Elmwood Nursing Home Ltd

Pinewood Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 18 and 30 January 2017. Pinewood Nursing Home provides accommodation for up to 33 people who need support with their personal care. The home provides support for older people requiring nursing care and for some people who are living with dementia. The home is a large, converted period property with sea views. Accommodation is arranged over four floors and there is a talking passenger lift to assist people to get to all floors. The home has 31 single bedrooms, with two which can be used as double rooms if two people choose to share. There were 28 people living at the home at the time of our inspection, two of these people were residential and had their nursing needs met by the community nurse team.

We had previously carried out a comprehensive inspection of this service in November 2014. A breach of a legal requirement had been found at that inspection. The breach was because there were not accurate records in relation to the care and treatment people were receiving. At this inspection we found action had been taken regarding these concerns and the requirement had been met.

The registered manager had left the service in December 2015 and has submitted their application to deregistered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager was in post who had undertaken an induction period with the registered manager before they left. The manager had started the process to registered with the CQC to become the registered manager at the service. Staff were very positive about the new manager saying they were approachable and always available if they wanted to talk with them.

There were adequate staffing levels to meet people's needs. The manager had made changes to the deployment of staff which staff said meant they could meet people's needs more effectively. There were also two registered nurses on duty each morning which enabled improved record keeping. People felt there were adequate numbers of staff on duty and that staff responded to bells promptly.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff had received training and developed skills and knowledge to meet people's needs. Staff relationships with people were caring and supportive. They delivered care that was kind and compassionate.

Individual risks to people's safety had been assessed and plans written to show how these were being addressed. The home had a contingency plan and had also developed individual personal evacuation plans to support each person.

Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed. Improvements were made during the inspection to ensure staff were clearly guided regarding

the prescribed administration of topical creams.

Care plans were personalised and recognised people's health and social needs. We raised concerns with the registered manager that care plans did not always cover people's emotional and psychological needs. During the inspection the registered manager and deputy manager put in place care plans where needed to ensure all people's emotional and psychological health needs were covered.

People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, hand written mental capacity assessments had been completed. The responsible person said they were working with the computer software company to have capacity assessment added to their computerised documents.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. Where there were concerns or complaints, these were investigated and action taken. The premises and equipment were managed to keep people safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

There were sufficient staff on duty to meet people's needs.

Appropriate risks to people were identified and reduced as much as possible.

People were protected by a safe recruitment process which ensured only suitable staff were employed.

Accidents and incidents were monitored and any trends identified.

Is the service effective?

Good

The service was effective.

Staff asked for consent before they carried out any personal care. The Mental Capacity Act (MCA) (2005) was followed. Improvements were being put into place on the provider's computerised system to record MCA documentation.

Staff received regular training and supervisions. Appraisals had been scheduled for all staff.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and nutritious diet.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

Staff knew people very well and showed concern for their well-

being.

People and their families were involved in making decisions about their care.

People were treated with dignity and respect.

Staff recognised the importance of maintaining family contact. Visitors and friends were welcomed.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed. Care plans were developed to meet people's needs. However improvements were needed to ensure there were care plans in place for people's emotional and psychological needs. Action was taken to put these in place.

People had been involved in planning their care.

People were encouraged to do activities they were interested in.

There was an effective complaints procedure in place. People knew how to make a complaint and they had opportunities to offer feedback about the service.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the new manager and the changes they had made. The manager and responsible person were visible at the service and inspired staff to provide a quality service.

People, relatives and staff views and suggestions were taken into account to improve the service.

The new manager had developed an action plan where they had identified concerns at the service. There was an effective audit program to monitor the quality of care provided and ensure the safe running of the service.

Pinewood Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 18 and 30 January 2017. The first day was unannounced and the inspection team consisted of two adult social care inspectors. We made arrangements for one adult social care inspector to return on a second day to complete the inspection.

The provider had not been requested by the Care Quality Commission (CQC) to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Therefore we reviewed the information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed the majority of the people who lived at the service and received feedback from eleven people who were able to tell us about their experiences. We also spoke with four visitors and a visiting hairdresser to ask their views about the service.

We spoke to 14 staff, including the new manager, deputy manager, a nurse, senior care workers, care workers, the cook, housekeeping staff, the administrator and the responsible person.

We reviewed information about people's care and how the service was managed. These included three people's care records on the provider's computerised care system and five people's medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits and minutes of residents and team meetings. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from two health and social care professionals.

Good

Is the service safe?

Our findings

People said they felt safe at the service. Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. Staff were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the manager and responsible person about any concerns raised. They also knew they could report concerns to other organisations outside the service if necessary. The manager and responsible person were aware of their responsibilities in regard to safeguarding people.

People received their medicines safely and as required. People's medicines were administered by nurses. The nurses had received medicine training and had their competencies assessed. Nurses were seen during our visits administering medicines in a safe way. They had a good understanding of the medicines they were giving out to people. The manager said they were delegating the oversight responsibility to the deputy manager so there was a clear lead to ensure the continued safe management of medicines.

Where people had medicines prescribed as needed, (known as PRN), protocol care plans were in place for some, but not all, about when and how they should be used. By the second day of our visit the manager confirmed protocols had been put in place for all PRN medicines.

There was a system in place to monitor the receipt and disposal of people's medicines. There was a procedure to monitor daily the temperature of the medicine fridge and the room where medicines were stored and that it was at the recommended temperature. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed and any signature gaps had been identified by the nurses and action had been taken to ensure people had received their medicines. The pharmacy that supports the service had undertaken an audit in September 2016 and raised no significant concerns.

Improvements were needed in relation to the administration of topical creams, as this was not always safe. Prescribed creams were recorded on people's medicine administration records (MAR). The information had been previously transferred on to the provider's computer system which care staff marked when topical creams had been administered. However the information had been removed from the computer system so staff were not able to indicate if they had administered topical creams as prescribed. By the second day of our visit people's prescribed topical creams had been reinstated on the computer system so it was clear people had their topical creams applied as prescribed.

Our observations and discussions with people and visitors showed there were sufficient numbers of staff on duty to keep people safe. Staff were seen to be busy but appeared to have time to meet people's individual needs. During our visits call bells were answered in a timely way. People said staff responded quickly to call bells. The call bell system allowed people to indicate the urgency of their call and said staff responded well, within 10 minutes at most.

The staff schedule showed during the morning there was two nurses on duty, with a designated senior care worker and six care staff who might also be senior care workers. In the afternoon there was one nurse and five care workers although a care worker came in for a twilight shift between three and nine pm. At night there was a nurse and two care workers. They were supported by a lead housekeeper, housekeeping staff who also undertook laundry duties. There was also a cook, kitchen assistant, activity person, two maintenance staff and an administrator who also interacted with people while undertaking their roles. Where there were gaps in the staff schedule, staff would take on extra duties and if necessary agency staff would be used. One care worker said, "It is now good we have been short in the past but (responsible person) is really good about having agency if we need them." Another explained that the manager, the second nurse and the administrator who was trained to deliver care would also step in to assist if short staffed.

The manager said they felt the service was well staffed for the current needs of people. They had made changes since being at the service to the deployment of the care staff at the home to make it more effective. They had assessed people's needs and delegated staff more evenly. Staff worked in pairs with a single care worker being a 'floater' who could support people with minimal needs and respond to bells and people's requests. The manager had prepared a morning and afternoon allocation sheet which identified people's preferred getting up and going to bed times. There was also a prompt to remind staff to ask people their breakfast choice and where they would like to sit. Staff were also reminded to record support they had delivered straight away after the completion not later. This ensured there was a clear audit trail and stopped alerts flagging up when tasks had not been carried out.

Staff were full of praise regarding the change. One care worker said, "(The manager) always tries to ensure there are seven carers on in the morning which is so much better we have three teams of two and a floater. I come to work and don't dread who I am going to get because it is evenly shared out now." Others said, "The changes being put in place are for the better" and "The manager has made some good changes for the team. The delegation of work is more evenly delegated and we work in pairs."

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken. Any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures.

People were protected because risks for each person were identified. Risk assessments about each person were undertaken which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity, bed rail, nutrition and manual handling. People assessed as at risk of developing pressure sores had equipment in place to protect them. This included pressure relieving cushions on their chairs. For example, where someone had been assessed as at risk of their skin breaking down. Staff were advised that a pressure mattress was in place and that the pump setting was according to the person's weight. Staff were reminded to report to the nurse on duty any concerns regarding redness or pressure damage and follow their advice. Where the nurses were responsible to monitor people's blood glucose levels. They ensured the blood glucose monitoring device used to calculate this was regularly calibrated to ensure it was accurately recording people's blood sugars.

The environment was safe and secure for people who used the service and staff. A designated team of two maintenance staff over saw the maintenance at the service. They undertook checks which included weekly

checks of the pressure mattresses and water temperature monitoring. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire risk assessments and general risk assessments and the monitoring of environment had been undertaken. Where concerns had been identified these had been addressed. For example, where wardrobes were not secured to wall they had been.

Fire checks and drills were carried out and regular testing of fire and electrical equipment. Legionella precautions were in place. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance team. Where water temperatures from three taps in bedrooms had hot water that sometimes exceeded 44 degrees. The manager had arranged for thermostatic mixer valves to be fitted to those rooms. There were plans to improve some areas of the home. These included a plan to fit bifold doors at the bottom of the stairs near the kitchen to given people in that area less noise and more privacy. There were also plans to improve the reception to offer more privacy, creating an alternative sitting area for people and space for staff to take their breaks.

The home was very clean throughout without any odours present and had a pleasant homely atmosphere. Two visitors were full of praise for the cleanliness of the home. Their comments included, "Spotlessly clean." There were cleaning schedules for housekeeping staff to follow and records kept of deep cleaning undertaken in rotation. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. The laundry was well managed and had adequate chemicals and processes to ensure the lint filters were cleaned regularly. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Emergency systems were in place to protect people. There were individual personal evacuation plans which took account of people's abilities, the assistance they required, room location and equipment needed. These were held in people's care files and inside the fire book accessible to the fire services in the event of a fire emergency. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely. The provider also had a contingency plan in place in the event of an emergency such as fire or loss of utilities. This included a list of people to call in an emergency.

Accident and incidents were reported and identified the immediate actions taken to reduce risks. For example someone at high risk of falls had regular checks to anticipate their needs and pressure mats and individual pendant alarms so staff could respond quickly to people needing help. They were reviewed to identify trends about, time of day/night and the frequency of accidents.

Good

Is the service effective?

Our findings

People received care and support from staff that received training and support on how to undertake their role safely and effectively. The mandatory training which staff were required to complete included, Mental capacity Act (2005) and Deprivation of Liberties Safeguards (DoLS), fire safety at work, first aid, infection control, moving and handling, food hygiene, challenging behaviour, health and safety, customer service and safeguarding vulnerable adults. The manager had taken action to arrange update training for staff where there were gaps in their training records. They were also working with staff to undertake higher qualifications in health and social care. Staff were observed moving people with the assessed equipment they required, this included hoists. They were skilled and confident and people seemed quite relaxed being moved around. A person we observed being moved said, "They felt safe."

Staff were positive about the training they had received. Comments included, "The training is really good, interesting and eye opening" and "Love doing the training. It can be quite emotional."

Checks were made to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. A visitor who themselves was a health care professional praised the trained nurses at the home. They said, "The qualified nursing staff are excellent they take the time to talk to you."

Induction training for new staff consisted of a period of 'shadowing' senior care workers to help them get to know the people using the service. The manager said new care workers who had no care qualifications would undertake the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice. One new care worker said, "I came for an induction day and did lots of paperwork and a second day where I learnt about the role." Another said, "If a new member of staff we put them with experienced staff but not the same one we vary so different (new staff) learn differently. They do two shadow shifts and an induction day and if they feel they need more they can do more."

Staff confirmed they received supervision and felt supported in their roles. The manager had made changes to the supervision system being used and had placed staff in teams. The supervisions would then be cascaded down through the teams. For example, the nurse would undertake the senior care workers supervision and the senior care worker would do care workers. The manager would be supervising the nurses and heads of department who would undertake supervisions of their teams. The manager had scheduled appraisals and was also planning to undertake 'spot checks' to check on staff practice.

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

The nurses at the service assessed people's capacity to make specific decisions. Where people had been assessed as not having capacity, for example whether they could consent to the use of bedrails there were processes in place to make best interests decisions on their behalf. However this information was not captured on the computerised care system. The manager said they were working with the software company to add this detail to the system to have a clearer trail of the decision making process.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under MCA. The application procedures for this in care home are called the Deprivation of Liberty Safeguards (DoLS). The staff had identified eight people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body, although they said they were all waiting to be assessed. The manager was fully aware of the procedure to follow should a DoLS application be necessary.

People had access to healthcare services for on going healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. People's care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. Staff worked with health professionals such as the community nurses, dietician, speech and language therapist (SALT), occupational therapists and physiotherapists. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. One person said how the physiotherapist visits him regularly to help with their exercises.

Staff managed a person with some challenging behaviour really well during our visit. Staff responded regularly when the person called out frequently. They recorded in their daily notes the conversations they had and what they had offered the person each time. For example, accompanying the person to the lounge and getting the person to choose where to sit. Keeping the person busy by giving them their knitting and getting them to help roll up sewing tape. The staff had involved health professionals including the person's GP and Community Psychiatric Nurse (CPN) to manage this person's needs.

People reported positively on the food choices at the home. Kitchen staff spoke with pride about their work and the importance of food for each person. The cook chatted to people regularly about their food likes and dislikes and changed the menu every two weeks. Kitchen staff had good information from nursing staff about any allergies, and people who needed a reduced sugar diet because of their diabetes.

All meals were cooked from scratch using fresh ingredients. In the morning, staff rang the kitchen with people's breakfast orders that included the option of a cooked breakfast. Lunch and supper were ordered from a menu the day before but people could change their mind on the day if they wished. Two choices for main course and a salad alternative were offered and people could have snacks at any time. Kitchen staff were aware of which people needed encouragement to eat and drink and made homemade milkshakes and increased calorie content of their food using cream and butter. The manager was also planning to introduce snack boxes for those people. They were also planning to provide information on people's weight progress to kitchen staff. This was so they were aware of whether people had recently lost or gained weight and therefore could work with each person to help keep them at a healthy weight.

Where staff identified concerns about hydration people's fluid intake was monitored and prompts placed on the computerised system to remind staff. The nurses had assessed people's individual recommended fluid intakes and each day calculated their fluid intakes. Staff were made aware of people's intake the previous day on a handover sheet they received at the beginning of their shift. Improvements were made during the inspection to include people's intake for several days so staff were aware of the cumulative intake over

several days and could assess more accurately who was at risk.

We observed a lunchtime meal in the dining room during our visit. There were 12 people using the dining room with others choosing to have theirs in their rooms or the lounge on the first floor. Lunchtime was very sociable; care workers were very attentive to people's needs. People were offered wine, sherry, coke, lemonade, water or fruit squashes with their lunch. One care worker said, "They can have what they like." There was lots of conversation and banter and several staff joined people to have their lunch. However people were not aware of the meal option because there were no prompts to remind them. The manager said they had recognised this and had ordered new menu display.

Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented. Where people had been assessed as at risk of weight loss, they had their weight monitored regularly.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. We spent time talking with people and observing the interactions between them and staff. Staff were thoughtful, friendly and considerate towards people. The manager said since they had come to the home they had seen, "Staff take pride in what is done here they build relationships with the residents."

People were seen positively interacting with staff, chatting, laughing and singing. People said they were happy at the home. Comments from people included, "Staff are very caring" and "They are all very good." A relative said, "They have been brilliant, so kind, and wonderful. " Another said, "Absolutely, it's more like a family." A third said, "Not a thing I can say bad about the place. Everyone is cheerful, everyone talks to you, it is very good. It is much more like a family."

Staff said they felt the care was good at the service. Comments included, "I think it is such a nice place, everyone is caring, everyone gets well looked after. The food they get is unbelievable the menu choice is great" and "I love making a difference to someone's life and make them smile."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care. Comments included, "I make sure the door is shut, curtains are closed. Some people say can you leave them open and I respect their wishes. I ask if family mind leaving the room if doing a comfort round but again it is up to the person." This ethos was spread across all staff groups. A member of the housekeeping staff said, "If I walk into a room I ask them if I can come in and clean their room and wait for an answer. It is about recognising they are people and have choices."

At lunchtime people who needed it were offered a protective covering to keep their clothes clean and maintain their dignity. Where people needed help to eat independently, adapted cutlery and crockery was provided, such as plate guards and spoons that were easy to hold. Where a person needed help and prompting to eat, a staff member sat patiently with them, made good eye contact and went at the person's pace, encouraging and praising them. Where people needed assistance, for example to cut up their food, this was offered discreetly. For example, one care worker was observed assisting a person. They told them what the meal was and asked if the food was nice and whether they would like any more, asking gently "Would you like to try another mouthful?" They did not rush the person and offered the food at a suitable pace. The person appeared relaxed in their company.

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people with affection and by their preferred name and people responded positively. Another example was where a staff member complimented a person who had their hair done. The atmosphere at the home was calm.

Staff took the time to get to know people as individuals. Where one person was not drinking very much staff

had a chat with them and established they did not really like water and particularly liked lemon squash and orange juice. Therefore staff had ensured that is what they had and their fluid intake had increased significantly. One care worker said, "Every day I always take ten minutes to chat with people, to get to know them."

Staff involved people in their care and supported them to make daily choices. For example, people chose the activities they liked to take part in and the clothes they wore. We observed a care worker attending to a person to see if they were ready to get up and dressed for the day.

Staff described ways in which they tried to encourage people's independence such as dressing themselves with minimum support. Staff said they knew people's preferred routines, such as who liked to get up early and who liked to stay in bed. They ensured people were given a choice of where they wished to spend their time. Staff recognised when they could put in place measures to assist people to remain as independent as possible. For example, staff brought a seat for a person with reduced mobility so they could sit down during their shower. This meant they could shower themselves. Other examples were where staff were prompting and reminding people to use their mobility frames to get about.

There were numerous messages of thanks which had been sent to the management team and staff. These included, "Pinewood always had a lovely, welcoming feel, both from staff and residents. I congratulate you on a well-run, caring nursing home"; "Whilst writing I would like to take the opportunity of thanking you and all the staff, not only for making her birthday so special, but also for everyone's care of her on a day to day basis. All of you are so kind and patient with her and whenever I come down to visit I am always impressed with the way in which her dignity is protected and how loving and respectful you all are" and "Thank you for all so much for everything you do for Mum), we know that it's not always easy, but without you we'd be up a creek without a paddle. It is appreciated."

Family members and other visitors were welcomed in the home and could pop in any time. People bedrooms were very personalised with things that were meaningful for each person, family photographs, items of furniture and pictures.

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse.

Good

Is the service responsive?

Our findings

At our last inspection, there was a breach of the regulation. This related to records regarding people's care and treatment which were not accurate. At this inspection, improvements had been made. The provider had implemented a new computerised care system which was still being developed. People's care records had been transferred onto the system. They were person centred and identified people's care requirements and guided staff how to meet those needs. There were also improvements in the recording of activities people had undertaken.

The service was responsive to people's needs because people's care and support was delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This enabled staff to complete comprehensive care plans about people's wishes.

The care plans related to people's communication, continence, medication, mobility and falls risk, nutrition and fluids, pain management, personal care, social emotional and psychological and advanced care plan regarding people's end of life wishes. The plans identified people's needs and the planned outcome and how the staff needed to support people to achieve them. For example, where one person had been identified as having a high level of risk regarding their nutritional and fluid intake. Their care plan advised staff of the support they required. The person also required a puree consistency diet as advised by the speech and language therapist (SALT). The care plan included, "I need assistance to meet my nutritional needs. I need all meals to be provided for me. Please assist me during my meals." Staff had also been advised that they should stop if they noticed any coughing, choking or a wet sounding voice and to make the nurse aware. We identified staff were assisting this person appropriately and the meal we saw them having was suitable. They were aware that they needed to advise the nurses if they had any concerns. The cook demonstrated a good knowledge about the needs of people with swallowing difficulties and possible choking risks. They were informed about who needed softened or pureed food and about foods which could not be safely pureed, such as peas and beans.

We discussed with the manager that there was not an emotional and psychological care plan for one person who was receiving end of life care. On the second day of our visit this had been put into place. The manager said they also intended to undertake a full audit of people's care records.

The manager was working with the computer software company to make it more person centred. For example they had already added detail regarding consenting for personal care and the choices offered by staff. All staff could access the system in accordance with their role. For example, a staff member doing morning drinks showed us how they completed detailed records of food/fluid taken for people who were at risk of malnutrition or dehydration.

The manager wanted more detailed information about people's life history so staff would know about the person before they came to live at Pinewood Nursing Home. They were in the process of sending out "This is

me" similar to the Alzheimer's society format to families to gather more history. They then intended to add a medical and social history to the computer care records.

People confirmed the daily routines were flexible and they were able to make decisions about the times they got up and went to bed; how and where they spent their day and what activities they participated in.

The provider had a new computerised care record system which had been put in place since our last visit. The house keeper had been instrumental in putting in place the new computerised records and was working with the manager and staff to make further improvements. People's care plans and risk assessments were on the computerised system and had been regularly reviewed. Staff carried handheld devices (iPod) which looked like mobile phones which were linked to the computerised system while on duty. They inputted tasks on the iPod they had undertaken and had a clear schedule of checks and jobs they had to undertake. The system enabled them to see changes in people's care when they started a shift. The system had prompts for staff which had been inputted into the computer regarding people's individual needs. For example, for one person to have breakfast at 8 at 8.30 if this had not been carried out and the task not ticked on the computer an alert would show up. This system could be accessed by all of the care team on duty and by the manager and responsible person even when they were not at the home. This meant they could check people were getting the assessed support they required.

People's care plans were reflective of their health care needs and reflected how they would like to receive their care, treatment and support. The service had a system called 'resident of the day.' This meant each person on a designated day would have their care plans and risk assessments reviewed. Staff would speak with the person and their relatives to discuss changes. The person's room would undergo a thorough clean and a member of the management team would visit the person. The deputy manager said, "When I do a review. I ask the carers their views especially any issues around personal care and I go and see the person to go through their care plan. If they haven't got capacity I talk to the relatives either in person or I will telephone them. I ask them how things are going."

The manager was looking to improve this system further by delegating specific nurses and keyworkers to people to review their care plans and assessments. The manger was also working with the computer software team regarding being able to allow people and their relatives as appropriate to access the care records on the computer. This would need to limit permissions on the system so people and their relatives as appropriate could only look at information relevant to them. The manager said it would empower people and relatives to be more in control and informed. The deputy manager said the new care plans were easier to review on the computer system and could calculate some things automatically. For example MUST an assessment tools regarding assessing people's nutritional risk and Waterlow assesses people's risk of their skin becoming sore. The nurses made a daily entry each day. One nurse said it was easier having two nurses working each morning it gave them time to record more details.

People were supported to follow their interests and take part in social activities. There was a designated staff member employed at the service for six hours a week to oversee activities. A second staff member also supported people to partake in outings and activities along with a volunteer who visited people in their rooms if they chose not to or were unable to go to the events arranged. There was a programme of activities for people, for example, organised activities such as Tai chi, mini bus trips, pub night and movie night. On the first day of our visit people visited a farm in the morning and went on a trip to the garden centre in the afternoon. People were also looking forward to the movie and pub nights.

External entertainers visited and outings were arranged each Wednesday in the provider's minibus to local attractions. The provider had a Facebook page which people had consented to having their images on. The

Facebook page had photographs of people enjoying Christmas lunch and people undertaking activities with children from a local school visiting and playing board games. It also contained key information about activities which were available and meetings. For example, visitors and staff were made aware of a firework display held at the home in conjunction with the local lions club of Budleigh Salterton and invited to a tea party to say goodbye to the registered manager.

The registered manager recognised the importance of social activities and was looking at ways to extend the range and timescale of activities at the home. Where people chose to remain in their room, they said staff popped in regularly. One person said, "I'm quite happy, I get left alone to do my own thing." Several people had a daily paper delivered and others enjoyed TV, listening to music and reading.

We were given examples of where staff had gone the extra mile to help people socialise. For example, a staff member had come in in their own time to enable a person to attend church. Where another person had a particular interest in tennis the staff member in her own time came to the home with her bag of goodies and sat with the person to enjoy the games together. The responsible person and manager both had dogs which they brought into the service which we were told people enjoyed seeing.

On the third Thursday each mouth there was an open day at the home where relatives and friends could arrange to have lunch at the home and spend the afternoon there and enjoy entertainment. This was also offered to people using the home care agency run by the same provider.

Some areas of the home such as corridors were shabby and scuffed and in need of decorating. This was in hand and on the second day we saw a mural of a sea scene had been put up in one corridor. We were also shown another which was planned to be put up in the dining room. The manager said this would make it more homely and enable people to orientate themselves. The manager said they had recognised the main corridor was in need of redecoration which was planned in the next few weeks in the evening to reduce disruption. They said the corridors were narrow and had plans to have a beach hut theme in that area. Several vacant rooms had also recently been decorated to put contrasting colours below dado rails. One staff member said they had been hesitant about the decision but said it looked really nice now it had been done.

Visitors were happy they could raise a concern with the responsible person, manager or deputy manager. People were made aware of how they could raise a concern. One relative said her relative received "some amazingly good care." They went on to tell us that they felt the manager had some great ideas and had arranged a meeting to talk through some concerns they had regarding their relatives routine.

People had access to the provider's complaints policy. There were leaflets available in the main entrance which people could also request in large print. People were also advised of a local advocacy service they can contact if they require support. The complaints procedure identified outside agencies people could contact. People said they would feel happy to raise a concern and knew how to. We did not see any complaints received at the home before December because they had been archived. There had been two complaints regarding a staff member's attitude and practice in December 2016. The responsible person and manager had taken action and the staff member no longer worked at the service. They also met with the family of one person and apologised that their relative's care had fallen below the expected standard at the home.

Good

Is the service well-led?

Our findings

The registered manager had left the service in December 2015 and has submitted their application to deregistered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager was in post who had undertaken an induction period with the registered manager before they left. The manager had started the process to register with the CQC to become the registered manager at the service. The manager had been in post for a month and had made some improvements and identified other areas for further improvement. For example, arranging more staff training and getting people's care records up to date.

People and their relatives were positive about the manager. They said they were approachable and always available if they wanted to talk with them. One relative said that the home had an excellent reputation in the local area.

Staff described the manager as a "positive person" and "approachable." One care worker commented, "Amazing, (manager) is brilliant so easy to talk to and values everyone." They were all positive about the service and said they felt happy working at the home. Comments included, "There is an amazing staff team here, kind and caring and responsive to change. Everyone has been very receptive to change"; "(the manager) is on the ball and so lovely, really nice. I can knock on the door and ask anything. (The responsible person) is really good and listens"; "Everything is on the up here. I go home with a smile on my face" and "We have a really good team we all work together, there is a nice atmosphere."

Staff said there were lots of changes, all of which had made improvements. This included where they had organised staff into three teams, who each cared for a group of people and had improved teamwork. They were also planning to extend this so each person had a named keyworker leading their care.

The manager was supported by the responsible person who was based at the service. The manager and responsible person work closely together and discussed changes. The responsible person described their leadership style as "open door" where they regularly spoke with people, relatives and staff. They said, "I ask them where we are doing well and what can we improve. They are welcome to talk to me at any time." The manager was also working closely with the registered manager of the home care service which operates from the same location. There were also plans to link with the registered manager from the other care home in the group to share ideas and to support each other.

Everyone had a clear understanding of their responsibilities and referred people appropriately to outside healthcare professionals when required. The staff knew each person's needs and were knowledgeable about their families and health professionals involved in their care. Senior staff on duty delegated duties to other staff and monitored their progress regularly. Any concerns about people were quickly communicated to the nurse in charge. One staff said, "We are all passionate about what we do." A visiting professional said "Staff are very organised" and always made sure the person was ready for their visit.

There were accident and incident reporting systems in place at the service. The manager monitored and acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided.

The provider had a range of quality monitoring systems which were used to continually review and improve the service. These included an audit program which the manager completed with the nurses and responsible staff. For example medicines, wound care and kitchen audits. Where concerns were identified these were addressed and staff advised. For example the kitchen audit identified some cracked flooring and replacement lino had been arranged. The manger had planned to undertake a care record audit the day we visited which they decided to reschedule. Since starting at the service the manager had developed a plan of areas they had identified which required improvements and was working on implementing these with a schedule in place.

The service encouraged open communication with people who used the service and those that matter to them. There were regular opportunities for people and relatives to share their views. A 'residents and relatives meeting' had been held in December 2016 where proposed changes to car parking were discussed to make more room for visitors. The manager had also put up a notice of meeting dates to be held every three months for the forthcoming year so people and relatives were aware and could plan to come. The manager had set up a 'manager's workshop'. This is where people, relatives and visitors can meet with the manager to discuss any concerns or put forward ideas. Comment cards were also available in the front hall. The manager said "I can deal with problems if I know about them. This time is set aside so they can come and talk with me." People and staff had been involved with the recruitment of the new manager. The responsible person said that a service user representative and two staff were involved in the selection process.

The provider conducted an annual survey of people, relatives and staff. The responses from the last survey had been very positive. People and staff had been advised of the responses and any changes which had been made as an outcome.

Where any concerns about standards of practice were identified for individual staff, they were dealt with through individual supervision and training. Where concerns persisted, people were protected because these were dealt with through formal disciplinary and capability procedures.

Staff were actively involved in developing the service. A whole staff meeting was carried out on the evening of our first day. The manager also had meetings with heads of departments and the nurses. The last nurses meeting in November 2016 there was a lot of discussion about link nurse roles, for example acting as a resource on evidence based practice on an area of interest and or expertise such as tissue viability, end of life care and care of people with diabetes.

It was evident that action was taken in response to concerns raised by people and staff. For example improvements had been made regarding standards of cleanliness following concerns raised about dust under beds. Another example was about communication difficulties regarding staff whose language was not English. The responsible person was happy to support them to undertake English lessons.

Staff felt consulted and involved in changes and able to contribute their suggestions. The records of the last staff meeting held on 8 December 2016 showed evidence of sharing information and discussions. For example staff were reminded to keep fire exits clear, discussions about a person with challenging behaviour

and the importance of incident reporting. Other areas of discussion were about complaints and grumbles shared, call bells and suggestions regarding equipment which might be beneficial.

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared and any issues brought forward. The manager said they had strengthened the handover by getting all staff into one handover meeting and providing detailed written handover summaries. For example, details of people who needed encouragement to eat and drink, what help people needed with activities of daily living, mobility needs, and any recent changes in care needs. Staff were not allowed to take these home, they had to be shredded at the end of each day to protect people's confidential information. The manager also attended morning handovers on the days they were at the service. The manager said "staff appreciate that I come in for handover each day and it also gives me the opportunity to speak with the night staff." This meant the manager and staff were kept up to date about people's changing needs and risks.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested.

The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website. The provider met their statutory requirements to inform the relevant authorities of notifiable incidents.