MAPS Properties Limited

Nightingale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 5 and 6 April 2016.

The Nightingale Care Home is a care home that provides accommodation and care for up to 47 older people who are living with dementia. On the day of our inspection, there were 37 people living within the home.

There was a manager working at the home who is registered with us. 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 and associated Regulations about how the service is run.

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

People did not always receive care in a timely manner to meet their individual needs. The staff had not been deployed effectively to enable them to do this. Risks to some people's safety were not being mitigated effectively to protect them from the risk of harm.

The main areas of the home were clean but some equipment that people used was not. The principles of the Mental Capacity Act had not always been followed when some decisions had been made on behalf of people who were unable to consent to them.

Some staff were kind, caring and compassionate and they treated people with dignity and respect. However, other staff did not always act in this way.

Most staff had received training on how to provide people with safe and effective care. However, although their competency to provide this had been assessed, some staff provided people with poor care. The environment was not fully designed to promote people's independence.

Some of the current governance systems in place were not effective at assessing and identifying improvements that were needed to the quality and safety of the care that was being provided. Improvements identified by an external body had not been fully acted on within the time-scales given.

The staff knew how to protect people from the risk of abuse and people received their medicines when they needed them. People received enough food to meet their needs. People were encouraged to participate in activities that complemented their hobbies, interests and that promoted their wellbeing.

There was an open culture where people, relatives and staff could raise concerns that were listened to and acted upon. Staff were happy working in the home.

We have made a recommendation in relation to providing an appropriate environment for people living with dementia.

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.

Actions had not always been taken to mitigate risks to people's safety.

The staff were not deployed effectively to reduce the risk of people experiencing harm and to meet their needs in a timely manner.

The communal areas of the home were clean but some equipment that people used was not.

The provider had systems in place to protect people from the risk of abuse.

People received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training on how to provide people with effective care. However, some staff demonstrated poor care practice.

The principles of the Mental Capacity Act had not always been followed when decisions had been made on behalf of people about their care.

The environment required improvement to help people orientate themselves within it.

People received enough food to meet their needs.

People were supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most staff were kind and compassionate but some did not

always treated with respect or kindness.

People's relatives or representatives were involved in making decisions about their family members care.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received the care they required but this was not always provided in a timely manner.

Some people's care records contained inaccurate or conflicting information and were not person centred.

People participated in activities that provided them with stimulation and enhanced their wellbeing.

Any complaints raised were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Timely action had not always been taken to make sure that people received safe, high quality care.

The current systems in place to monitor the quality and safety of the service were not effective.

There was an open culture within the home where people, relatives and staff could raise concerns without hesitation.

Staff felt supported in their role and they were clear about their individual roles.

Nightingale Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 April 2016 and was unannounced. The inspection team consisted of one inspector 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. One inspector visited the home on 5 April 2016. The same inspector and an expert by experience visited the home on 6 April 2016.

Before the inspection, 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. We also reviewed other information that we held about the service. Providers are required by law to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

We spoke with ten people who lived at Nightingale Care Home. However, they were only able to give us very limited feedback on the care they received. We therefore spent time observing how care and support was provided to people. Along with general observation, we used the Short Observational Framework for Inspection (SOFI) to assist us with this. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

In addition we spoke with six visiting relatives, five care staff, two activities co-ordinators, the chef, one kitchen assistant, one domestic staff member, the administrator, the registered manager and the provider.

The records we looked at included seven people's care records and other records relating to their care, three staff recruitment files and staff training records. We tracked the care that four people were receiving in detail. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Most risks to people's safety had been assessed and in some cases, actions had been taken to reduce the risk of people experiencing harm. For example, some people who were at high risk of falls from their bed had a bed low to the floor and a crash mat in place. However, some risks were not always being managed effectively.

Two people had been assessed as being at very high risk of developing a pressure ulcer. To help mitigate this risk, one person was on an air flow mattress (a specialist mattress to help regulate pressure). However, the mattress was not at the correct setting for the person's weight. It had been set at 150kg but the person weighed much less than this. Therefore, using the mattress may not have been effective. We brought this to the registered manager' attention who corrected the mattress setting.

It was recorded within the other person's care record that they required a specialist cushion to be on their chair when seated. On both days of the inspection this was not in place. We had brought this to the attention of a senior carer on the first day of the inspection who had agreed to rectify the matter. However, on the second day of the visit it was still not in place. It was also recorded within this person's care record that they needed their position changed every two hours but this did not occur. The person was observed to remain in their wheelchair for longer than this period on the first day of the inspection.

Two people had been assessed as being at risk of choking. To mitigate this risk they required a specialist diet and for their drinks to be thickened. However, it had been recorded on one person's food chart that they had been given ice cream. The speech and language therapist had identified and recorded within this person's care record that the person should not eat this type of food as it posed a risk to their safety. There was also confusion amongst the staff regarding how much thickener should be put into both these people's drinks to make sure they were safe to drink. Although staff were thickening these people's drinks, they were not always following the instructions given by the speech and language therapist to make sure it was of the correct consistency to be safe.

The registered manager told us that one person did not drink very much. However, their risk of dehydration had not been assessed and was therefore not being monitored. This person had been identified by the night staff as requiring extra drink during the day of our inspection. This was clearly recorded on the handover sheet for the day staff. However, three of the day staff we spoke with were not aware of this. One of the staff spoken with had the specific task on that day of providing people at risk with extra drinks. We did not see staff providing this person with extra drinks throughout the day.

This has resulted in a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] 2014.

The staff were not being deployed effectively to enable them to meet people's needs in a timely manner or to keep them safe from the risk of harm.

We received mixed views from the people and relatives we spoke with regarding staffing levels. One person we spoke with told us, "They [the staff] come as quickly as they can." However, another person said, "There are not enough people [staff] here."

All of the staff we spoke with told us they felt there were enough staff to meet people's care needs and to keep people safe. The registered manager told us that staffing levels were calculated based on people's needs. They added that any unexpected staff shortages were either covered by existing staff or agency staff.

The registered manager told us that the number of staff on shift regularly exceeded the number that were actually required. When we checked the staff rota's for the four weeks prior to our inspection visit, we found this to be the case. However, we saw that on occasions, people had to wait for the assistance they required with personal care or with eating their meals. The staff were not always present within the communal areas of the home to make sure that people were safe.

Prior to the lunchtime meal, people were assisted into the dining room by the staff in preparation for their meal. We observed that people sat at the dining table waiting for their meal for an unacceptable amount of time. One person was seen to wait for an hour before they received their meal. Their body language during this time indicated that they were bored and distressed. We saw them holding their head in their hands, covering their face. This person required assistance to eat their meal but this was not given in a timely way. Their dessert was placed in front of them but they did not receive help to eat it for 15 minutes.

Another person had to wait for 45 minutes for their meal. A further person who required prompting to eat their meal did not receive this for six minutes after it had been placed in front of them by which time, the meal may have been cold. Another person had to wait for 25 minutes before their request for assistance with their personal care was met. A further person requested a wheelchair to help them get to the dining room as they felt unable to walk there. It took over 15 minutes for the staff to provide this person with the assistance they required.

On one occasion within the dining room, people were left for up to ten minutes with no staff being present. During this time, one person became increasingly angry with another person who was interfering with their wheelchair. This resulted in them lashing out at the person although they did not make physical contact with them. On a further occasion, we saw one person putting a tabard over their head which tightened around their neck. As this tabard did not have a quick release mechanism this could have resulted in the person experiencing harm. We brought this to the registered manager's attention. On another occasion within a communal lounge area, one person was becoming annoyed with another person who sat down near them. We observed them mocking the person who was utilising a doll for comfort and telling them to 'go away'. There were no staff present within this room for 20 minutes. Therefore, there was a risk to people's safety as staff were not present to de-escalate situations or monitor that people were safe.

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

In November 2015, the local authority infection prevention and control specialist had visited the home and conducted an audit in respect of how the home reduced the risk of the spread of infection. An action plan had been given to the home following this visit. We checked to see if the home was clean and that the necessary actions had been taken.

One of the relatives we spoke with told us, "Cleaning has improved and the dining room has recently been decorated." Another relative said, "There is not the nasty smell in the care home anymore, we use to hold our breath here."

We found that the communal areas of the home were clean. Five people's rooms that we checked were also found to be clean. The domestic member of staff we spoke with had a schedule in place to guide them on what cleaning needed to be completed. They were aware of their individual roles and responsibilities in relation to reducing the risk of the spread of infection as were the staff we spoke with.

One area within a communal lounge had been identified by the local authority as requiring repair as it could not be cleaned effectively. This was yet to be repaired but the registered manager told us that some quotes to complete the work had been sought. A number of chairs within the dining room and lounge areas had been replaced and this was on-going. Any commodes that had been identified as being inappropriate had been replaced.

However, a relative commented to us that their family member's wheelchair was not always clean. We therefore checked some of the wheelchairs that were stored within a cupboard. This cupboard had a strong unpleasant odour within it and some of the wheelchairs required cleaning. It was observed that the staff toilet clinical waste bin was overflowing and that a bath seat was rusty and required to be cleaned. The mops used to clean the home were being stored in damp conditions. All of these increased the risk of the spread of infection. We brought these issues to the registered manager's attention who agreed to rectify them immediately. Improvements are therefore required to make sure that people are protected from the risk of infection.

The relatives we spoke with told us they felt their family member was safe living at Nightingale Care Home. Most of the staff we spoke with were able to demonstrate to us that they understood what abuse was. They were clear about the types of concerns they had to monitor and report. One person was observed to have some bruising on their arms. This has been brought to the attention of a senior carer during our inspection so that it could be investigated. Other incidents of alleged abuse had been reported to the relevant authorities as is required by the registered manager. We were therefore satisfied that the provider had systems in place to protect people from the risk of abuse.

People received care and support from staff who had been appropriately and safely recruited. Staff told us the provider had sought employment references and a criminal records check before they started in their role. The recruitment records we viewed demonstrated these had taken place along with additional checks such as obtaining photographic identification. However, in two of the staff files we checked, gaps in their previous employment were evident. When we spoke to the registered manager about this, they were able to tell us about these gaps and demonstrated that they had explored this with the staff member prior to them commencing work at the home.

Risks in relation to the premises had been assessed and regularly reviewed. We saw that fire doors were kept closed and that the emergency exits were well sign posted and kept clear. Testing of fire equipment and the fire alarm had taken place. Staff demonstrated to us that they knew what action to take in the event of an emergency such as a fire or finding someone unresponsive within their room. The equipment that people used such as hoists had been regularly serviced to make sure they were safe to use.

We checked seven people's medicines records to make sure they had received their medicines as intended by the person who had prescribed them. The records we looked at confirmed this. There was clear information in place to guide staff on how to give people certain medicines and regarding whether people had any allergies that needed to be taken into account. People's medicines were stored securely so they could not be tampered with and for the safety of the people who lived in the home. We were therefore satisfied that people received their medicines when they needed them.

Requires Improvement

Is the service effective?

Our findings

New staff working at Nightingale Care Home completed induction training to prepare them for their role. One new staff member told us how they were currently working towards obtaining the Care Certificate. This is a nationally recognised qualification for staff to complete who work in Health and Social Care. They told us that they spent time shadowing more experienced staff who provided them with guidance and support.

The training staff received was provided by an external company. This was performed in a classroom format which the staff told us was a useful way to facilitate their learning. A programme of future training had been booked by the registered manager in the subjects of care planning, safeguarding adults from the risk of abuse, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, moving and handling, falls prevention and nutrition in dementia.

The staff we spoke with told us they had received enough training to enable them to provide people with effective care. We checked six staff training records in detail to see what training they had received. We found that most staff had completed training in a number of different subjects including how to assist people to move safely, infection control, safeguarding people from abuse and dementia. Some staff had also attended training in respect of nutrition, pressure care and end of life care. However, we saw that one staff member who was working on the first day of our inspection had not completed any official training. This staff member when spoken with, demonstrated good knowledge in relation to important aspects of providing care to people. However, it is important that staff receive the necessary training. Another staff member who was working independently with people had not received any training in safeguarding adults. When spoken with, they were not aware of how to protect people from the risk of abuse. The registered manager agreed to arrange the necessary training for these staff members immediately.

The staff we spoke with told us that their competency to perform their role was monitored regularly by the senior staff. They added that they received feedback on their performance and re-training as necessary. They also said that they received enough supervision to help them perform their role effectively. However, we found that some staff did not always treat people with dignity and respect or follow the principles of the MCA which demonstrated poor care practice. Therefore improvements are required to ensure that staff have the required skills and knowledge to provide people with effective care.

The corridors within the home were wide allowing access for wheelchairs and equipment to help people to move easily. People's rooms were also spacious and set in a way to enable the staff to help people move safely. The communal lounges and dining room were also spacious and did not contain any obvious trip hazards. There was a secure outside area that people could access when they wished to so they could get some exercise or fresh air.

Although the home is a care home for people living with dementia, the environment was not designed to help people with memory difficulties orientate themselves around it. We observed that some people living in the home had difficulty with this which resulted in them wandering around the home asking staff for assistance. One relative told us, "I would like to see it decorated more for the residents living with dementia."

Some of the staff we spoke with also told us they felt improvements needed to be made to the environment.

There was a lack of clear signage directing people to the communal areas within the home. The walls of the corridors and the doors to people's rooms were painted in the same light colour. There were no clocks or signs to tell people what the date or time was. There were some tactile items for people to pick up such as dolls, toys or blankets but these were kept within one communal lounge which was not used by many people. We also saw that a carpet in the downstairs corridor was stained and worn in areas and an upstairs carpet was coming apart in places which could present a trip hazard. The registered manager told us they had identified these issues and that plans were in place to improve the environment for the people living there.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

The staff told us that a number of people who lived at Nightingale Care Home lacked capacity to make decisions about their care. Staff had varying knowledge regarding the MCA and how it affected their daily practice. Some staff had a good awareness and we saw them supporting people to make decisions about their care and asking them for their consent before performing a task. For example, helping people make a decision about what food they wanted to eat or whether they wanted to wear a tabard to protect their clothing during mealtimes. We also saw some staff discussing with people where they wanted to reside within the home. However, other staff were observed not to always follow the principles of the MCA. We observed that on occasions, people were assumed to lack capacity to make a decision and were therefore, not always asked for their consent before a task was performed. For example, three people were not asked if they wanted to leave the dining room by the staff. The staff did not take the time to talk and discuss where they would like to move to and moved them without asking their consent first.

For specific decisions about people's care that fall outside of those made on a day to day basis, we did not see that the principles of the MCA had been applied. For example, two people had sensor mats by their beds to alert staff to their movements. This is a form of restraint. No assessment of the person's ability to consent to this decision had been made in relation to this particular decision. There was nothing to show what support these people had received to make these decisions, whether any less restrictive actions had been considered or who had been involved in making this decision in the person's best interests.

It was noted within people's care records where there was doubt that they were able to consent to some decisions about their care. However, this was a general statement in each of the care records we looked at and people's individual needs in relation to their ability to consent to specific decisions had not been assessed. The registered manager told us they were aware that the care records and MCA assessment process required improvement. They showed us the new assessment they were about to implement and had plans in place to improve the content of people's care records.

The registered manager had assessed which people required a DoLS and had made applications to the local authority for authorisation to do this. We were therefore satisfied that people were not being deprived of their liberty inappropriately.

Most of the relatives we spoke with told us they felt the food was good. One relative said, "Yes the food is nicely presented." Another said, "The food is good." One person told us, "The food is okay."

People were offered a choice of main meal which they were shown so they could choose what they wished to eat. A choice of drink was also given which included an alcoholic beverage such as sherry. Alternative meals were offered to people who did not like the choice on offer. However, we saw that the mealtime experience was not pleasurable for many people. This was due to them having to wait for their meal. During the second day of our inspection visit, people showed their frustration with having to wait for their meals by singing, 'why are we waiting'.

People who required specialist diets and who needed help to eat and drink in the main, received this. The staff we spoke with who worked in the kitchen knew about people's dietary needs. They told us that the communication between them and the care staff was good to make sure that people received the correct diet.

Referrals had been made to the GP for specialist advice when the staff became concerned about people's food intake. People who were of low weight were having their food fortified with extra calories such as butter and cream and some people were receiving dietary supplements.

We saw that a GP visited people regularly and worked with the staff to implement any changes that were required to support people's healthcare. One person who was unwell during the inspection had seen the GP the day before our visit. The staff had requested the GP visit quickly so that the person could receive the support they needed with their healthcare. People also had access to other healthcare professionals such as mental health professionals, occupational therapists, physiotherapists and chiropodists. We were therefore satisfied that the staff supported people with their healthcare needs when this was required.

We recommend that the service considers current best practice information regarding an appropriate environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

The people we spoke with and visiting relatives told us that the staff were kind and caring. One person said, "The staff are very good to me." A relative told us, "The staff they try to do their best." Another relative said, "The staff here are friendly and caring."

We saw some good examples of staff being caring, kind and compassionate to people who lived in the home and treating them with respect. Some staff were seen to laugh and joke with people which put them at ease. One staff member helped someone to move from a wheelchair into a chair using positive and encouraging words so the person felt reassured and safe. Another staff member was seen to crouch down when talking to one person so they could make good eye contact and they listened to the person intently, holding their hand as they did so. However, we also observed on occasions, that some people were not treated with kindness or respect. Therefore, improvements are required within this area.

One person who was in the dining room, regularly called out for a member of staff to help them as they were uncomfortable in their wheelchair. Three staff entered this room at various times but ignored the person. The person had to wait for 30 minutes before staff took action to re-position them within their wheelchair to make them comfortable. This person also shouted out, 'leave me alone' when another person was bothering them. This was in the presence of a staff member but no action was taken to check how the person was feeling or to rectify the situation.

Another person was observed walking around the home in bare feet. They told us, "I think I have left my slippers in my room, I have asked the staff to try to find them." But throughout the visit on the day the slippers did not appear nor was anything placed on this person's feet.

Another person had to sit at the dining room table watching other people at their table eat and finish their meal before they received theirs. We heard staff say this was because they required assistance to eat their meal. Two people were seen sitting in wheelchairs that were too big for them. One person therefore had to lean forward to reach their food which they found difficult. The other person had to rest their elbows at an awkward angle on the arms of their wheelchair. No attempts had been made to make those people more comfortable.

We noted on the second day of the inspection visit that the communal lounge areas were cold. Two people were seen to be rubbing their hands and saying they were cold. However, none of the staff immediately noticed this and it took some time for this to be rectified.

Most of the staff we spoke with knew the people they cared for well. This included details of people's past lives, their likes and dislikes and people's preferences.

The majority of people who lived at Nightingale Care Home had limited ability to be involved in their care planning. The relatives we spoke with all told us that they felt fully involved in making decisions about the care their family member received. Where people did not have any family, we saw that access to an

advocate was available should it be required to assist them to make decisions about their care.

The staff we spoke with had a good understanding of how to respect people's privacy. We observed staff knocking on people's doors before entering their rooms and making sure that doors were closed when assistance with personal care was being given. An activities co-ordinator noticed one person pulling their dress up to expose their under garments. They intervened quickly and provided them with a blanket to protect their dignity.

The relatives we spoke with told us they could visit their family member at any time. They added that they were always made to feel welcome and were kept fully up to date about the care of their family member.

Requires Improvement

Is the service responsive?

Our findings

Most of the relatives we spoke with told us they felt their family member's preferences about how they wanted to be cared for were being met. The staff we spoke with also told us they were able to meet people's individual needs and preferences. However, although we saw that people's needs were met, this was not always completed in a timely manner with some people having to wait for staff to respond to their care needs. This included assistance with personal care and for their lunchtime meal. Improvements are therefore required to make sure that people receive care that meets their individual needs in a timely way.

People's care records required improvement to ensure that they reflected people's individual needs and gave staff access to accurate information to guide them on how to meet these needs.

People's care needs and preferences had been assessed. However, a lot of the information contained within the care records was general in nature. Care plans were not always in place to guide staff on the care that people required. There was no information regarding how to assist people who became upset or distressed or those who had diabetes. There was no information about the correct setting required for people who had air mattresses on their bed to protect them from the risk of pressure ulcers. One person who the registered manager told us was reaching the end of their life, had not had their needs in respect of this assessed.

Some of the care records we viewed contained conflicting or inaccurate information which could be confusing for staff. For example, one person's care record said they needed to have their food and drink intake monitored and that they had a restriction on the amount they drank each day. However, the registered manager told us this was no longer the case. It was also recorded in one section of this person's care record that they had capacity to make their own decisions but in another that they sometimes did not.

Another person's care record stated they needed full assistance to eat their meal but again, the registered manager told us this was incorrect. Another's said they walked with a frame but we were told this was inaccurate information. Two people' care records did not contain clear information in relation to how much thickener was required within their drink to make sure it was safe to drink. This led to confusion amongst the staff with some thickening drinks incorrectly. The registered manager told us they had recognised that people's care records required reviewing to make sure they were personalised and accurate and that they had plans in place to complete this.

People received stimulation and were able to participate in activities to enhance their wellbeing. The home has two designated activities coordinators who knew people well. This included people's life histories which they told us helped them to design activities for people based on their individual needs. The activity coordinators involved people in a variety of physical activities which we observed people to enjoy. The activities coordinators told us that they changed the activities depending on how people felt each day.

There was a few old items from days gone by that were used to help people reminisce about the past. These included a sewing machine, copper kettle and a copper bed warmer. These were placed on the mantel piece and on the walls within the lounge areas. One activities coordinator explained how they tailored the

use of these items to people's past lives such as brass cleaning.

One person was seen enjoying comforting a doll and the activities coordinator helped the resident to dress it. They explained that they were always going to car boot sales looking for items that could be placed in the home for the residents to remind them of their life experiences.

A minibus was available during the summer months to take people on outings to the coast or local garden centre. The activities coordinator told us that they hoped to facilitate the growing of vegetables within raised beds in the garden with some people she had identified who would be interested in this.

Most of the relatives we spoke with told us they were aware of how to make a complaint. Two relatives told us they had made a complaint in the past and that these had been acted on. Most told us they felt listened to and were confident that any concerns would be acted on quickly. One relative told us, "I have had one reason to complain when [family member] was in someone else's clothes, they [registered manager] responded very quickly and investigated it too and reported back to me." We saw that any complaints that had been raised had been fully investigated and the person who had made the complaint had been involved within this process.

Requires Improvement

Is the service well-led?

Our findings

There were not always systems in place to assess, monitor and improve the quality of the care provided and to mitigate risks to people's safety. Those systems that were in place were not always effective.

The registered manager said there were audits in place to monitor people's medicines and the accuracy of people's care records. However, they told us that they were behind in conducting some of these audits. No audits had recently been conducted in relation to the accuracy of people's care records. Five of the care records we looked at contained either inaccurate, conflicting or not enough information within them. This led to a risk of people receiving incorrect care which could be unsafe or compromise their dignity. This was of particular concern as some of the staff working in the home were either new or were agency staff. Some of the staff we spoke with were unclear about some aspects of care that people needed to receive.

The registered manager told us that there was no system in place to monitor that people received enough drink or the correct diet to meet their needs. People's records in relation to this were not being checked for their content or accuracy. When we raised the issue with the registered manager about the person eating ice cream who was on a specialist diet, they were not aware of this. Several of the charts we checked in respect of what people ate or drank had not been completed correctly. Therefore, the registered manager would not be able to establish from these records whether people who were at risk of not eating and/or drinking enough were receiving the care as required.

The completion of staff training was not being monitored effectively to make sure staff had completed the required training and that their skills and knowledge was up to date. Although staff competency was being informally assessed on a regular basis by the senior staff, this current system had not identified some of the issues with staff care practice and knowledge that we found during the inspection. This poor practice was having a direct impact on the care that people received.

The registered manager told us they walked around the home daily to check on the cleanliness of the home but we found some issues that required addressing that had not been identified during these walk rounds. Therefore the current system in place was not effective.

Timely action had not been taken to make improvements to the home that had been identified by an external authority. Actions from an audit conducted in November 2015 by the local authorities infection control team had not been completed within the timeframe stipulated. The registered manager was not able to provide us with an explanation for this.

The staff were each allocated individual tasks around the home each day. For example, some staff were responsible for making sure that people had access to enough food and drink during the day. This helped staff to understand their individual roles and responsibilities. However, staff were not being deployed correctly to meet people's needs in a timely manner during our inspection or to keep them from the risk of harm. This was not being monitored effectively.

Communication between the staff was not always effective. Although daily handovers were conducted, some staff were either not told important information or could not recall it in relation to concerns about people's care.

The registered manager told us that the provider did not conduct any external audits of the quality and safety of the home themselves. Therefore, there was no external overview being conducted by the provider to make sure the home was meeting the required Regulations and standards.

People and relatives had been asked for their opinion about the care provided in June 2015 through the completion of a quality survey. We looked through a sample of these and found that in the main, the feedback was positive. However, there were some suggestions for improvement but the registered manager had not analysed this information or produced an action plan in relation to these suggested improvements.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Accident and incident forms that had been completed by the staff were passed to the registered manager for their review. The registered manager told us they looked at these each month. They were able to give us an example of where they had identified patterns and subsequently taken action to reduce the risk of one person experiencing harm in the future. However, these were not formally being analysed each month which the registered manager told us was a requirement by the provider. The registered manager told us they had the information 'in their head' to help them identify any patterns. Therefore in the registered manager's absence, these patterns may not be acted on in a timely way.

The registered manager was passionate about providing good quality safe care to the people who lived at Nightingale Care Home. However, although they were supported by an administrator they told us they were behind in a number of areas, some of which we identified during this inspection. They told us that to help them with this, the provider was currently advertising for a deputy manager who would take on responsibility for some areas that the registered manager currently had to complete.

The relatives we spoke with told us they were happy with the care that was being provided and that they had seen some improvements in the care provided within the last 12 months. One relative told us, "Over the past months you have seen an improvement, there is not so much of the bad smell." Another said, "The care here is satisfactory. [Family member] is clean and dressed well."

Most of the relatives we spoke with told us that communication between them and the home was good and that they were kept informed about their family members care. However, some relatives said they wanted to be more involved in the running of the home but that they did not feel that they were asked regularly for their opinion regarding this. One relative, when asked if they attended any meetings held by the home, told us, "I don't know of any relatives meetings." This was echoed by the other relatives we spoke with. Some relatives we spoke with were keen to be involved in fund raising and helping to make the home more dementia friendly. We spoke with the registered manager about this. They told us they had tried to arrange relatives meetings but that no one had responded. They agreed however, to try to facilitate these in the future.

All of the staff we spoke with told us they felt supported in their role. They added they would be happy to raise any concerns they had if needed and felt confident these would be acted upon by the registered manager. Most of the staff said their morale was good and that they felt valued. They all told us they would be happy for a relative of theirs to be looked after within the home. They added that staff meetings were held where they could discuss issues relating to the running of the home or the people who lived there.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people's safety had not always been assessed or action taken to mitigate these risks. Regulation 12 (1) (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to assess, monitor, and improve the quality and safety of the care provided or to mitigate risks to people's safety. Some records were not accurate or complete. Feedback was sought but not always analysed or acted upon. Regulation 17 (1) (2) (a) (b) (c) (e) and (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The staff were not deployed effectively to meet people's needs in a timely manner or to keep them from risk of harm. Regulation 18 (1).