Progress Adult Living Services LLP

Nightingale House

Inspection report

Nightingale House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection focused on two different service types which operate from the same premises. The first being a residential care home and the second being a service offering support to people living in their own homes.

This inspection took place on 14 September 2017 and was announced. The provider was given 24 hours' notice, as when we had previously attempted to inspect the service, everyone was out. This meant the provider and staff knew we would be visiting the service's office before we arrived. This was the first inspection since the provider's registration on 26 February 2016.

Nightingale House is situated close to Derby city centre and provides a care home service for up to 12 people. The service specialises in caring for children and young adults with complex health needs and acquired brain injury, including learning disabilities or autistic spectrum disorder and sensory impairment. Nightingale House provides eight long term beds and 4 short term beds. At the time of our visit four people were living at Nightingale House and four people were being supported in their own homes with personal care. In addition to this one person was at the service for respite. The young people using the service at the time of the inspection were 14 years of age and above.

There was a registered manager in post. 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.'

We found that the provider's systems had not picked up the issues we identified at this inspection visit. This demonstrated that the management systems were not always effective in recognising areas which required improvements.

Two staff told us that they had not received training and induction to carry out their roles safely and effectively. Relatives were not confident that staff could meet people's needs safely as they felt they were not suitably trained or experienced.

People who were supported with their medicines were not always protected against the risks associated with poor medicines management as their medicines were not always stored safely. For example we found that the stock balance of people's medicines was not always correct.

People's care records showed risk assessments were completed. Assessments related to people's assessed needs such as moving and handling. However we saw that staff did not always support people adequately to ensure any difficulty to manage behaviours were not exacerbated.

We received concerns that people were not always supported to pursue their hobbies and interests. On the day of the inspection visit we did not see people involved in daily living tasks.

The provider understood their responsibility to comply with the requirements of the Mental Capacity Act (MCA) 2005. Some people were subject to restrictions and the provider had identified where their support needed to be reviewed. This provided assurance the principles of the MCA 2005 were followed.

People were supported to maintain their health and well-being and had access to a range of healthcare professionals such as GP's when required. We observed staff treated people kindly and in a way which respected people's privacy and dignity.

The provider's complaints policy and procedure were accessible to people who used the service and their representatives. People's relatives knew how to make a complaint.

People's relatives did not feel that the service was well managed. Staff felt supported by the management team and enjoyed working for the provider.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The management of medicines did not provide assurance that people's medicines were stored safely. Risk to people were minimised to ensure the safety of the person and others. However risk assessments were not always reviewed to ensure they remained up to date. People were supported by staff who knew how to recognise signs of abuse or harm, and how to act on these. Recruitment procedures did ensure suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Relatives were not confident that staff were competent in their roles. Staff had not always received induction and training to ensure they had the necessary skills and knowledge to carry out their roles safely and effectively. Health professionals were involved appropriately in people's care. People were supported to access healthcare services when required.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff. People and their relatives were involved in planning for their care. People were treated with dignity and respect and they had a right to privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some relatives felt that people supported in their homes did not receive continuity of care. A relative was not confident that their family member was supported to pursue interests and hobbies which were important to them. The provider's complaints policy and procedure was accessible to people's relatives and representatives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had a registered manager, in post. The management systems were not always effective in recognising areas which required improvements. Relatives expressed that communication with management was not well managed. We were unable to look at systems for assessing and monitoring the quality of the service provided as the information was not accessible in the registered mangers absence. The provider did not have suitable arrangements in place to monitor the safety of the premises and equipment. Staff told us they enjoyed working for the provider.

Nightingale House

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 14 September 2017 and was announced. The provider was given 24 hours' notice because the location also provides a domiciliary care service and we needed to be sure that someone would be available at the office. Also when we had previously attempted to inspect the service, everyone was out.

The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience did not attend the agency's office, but spoke by telephone with people's relatives. The telephone interviews took place on 14 September 2017.

Before the inspection visit, the provider completed 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. As part of our planning we reviewed the information in the PIR. We also reviewed the information we held about the service, which included notifications. Notifications are changes, events or incidents that the registered provider must inform CQC about.

We spoke with one person who used the service as the majority of the people were unable to communicate with us verbally due to their complex health conditions. During the inspection visit at Nightingale House we observed staff support people who used the service. We spoke with one person who used the service and four people's relatives. We spoke with the deputy manager, senior residential support worker and four support workers. Staff provided support in the home and in the community. There are permanent core staff that mainly work at the home and flexi staff that generally work in the community but also work at the home.

We reviewed records which included four people's care records to see how their care and treatment was

planned and delivered. We reviewed three staff employment records and other records which related to the management of the service such as quality assurance, staff training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

A relative of a person supported at the care home told us they felt their family member was safe with the support provided by staff. However two relatives of people supported in their own homes raised concerns about their family member's safety whilst being supported by staff. One relative was concerned that staff did not have sufficient knowledge regarding their family member's health condition to support them safely. Another relative raised concerns about security they said, "There is no prior notification when staff are changed, not even a phone call and the staff have no identification."

Risks to people through their specific health conditions and their environment had been assessed. We looked at four peoples care records, these included risk assessment including the use of equipment such as a hoist for moving and assisting, as well as the support a person required whilst travelling in a car. The assessments included the actions needed to reduce risks. For example one person who required aids such as a hoist and wheelchair, the risk assessment provided instructions for staff on how these were to be used. Staff told us they were aware of risks to people and that they had access to personalised risk assessments. However one person's risk assessments had not been reviewed since 2015. For another person we saw that their risk assessment and care plans were not dated. This did not provide assurance that risk assessments and care plans always reflected people's current level of needs, so that staff could manage risks to people in a safe way.

We saw that staff did not always support people safely to ensure difficult to manage behaviours were not exacerbated. For example our observations showed that a staff member did not use the appropriate approach when supporting a person. This then caused the person to become upset. Staff intervened to reassure the person and supported them in their bedroom.

Following the inspection visit we received information of concern from the local authority. We were told about incidents around the use of inappropriate restraint, which was currently being investigated by the local safeguarding team. We will continue to monitor this and determine if any action is required by CQC.

Some people's parents retained responsibility for medication administration in their home. However a relative of a person who required staff to administer their medicines said, "Errors have been made with the administration of medicines by staff, we noticed the wrong number of tablets were left."

We found the management of medicines did not always provide assurance that people's medicines were stored safely. The stock balance of people's medicines was not always correct. For example we saw that one person had three missing tablets. Whilst another person had one tablet missing. This had not been identified by the provider as no audits were taking place. We saw there were four gaps for medicines fridge temperatures during September. We also found that medicine room temperatures on some occasions were outside the recommended range. This meant that medicines were not always stored safely and there was the potential for their efficacy to be reduced. Records showed that not all staff had undertaken medication training. We looked at a sample of medication administration records and found these had been completed accurately.

There were appropriate arrangements in place to protect people from harm. This included a process for reporting concerns as well as a whistleblowing process. During discussions with staff they were able to explain what to do if they had concerns about the welfare of any of the people who used the service. However training records seen showed that not all staff were trained in safeguarding adults and children. Staff told us they had confidence that any concerns they raised would be listened to and action taken by management.

All the staff we spoke with told us there was enough staff available to meet people's needs and enable people to access the community. However one person's relative told us "It does cross my mind that there are not enough staff. The number of people using the service has increased, but staffing levels don't appear to have changed. When [person's name] is in their room, I'm not sure how often the staff go into them." Our observations showed that there were enough staff on duty during the inspection visit to support people using the service. The deputy manager told us that staffing levels were determined by the needs of the people. The staffing levels in the day were variable during school term time and weekends depending on the number of people at the service. There were two waking night staff on duty through the night. The deputy manager told us that they had recently used agency staff due to sickness and annual leave and that the same agency staff have been used for consistency. There were currently two waking night staff positions, which were covered by agency staff until the positions could be recruited into. We were also told by the deputy manager for safety reasons there were always two staff in a vehicle when taking people out.

We looked at the recruitment records in place for three recently employed staff members. We saw recruitment practices included completed application forms and references from previous employers. We saw Disclosure and Barring Service (DBS) checks were in place. The DBS is a national agency that keeps records of criminal convictions. This demonstrated that the provider had checks in place to make sure that staff were suitable to work in people's homes and at Nightingale House.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback from relatives we spoke with about the support their family members received from staff. A relative said, "Several staff are good at the job, however others are lackadaisical." Another relative said, "The core staff from Nightingale house are fine and do things well but the flexi staff have limited experience." Another relative said, "Staff are not trained and fully competent. Training and experience is an issue for complex care needs."

We received mixed feedback from staff on the induction and training they had received. Two staff told us that they felt they had received the relevant training to support people using the service. However one staff member said that they had not received any induction other than being shown how to complete timesheets. Another staff member stated that they had only received training on safeguarding and no further training. Both staff told us that they had not received fire training including not being shown fire exits at Nightingale House. Training records we looked showed that not all staff had received training in all areas as required by the provider. We also found that not all staff were included on the training records we looked at. This did not provide assurance that staff had the necessary skills and training to meet people's needs safely.

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

Staff understood the importance of gaining consent before care and support was provided. Staff knew about people's individual capacity to make decisions and understood their responsibilities for supporting people to make their own decisions. We saw that mental capacity assessments were in place were people were identified as lacking capacity, as well as best interest decision making information. Relatives told us that they had been involved in decision making and were able to voice how best to support their family member. A relative said, "Staff do listen to me about [person's needs].

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

A DoLS provides a process by which a provider must seek authorisation to restrict a person's freedoms for the purposes of their care and treatment. An application to lawfully restrict a person's liberty to keep them safe had expired. The deputy manager told us that the registered manager had submitted an application for this DoLS which had expired. Training records we looked at showed that some staff had undertaken training on DoLS, however there was no information on whether or not staff had specific training on the MCA. Following the inspection visit the provider submitted information which showed that MCA training was included as part of the DoLS training.

At Nightingale House we observed the lunch time meal. We saw people who needed assistance were offered this. Staff were observed engaging with people throughout the meal. Our observations showed that staff were patient whilst they offered people support and assisted people at their own pace. The meal time was not rushed and provided a relaxed experience for people. Where people required special diets these were provided. However in the community one person's relative raised concerns about the lack of understanding some staff had regarding food preparation in relation to a person's medical condition.

Peoples care records contained information on their nutritional requirements and their preferences. Two people required support by staff to ensure they received adequate nutritional intake due to difficulties with swallowing; as they were unable to take enough food or fluid to meet their nutritional requirements. Training records showed that staff that supported these people had received the relevant training to support them with the administration of their feed. This is was provided through a Percutaneous Endoscopic Gastrostomy (PEG) tube. This is a feeding tube which passes through the abdominal wall into the stomach so that feed, water and medication can be given without swallowing.

People were supported to maintain their health and wellbeing. People had access to relevant healthcare services when required. Staff supported people to attend health related appointments when required. A relative said, "[Person's name] has been taken to hospital by staff." People's files contained detailed information on their medical conditions and history. Care records provided staff with clear instructions to follow. For example one person's file contained detailed guidance from an epilepsy nurse about the types of seizures they experienced and the protocol to follow.

Good

Is the service caring?

Our findings

A person living at Nightingale House told us that they liked living at the home and that they liked the staff. We observed a positive and caring relationship between people who used the service and staff. They were polite when they spoke with people. The staff demonstrated a good understanding of people's needs and treated them with respect and in a caring way. A relative said, "They [staff] seem to be kind and caring towards [person's name]. I have not seen anyone being unkind." A relative of a person supported at home stated, "The staff are caring in their approach and seem genuinely interested in [person's name]."

People were supported to maintain their dignity and privacy. Relatives told us staff treated their family members with respect and treated them with dignity. A relative said, "The staff always respect [person's name] privacy and dignity. When they are carrying out personal care they close the bedroom door." A relative of a person supported at home said, "Oh yes they [staff] definitely respect [person's name] dignity."

Information seen in care records demonstrated that people's gender preferences with support and care were met. A relative of a person living at Nightingale house verified this. They said "The service have met the gender preference of staff who support [person's name]." We also saw information on care records which showed peoples relatives had been involved regarding the person's individual preferences such as how they liked to have their hair.

Care records we looked at for some people living at the care home and people being supported in their own home contained details on their method of communication. For example one person's records showed that they were involved in decision making by using body language such as touching items of clothing to wear. This demonstrated that staff were provided with information regarding people's methods of communication.

Staff described the contact individual people had with their relatives and other people who were significant to them. A relative of a person living at the service told us that they were regularly able to visit their family member. Records showed that a person was supported by staff to visit their relative and maintained contact via video calls. This demonstrated that staff supported people to maintain relationships with people who were important to them.

Individual's bedrooms were personalised to reflect people's individual personalities and preferences. People had pictures and memorabilia in their rooms which were important to them.

Requires Improvement

Is the service responsive?

Our findings

Relatives of people supported in their homes told us that their family member's did not receive continuity in the support they received. They felt that their family members were not supported by a regular team of staff that knew and understood their needs. A relative said, "The flexi staff don't read [person's name] care plan, I feel they are not very good." Another relative said, "I am not confident that different staff are up to speed with the care plan." Another relative said, "The flexi staff don't understand [person's name] needs and how to support them." This demonstrated that the provider did not always meet people's individual needs.

The deputy manager told us that the registered manager visited people and their relatives as part of the initial assessment process. This was to ensure that the provider understood the support people needed, so that the peoples relatives or representatives could be confident that the service was right for them. Relatives told us that they had been involved in this process. A relative said, "We visited the home before [person's name] moved in. We were also involved in the assessment process and were asked about [person's names] likes and dislikes." A relative told us that their family members care reviews was not due yet.

Care records we looked at for people living at Nightingale House were individualised. However the care records for people supported in their homes were not detailed. For example they did not provide information regarding the actual tasks staff were supporting people with. This did not provide assurance that people in their homes were supported consistently with the tasks they required support with. Most relatives told us they had felt involved in planning their family members care needs. A relative said, "The manager came to out to our house with staff, I was able to explain [person's name] needs." However another relative said, "Initially there was no care plan in place. We told the manager and we drew it up for them. It's a concern."

Prior to the inspection visit we received information which suggested that people were not always supported to pursue hobbies and interests, which were currently being investigated by the local authority. A relative told us they did not feel confident that staff supported their family member to carry out activities. They said, "Not sure what activities the staff do with [person's name], when I ask they [staff] say nothing." One person wanted to carry out an activity which had been agreed with them by a member of staff. However the staff were then unable to facilitate this. This then caused the person to become unsettled. Two peoples care records who lived at the care home showed they were supported to follow their interests and access community facilities. For example, staff supported some people to attend school and leisure facilities. This was also confirmed by staff we spoke with. On the day of the inspection staff told us two people were taken out by staff into the community. However we did not observe people being involved in any daily living tasks. People's care and support plans we looked at included information on their hobbies and interests. Activity plans were in place showing how people spent their time. We also saw that the provider had their own vehicle to take people out when required. One person had their own car which the staff used to take them to school as well as attend appointments.

There was a sensory room at Nightingale House. A sensory room is an interactive space with special lighting and sounds. The sensory room also doubled up as a cinema room. Staff told us that people had access to

the garden, which they used when the weather was better. The garden area was on one level and was accessible for people using wheelchairs.

Systems were in place to manage complaints, a complaints procedure was in place. Two people's relatives told us that they were aware of the complaints procedure. On relative told us that they had raised a complaint which has been resolved. Another person said, "I have no concerns. But staff turn up for then they are not needed, I let the office know but they still turn up."

Complaints records we reviewed showed that during 2017 the provider had received three complaints regarding Nightingale House. Action had been taken to resolve two complaints. This included a meeting with staff about the importance of their professional conduct. The deputy manager told us that one complaint was ongoing which would be followed up by the registered manager when they returned to work.

Requires Improvement

Is the service well-led?

Our findings

At this inspection visit we identified that the provider's management systems were not always effective in recognising areas which required improvements. For example we found that for people who were supported in their homes, their care records did not provide details of the actual tasks staff were carrying out with them. In addition to this for one person living at Nightingale House their care records had not been reviewed since 2015. The lack of maintaining accurate care records placed people at risk of inappropriate or unsafe care and did not ensure people received consistent care. Training records showed that not all staff had received training to support them in their roles, which was also confirmed by two staff.

Some people's relatives we spoke with felt the service was not managed well and communication was not effective. One relative said, "The registered manager doesn't communicate well with you. They get other staff to communicate with you." Another relative told us, "The management are not overly pro-active, it's quite frustrating getting information. It's me who has to chase and call them. On one occasion we had a call at very short notice to say one of the staff couldn't attend and the package was cancelled. It's not good enough. It has not been a smooth process. I would recommend the service for general needs but not for complex care needs. The service is higgledy- piggledy and not very clear. We do not have a rota so for example I may ring in the morning to ask who is coming and I am told 'someone is arriving.' I have no confidence." Another relative stated, "I don't know who the manager is." Following the inspection visit the provider submitted evidence showing that correspondence had been sent to relatives, including informing them about changes to the management of the community service. This showed that systems used for communication between relatives and management were not effective. One person's relative told us they were happy with the agency. They said, "They [staff] do a good job, only issue is the rota which is a management issue."

Staff told us they felt the provider's maintenance arrangements were not adequate. They told us they needed a list of any repairs required at the service, before maintenance staff would attend to carry out the necessary works. A staff member said, "The maintenance people come from Walsall so jobs need to build before they come out." We saw an error message on the fire board, which staff told us had been reported to maintenance. Staff said they felt despite the error message the fire board was working. However this did not provide assurance that the fire board was working effectively. During the inspection visit a member of the inspection team switched the light switch on which gave off a bang as well as sparks. There was no signage to advise that the switch was faulty. We were then informed by staff that the switch was not working and that the sign to advise this had come down. However this had not been replaced. We saw that the maintenance log was maintained electronically but had not always been updated when jobs had been completed. This demonstrated that the provider did not have suitable arrangements in place to monitor the safety of the premises and equipment.

The service had a registered manager in post since February 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. The registered manager was supported by the deputy manager and care staff. Staff we spoke with told us that the enjoyed working for the provider. One staff member said, "The staff team are lovely and very supportive. The management are

very approachable." Another staff member stated, "All the staff are really nice and there is good team work. I have been supported really well. I enjoy supporting the young people." Staff told us regular team meetings were held which was an opportunity to discuss peoples support and any changes or issues.

We were unable to look at the arrangements in place to monitor the quality of the service. As in the absence of the registered manager not all information was accessible to the rest of the management team. For example the deputy manager was not able to access quality monitoring information such as satisfactions survey's and internal audits. All the relatives we spoke with told us they had not been approached to provide feedback on the quality of the service and care provided to their family members. We were shown a copy of a quarterly audit carried out by an independent consultant on behalf of the provider during June 2017. As a result of the audit eight recommendations were made. The recommendations left included having a system for gathering feedback from relatives and people's relatives.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit we received concerns from the local authority regarding their visit to Nightingale House. This included ineffective management systems and poor documentation. As a result of the local authority's findings the provider had put together an action plan, to address the issues identified.

At the time of the inspection visit we found the provider was providing care to children which they were not registered to provide. The deputy manager told us they would be updating their registration details with us to reflect these changes.

The provider was clear about their responsibility in notifying the CQC about incidents, events and changes that affect the health, safety and welfare of the people at the home and the running of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider did not have effective systems and processes to assess, monitor and improve the quality and safety of the services provided. Regulation 17