure and if we have it in, they get it." We asked how those who may be unable to make a choice were assisted and were told, "We know what they would like." This brochure was comprehensive and included the whole range of frozen meals which the catering supplier provided. We asked members of staff how people with specific cultural requirements had their needs met. Some staff were well informed but others were not clear about this, but when we looked at the brochure we saw there was a note which said 'special diets, including diabetic, Halal, Kosher and Caribbean available on request.'

One family member told us they "bring in freshly cooked food every day because my relative would not touch the food on offer and would starve." They told us how the home was organised "along hospital lines, therefore there is no flexibility or individualisation with the food, because there is no chef on site." We noted how there was no kitchenette in the units for permanent and respite nursing care in which relatives or staff could cook for, or assist people to cook food separate from that on offer from the caterer's brochure. One relative said, "you cannot even cook an egg here."

We conducted another lunchtime observation, on the second day of the inspection. The meals appeared visually attractive, including the pureed meals which had been laid out and shaped to represent separate food items. All meals required heating in the microwave and came with heating instructions. The health care assistants were observed heating meals as and when required and using a thermometer to test the temperature of the meal before serving. We observed that meals were covered during transfer from the kitchenette to people using the service, to maintain the temperature of heated food and promote good hygiene. A health care assistant told us that people could choose their meals in advance but could change their mind, as some alternative meals were available on the day. Salads were also available, as were sandwiches, toast and a choice of deserts. This staff member told us they tried to encourage people to eat and would offer alternatives if someone was not eating well or required extra encouragement. They appeared knowledgeable about how to meet individual preferences and needs, and the importance of offering choice as well as a balanced diet. We were told about one person who had a poor appetite and needed encouragement to eat sufficient amounts. The staff knew the person loved rice pudding, so they always had one in reserve in case they could not get them to eat or they did not fancy anything else on offer.

People were supported to maintain good health and had access to health care support. Where there were concerns people were referred to appropriate health professionals. Most were registered with a local GP surgery, who visited on a regular basis and a consultant geriatrician visited every two weeks. We spoke with the consultant who told us "I look to the nurses to keep me updated on how a person is and have confidence that they will do so as they know the person very well." People also had access to a range of visiting health care professionals, including speech and language therapists and dietitians. The registered manager told us that some health care services were easier to access, for example the service was adjacent to a community dental clinic at St. Leonard's Hospital. However, there had been concerns about prompt and regular access to podiatry services, which people and their relatives had also informed Healthwatch Hackney about. The registered

Requires improvement

Is the service effective?

manager said he had taken some action to try to improve this, which included discussions with the podiatry service to request allocated podiatrists for the service, which could not be achieved. We were told that staff referred people to the podiatrists and then booked in return visits after each appointment. The registered manager said he carried out checks on people's finger nails and toe nails and provided basic nail care for people who were not assessed to require the input of podiatrists.

Good

Is the service caring?

Our findings

People using the rehabilitation unit were all positive about the caring and helpful approach of staff. One person told us, "Staff are friendly and caring" and another person said, "It is more homely here than the Homerton Hospital. I feel I have more freedom and I am happy." A third person agreed they were also happy.

A person living on one of the nursing units told us, "The staff are kind and speak nicely to me." Another person said, "It is pretty good being here. The staff are very good." One relative said, "Staff keep my relative very clean and most of them are really quite helpful." Another relative informed us, "The care is variable, especially if it is not the regular staff. Some are more willing to engage with [my family member] than others." They also said, "I would not want to come here if I did not have a relative to advocate on my behalf; you have to be constantly on their case because they are so busy with everyone else."

We saw from care plans how relatives had been asked to contribute to their family member's care planning. We sat in on a multi-disciplinary review with a relative and saw how they encouraged to participate in the discussion about their family member.

We saw examples of staff demonstrating kind attitudes, for example during meal times, but they always appeared very busy and did not have sufficient time to chat with people. We also noted that people were being referred to as 'patients', which did not fit in with supporting people to regard the service as being their own home.

A relative told us "Staff respect [my family member]. They understand that [he/she] has had to get used to being washed and have been very sensitive about this." Staff endeavoured to maintain people's dignity and privacy whilst providing their personal care, for example staff told us doors and curtains were always closed prior to providing people with personal care and we observed this to be the case during the inspection. However, we found that the curtains in some people's bedrooms did not close properly, which meant their dignity and privacy was compromised. We reported this to the registered manager, who evidenced that arrangements were being made to replace the curtains that were not fit or purpose.

We looked at the provider's Dignity Policy, which explained how dignity and diversity was incorporated into every care practices. For example, people were offered personal care from staff of their own gender if they wished and staff were required to knock on people's doors before entering, which we witnessed during the inspection.

The provider used a discreet signage system (a picture of a flower) to remind staff and professional visitors that a person was living with dementia and needed an individualised approach that was tailored to their needs. The registered manager told us the service was now receiving more referrals to provide permanent and respite care for people with dementia, which had not previously been the case. We were shown evidence of how the service was working with the provider's Lead Nurse for Dementia in order to develop compassionate services for people with dementia, which included plans to create reminiscence focused bedrooms and other spaces and additional staff training.

The provider had resources in place to make sure people had a dignified and comfortable death. The registered manager informed us that the service benefitted from being part of an NHS Trust, which meant they could access support and guidance from a range of palliative care medical, health care and nursing professionals. We did not speak with any relatives who could comment on how the provider supported people with end of life care needs, but we read some compliments from the relatives of people who had passed away at the service. We noted that some former relatives were now involved in the Friends of Mary Seacole Nursing Home group, which was a forum for current and former relatives to support the service and discuss ways to improve the quality of care. This indicated the provider had maintained positive relationships with the families and friends, following their bereavement.

We observed how the provider had set up a memorial book for people using the service and their representatives to record their condolences following a person's death. The registered manager told us this had been originally suggested by family members who attend the Friends of Mary Seacole Nursing Home group. We also saw plans for the development of a memorial garden.

People and their representatives were provided with an information guide, which informed them about living at the service, for example how to access hairdressing and chaplaincy services. The registered manager told us the service had links with various ministers of religion in the local community including imams and priests, who could

Good

Is the service caring?

be contacted to provide people with spiritual support at any point. This support also included visits to the premises that people of any faith or no faith could participate in, if they wished to. For example, an Anglican chaplain visited the service every Easter and brought a donkey for people to meet.

The information guide contained information about how to make a complaint and gave timescales for when to expect a response. People were provided with contact details for the Patient Advice and Liaison Service (PALS), which offers confidential advice, support and information on health related matters and can help people resolve concerns about using an NHS service.

Requires improvement

Is the service responsive?

Our findings

We received positive remarks about the quality of support and care from people using the neuro- rehabilitation unit. One person told us about their concerns about how they would manage when they returned home but thought that staff and other people using the service provided encouragement and reassurance.

We received a couple of comments from people about the frequency of occupational therapy and physiotherapy sessions, with people wondering if they should have more of these rehabilitation sessions each week. We discussed this with the service lead, who told us that people sometimes received misleading information prior to moving to the unit, possibly from clinical staff in different departments, relatives or other persons that did not have direct experience of how the unit operated. The service lead explained that people received support to meet their rehabilitation goals during sessions lead by the rehab workers and when they engaged in household chores in the kitchen and laundry room, supported by staff. The service lead stated they would look into how people, their families and other professionals could be given more information about how the unit worked, so that people were assured they were receiving an appropriate level of rehabilitation.

We looked at two care plans on the neuro-rehabilitation unit. They were detailed and provided clear information about people's goals. The provider used Goal Attainment Scaling (GAS), which is a method for setting rehabilitation goals and measuring achievements. One care plan showed that a person was not actively taking part in a rehabilitation programme and the provider had responded by ensuring the person had been referred for other relevant support, for example an assessment by a social worker to support the person to plan for their discharge from the unit.

We spoke with people using the nursing care service to find out how the provider responded to their needs. One person told us they were pleased with their care and thought they had settled at the service better than they had expected to. They told us, "I have a young person come in once a week, she is a volunteer here. We have a general chit-chat and she brought me a sunflower. I also have a physiotherapist privately who comes here twice a week." A relative said the care given to her family member "had improved in recent months." They attributed this to the fact they raised their concerns with the registered manager, who had responded appropriately. Another relative told us "Some staff will not engage in any activities with [my family member], I suppose because this is hard work." They also told us, "If it is not a regular member of staff, then I know they will keep my relative either in bed or sitting in a chair in their bedroom." The consultant geriatrician told us "Staff are very responsive; they are often dealing with difficult situations and people and manage this very well."

People's care records showed that before they moved into the home their needs were assessed through a pre-assessment and admissions process. We saw copies of these assessments in some of the care plans we looked at. There was an 'admission booklet' which we were told was used as part of the initial assessment for admission to the service, which contained comprehensive information, including health and social care information. Care plans described the support people required from staff, for example, with their communication methods, mobility needs and support they needed with personal and nursing care. There were separate care plans for every aspect of a person's care, for example, 'eating and drinking', 'mobilising' and 'working and playing', which related to activities. A relative told us how "Activities have improved in recent months; they even have plants in the garden now, which makes it pleasant for people to go out there."

The provider used a pack called 'Getting To Know Me' which was intended to house biographical information to support care planning, particularly where people had dementia and were not able to tell staff about their earlier life, former occupation and interests. It was voluntary for people and/or their relatives to complete this document. We looked in a care plan for a person with dementia and found the pack in their care plan but it was absent. There was no information recorded elsewhere in the care plan about how the person liked to spend their time or how their social needs were met. We looked in the care plans of two more people and they both had blank 'Getting To Know Me' packs.

A staff nurse told us that a person displayed behaviours that challenged, especially in relation to when they were being provided with personal care. The person could become distressed, which could be displayed in vocal distress and or by physically scratching staff. There was no information on a 'Getting To Know You' document to ensure staff knew this person's social history and the staff nurse could not locate information in the care plan that

Requires improvement

Is the service responsive?

explained the person's preferences. The person's specific care plan for meeting their personal care needs did not provide guidance about how best to support them, taking into account the behaviours that challenged. However, the staff nurse knew the person's former occupation and communicated kindly with them. This meant we could not easily establish how people's care plans' were personalised to reflect how they were supported with areas of care that might require special understanding, due to their dementia care needs.

We saw limited evidence of activities provided at the service during the inspection. Whilst there was a timetable, we did not see the prescribed activity taking place. It was also unclear how the activity would have taken place communally since some people were bed bound and therefore, would have required an individualised activity. The activity programme featured activities including bingo, newspaper discussions, soduku, jigsaw puzzles and film club. We joined the activities organiser for the film club, which was scheduled on the afternoon of the first day of our inspection. Two people attended and watched television, we were told there was a technical problem with the equipment used for showing films. We were provided with information about a therapeutic gardening project that took place every week and we observed a few people from the neuro-rehabilitation unit sitting in the garden. A pilot art project took place for a couple of months earlier this year and was delivered by a member of the provider's chaplaincy team at the Homerton Hospital. The registered manager told us the pilot was successful and was now being evaluated, with a view to longer-term funding.

Photographs on display in the premises showed the provider organised entertainments and seasonal events, including a Halloween party, summer barbecue, and visits from singers and musicians.

The registered manager told us that he usually investigated complaints from people using the service and/or their representatives, unless it was clear the complaint needed to be escalated to his line manager, for example if the complaint related to his conduct. We were informed that most complaints were informal, made verbally, not recorded and promptly resolved, such as a missing clothing item which was then located. Throughout the inspection people and their relatives expressed their confidence in the registered manager's willingness to respond to any concerns.

The registered manager stated he responded to all written complaints, usually in writing but in the main by arranging a formal meeting to discuss the concern with the individual raising it and coming to a resolution or compromise if the concern/complaint could not be resolved. There was a complaints file available for inspection which contained written complaints which had been received by the registered manager or his line manager. Although the registered manager was able to explain how all of these complaints had been processed, resolved and what learning had been identified, we were only able to track one of these from beginning to end due to gaps in record keeping. Therefore out of nine written complaints recorded during 2014 and two during 2015, only one had complete paper evidence to demonstrate exactly how it had been managed, which meant an audit trail was not available in the absence of the registered manager.

Various letters and cards had been received complimenting individual staff and/or the staff team in relation to the care, treatment and support offered, mainly from relatives. The registered manager said he said he fed back compliments to staff individually and in formal staff meetings. In addition, the home used 'you said we did' boards throughout the home which displayed comments made by people using the service, relatives and visitors. This board contained compliments made by relatives as well as responses to requests by people and their relatives. For example, relatives asked for a photo board with the pictures and names of all staff to be displayed in the foyer so that all staff could be easily identified, which was achieved.

Requires improvement

Is the service well-led?

Our findings

People using the service and their relatives told us they found the registered manager approachable and responsive. The registered manager told us he attempted to maintain a visible presence on the units, through attending at least three handover meetings each week and taking an active role at social events and functions. He also supported staff with clinical duties, for example assisting a staff nurse to carry out a dressing or another procedure. This provided opportunities to monitor standards of care and observe how people were supported.

We found areas of good practice in terms of management and leadership of the service. However, there were significant shortfalls found in relation to staffing arrangements and medicines management that had not been identified or addressed by the quality monitoring systems in place. This potentially posed a significant risk to people using the service. Therefore we were not assured that the systems in place were consistently effective.

The registered manager told us he strived to promote an open and inclusive culture. For example, the Healthwatch Hackney 'enter and view' visit took place prior to our inspection. The registered manager said he positively welcomed opportunities to learn from other organisations and was currently working on a response to the issues raised by Healthwatch Hackney. There was also a visit by representatives from the local Clinical Commissioning Group (CCG) who spoke with people and their relatives about their experience of using the service.

The registered manager belonged to a group that carried out benchmarking visits to other care homes with nursing. He told us about his most recent visit to a service and how he aimed to put in place the learning from the benchmarking exercise. For example, the other service invited family members to join people for a communal meal, with a glass of sherry or wine if people wished to. The registered manager told us he planned to raise the idea for discussion at the next Friends of Mary Seacole Nursing Home meeting.

We were told that the service's position within an NHS trust brought interesting prospects for clinical and managerial initiatives. The registered manager was a member of the Pressure Ulcer Scrutiny Committee organised by the trust, and attended by senior nurses and tissue viability specialists. He told us this group provided a forum for participants to develop their own knowledge about preventing pressure sores and this learning was brought back to the staff group. We noted there was a low incidence of pressure sores developing at the service. Accidents and incidents were recorded and reported to specialist groups for patient safety within the trust for analysis, in order to identify and address any trends.

We were shown a range of recent audits and checks carried out in order to monitor the quality of care and/or the safety of the premises. These included an audit of the standard and suitability of beds and mattresses, weekly water temperatures and fire alarm testing, night time monitoring visits by management staff, portable electrical appliances testing and emergency lighting testing. The provider had conducted a monitoring visit in April 2015, which was designed in a similar manner to a Care Quality Commission inspection. A wide range of suggestions had been made about ways to improve the service, which had been followed by the registered manager. The provider had been carrying out three monthly medicines audits; however, these had not identified the range of issues found during this inspection.

The provider sought the views of people using the service through trust –wide quality assurance systems, such as questionnaires. The registered manager invited the relatives and friends of people to attend the Friends of Mary Seacole Nursing Home meetings. We looked at the minutes and found the meetings were used to enable people to comment upon the quality of the service and the improvements needed. For example, relatives said they sometimes had to wait to gain entry into the building in the evenings and the weekends, when the receptionist was off work. The registered manager acted on this information and had submitted a bid to the provider for funding for an additional part-time receptionist.

We looked at separate information on the neuro-rehabilitation unit which showed that people's views about the quality of the service were being sought, in order to drive improvements. The feedback from people and their relatives indicated they were pleased with their care and support, and felt the service had met their own rehabilitation objectives. An evaluation report from a recent staff day demonstrated that although the service was relatively new, there was a clear vision of how it wished to develop.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with receiving a medicine service that was not safely managed Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected against the risks associated with receiving a service that did not have sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed at all times Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected from the risks associated with staff not receiving appropriate supervision to enable them to carry out their duties Regulation 18 (2)(a)