Nightingale Hammerson

Nightingale House

Inspection report

105 Nightingale Lane
Wandsworth Common
London
SW12 8NB

Tel: 02086733495
Website: www.nightingalehouse.org.uk

Date of inspection visit:
22 February 2016
23 February 2016
24 February 2016

Date of publication:
31 May 2016

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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

We conducted an inspection of Nightingale House on 22, 23 and 24 February 2016. The first day of the inspection was unannounced. We told the provider we would be returning for the second and third days. At our last inspection on 11 December 2013 we found that the provider was meeting all of the regulations we checked.

Nightingale House is a care home with nursing for up to 215 older Jewish people. There are five units at the home, each overseen by individual unit managers who are accountable to the Director of Care who is the registered manager of the home. Sampson and Ronson units provide care to people with advanced nursing needs. Sherman and Wine units provide residential care for people with dementia. Wohl unit provides residential care for people with advanced dementia needs.

There was a registered manager at the service. 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.

Staff had completed medicines administration training within the last year and were clear about their responsibilities. Pain assessments were carried out appropriately and these were monitored by the GP.

Risk assessments and support plans contained clear information for staff. All records were reviewed every month or where the person's care needs had changed.

Staff demonstrated knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005.

Staff demonstrated an outstanding understanding of people's life histories and current circumstances and supported people in an exceptionally caring way. Staff took time to get to know people to deliver empathic care that produced positive results for their well-being. One person had a newspaper activity group created specifically for them that other people also enjoyed as it allowed them to continue a pastime they had always taken part in. The service employed a 'Person Centred Care Facilitator' who helped care workers to provide a specifically tailored approach to people's individual needs. There were numerous examples of this being delivered in practice.

People using the service and their relatives were involved in decisions about their care and how their needs were met. People had care plans in place that reflected their assessed needs. These were clear and easy to follow.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role. Staff were provided with appropriate training to help them carry out their duties. Staff received regular supervision. There were enough staff

employed to meet people's needs.

People who used the service gave us good feedback about the care workers. Staff respected people's privacy and dignity and people's cultural and religious needs were met. The service employed a religious adviser who provided formal and informal guidance and friendship.

People were supported to maintain a balanced, nutritious diet. Staff and volunteers had participated in training called 'Meals Matters' which allowed them to understand the dining experiences of people with dementia and how they could improve this. People were supported effectively with their health needs and were supported to access a range of healthcare professionals. The service had access to many in-house services including occupational therapists, physiotherapists, dentists, GP's and an in-house pharmacy.

People using the service and staff felt able to speak with the registered manager and provided feedback on the service. They knew how to make complaints and there was a complaints policy and procedure in place. Complaints were taken very seriously and there was evidence of considerable planning to implement learning from complaints. This included reflective meetings and further advice from external experts whose recommendations were implemented.

Activities were innovative, creative and bespoke. People were encouraged to participate in activities they enjoyed and people's feedback was obtained to determine whether they found activities or events enjoyable or useful. An activities programme was in place which spanned seven days a week and this included a mixture of one to one sessions and group activities. Activities were tailored to meet people's cognitive and physical needs. The service also used numerous volunteers to help deliver the activities programme.

The organisation had thorough systems in place to monitor the quality of the service. Feedback was obtained from people through residents meetings and we saw evidence that feedback was actioned. There was evidence of auditing in many areas of care provided as well as significant monitoring from senior members within the organisation which included a care governance board that had overall responsibility for the running of the home.

There was evidence of considerable joint working with outside organisations including City, Kings College London, Kingston and also Surrey Universities and St George's Hospital. The service had also been awarded 'beacon' status by Trinity Hospice under the Gold Standards Framework which is the highest status offered, which meant they delivered innovative and established good practice in end of life care.

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. The service had adequate systems for recording, storing and administering medicines safely.

The risks to people's health were identified and appropriate action was taken to manage these and keep people safe.

Procedures were in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

Is the service effective?

Good

The service was effective. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff demonstrated a good knowledge of their responsibilities under the MCA.

People were supported by staff who had the skills and knowledge to meet their needs. Staff received an induction and regular supervision and training to carry out their role.

People were supported to maintain a healthy diet. People were supported to maintain good health and were supported to access healthcare services and support when required.

Is the service caring?

Good

The service was caring. People using the service and relatives were pleased with the level of care given by staff.

The service had developed and was delivering a person centred care programme run by a person centred care facilitator which helped staff to deliver individualised and empathic care. Staff were trained to think about people's experiences of the care they were receiving and how this could be optimised to create positive outcomes. For example, staff had specifically created an

activity for one person as this reduced their anxiety.

People's privacy and dignity was respected and care staff provided examples of how they did this. People's religious requirements were met by an in-house religious adviser who responded to people's individual needs in a caring way.

Is the service responsive?

Outstanding ☆

The service was outstandingly responsive. People's needs were assessed before they began using the service and care was planned in response to these.

People were encouraged to be active and participate in activities they enjoyed. Activities provision was innovative, creative and bespoke. There was a dedicated activities coordinator on each unit and the activities programme spanned seven days a week. This included group activities, one to one sessions and outdoor visits. The programme was also delivered by numerous volunteers who were organised by a specifically employed volunteer coordinator.

People told us they knew who to complain to and felt they would be listened to. Complaints were taken seriously and there was evidence of considerable reflective thinking and learning about complaints. We saw evidence of considerable planning to implement changes in response to one complaint received. This included reflective group sessions with staff involved and advice obtained from an external expert.

Is the service well-led?

Good

The service was well-led. Staff gave good feedback about the registered manager.

Quality assurance systems were very thorough. Feedback was obtained from people using the service in residents meetings. Unit managers completed various audits and these were overseen by senior boards within the organisation to provide feedback and further guidance. We saw evidence of action taken in response to recommendations made which improved the quality of care people received.

There was evidence of considerable joint working with outside organisations including Bradford University, Buckingham University and St George's Hospital. The service had also been awarded 'beacon' status by Trinity Hospice under the Gold

Standards Framework which was the highest status offered. This meant they delivered innovative and established good practice in end of life care. We saw evidence of feedback received from relatives of people who had received end of life care at Nightingale House. Feedback was positive and demonstrated gratitude to the staff involved.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22, 23 and 24 February 2016. The inspection team consisted of five inspectors, a specialist advisor and a pharmacy adviser. On this inspection the specialist adviser was a nurse with expertise in dementia care. The first day of our inspection was unannounced, but we told the provider we would be returning for a second day and third day.

Prior to the inspection we reviewed the information we held about the service. We contacted a representative from the local authority safeguarding team and spoke with two professionals who worked with the service to obtain their feedback.

During the inspection we spoke with 14 people using the service and seven relatives. Some people could not let us know what they thought about the service because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with 35 members of staff which included care workers, nurses, activities coordinators and the head of activities, the chief executive of the organisation, the registered manager, unit managers and members of individual teams including the pharmacy team and GP practice. We also spoke with the person centred care facilitator, the head chef and general manager and the religious adviser. We looked at a sample of 17 people's care records, 20 staff records and records related to the management of the service. We also spoke with two external social care professionals to obtain their views of the service.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. Comments included, "The building is secure" and "I feel very safe with the carers."

The provider had a safeguarding adults policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training and demonstrated a good understanding of how to recognise abuse. Staff knew how to report safeguarding concerns and explained the various signs of abuse and different types of abuse. One care worker told us "Reporting concerns is so important. Even small things could turn out to be serious problems." Another care worker said "It's so important to be aware. The signs are not always obvious." We spoke with a member of the safeguarding team at the local authority and they confirmed they did not have any concerns about the safety of people using the service.

The provider had a whistle blowing policy in place and staff explained this to us. One care worker said "We have a whistle blowing policy. I would use this to continue reporting upwards if I didn't think I was being taken seriously." Whistleblowing is when a care worker reports suspected wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

Staff received emergency training as part of their mandatory training which involved what to do in the event of an accident, incident or medical emergency. Staff told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. For example, one care worker described an incident that had taken place on the morning of the first day of our inspection. She explained that she assessed the person, called for help and reassured them. This person had not sustained any injuries, but we saw a report had been filled in for the incident describing what had happened and what action had been taken as a result. There was an emergency call bell in place to alert all staff to emergencies. We saw call bells were in place in people's rooms and that these were within reach and in working order.

We asked nurses about what they would do in the event of a medical emergency and they explained what training they had completed to respond to these situations. Nurses were aware who was for and was not for resuscitation. These details were in people's files on "Do not Attempt Resuscitation" forms which had been signed by their GP.

We looked at 15 people's support plans and risk assessments. Risks were assessed through a number of standard assessments and tools which were reviewed on a monthly basis. Assessments were conducted for moving and handling, falls risks, tissue viability, nutrition and hydration and pressure ulcer risks among others. Specific risk assessments were also conducted in relation to certain risks which were specific to individual people. The assessments included detailed information on the level of risk, when it was identified, any potential triggers and action plans for staff to minimise the risk. The assessments were reviewed at least every month or sooner if people's needs had changed. This meant that people's records contained up to date information about any risks associated with their care. Where people were identified as being at high

risk, specific care plans were also in place to help staff to provide care that was specifically tailored to meet their needs and protect them from avoidable harm.

Each person had 10 standard care plans in place in addition to the risk assessments. These were in place for medicines and pain management, eating and drinking, communicating, moving about, elimination, sleeping and end of life preferences among others. Additional care plans were also in place to document care specific to people's needs. These included care plans for pressure ulcers, challenging behaviours and covert medicines administration. Care plans included a summary of people's needs and practical guidance for staff in supporting people. Care plans were evaluated on a monthly basis by the person's key worker. A key worker is a person who has been assigned to work closely with the person and ensure their needs are met. Care plans were up to date, clearly written and easy to follow. Care workers demonstrated that they were aware of the details in people's care records. When questioned, care workers demonstrated that they were aware of risks to people and how to manage those risks.

Care workers told us they felt there were enough staff on duty to do their jobs properly. Comments included "We are fully staffed and there are enough of us rota'd at any time. The manager also works hard to cover for people who have called in sick" and "There has been a big recruitment drive to keep staffing levels constant. There have not been any problems."

Each unit had its own unit manager who organised the staffing rota. The numbers of staff were organised to account for the activities people were doing in a day, whether people had appointments or were receiving one to one care. Dependency levels were assessed using a 'staffing ladder'. This was a chart that tallied the occupancy rate with the skill mix of staff available to determine the numbers of staff required at any one time.

We reviewed the staffing rota for the week of our inspection and this accurately reflected the number of staff on duty. Staffing levels were appropriate to people's needs and where people required higher levels of care, they were assigned a care worker on a one to one basis.

Management at the service were proactive in ensuring staffing levels met people's needs. We spoke with the registered manager about the difficulties he had encountered in recruiting nurses. He explained that as part of a project conducted by Nightingale House he and other members of staff had conducted research into which European nursing standards most adequately matched those of the UK and on advice from the Nursing and Midwifery Council (NMC) had recruited eight nurses from Greece. Pending registration with the NMC, these members of staff were working providing non-nursing care to people.

We looked at the recruitment records for 20 staff members and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms. Records of nurses also included their Nursing and Midwifery Council registration details.

People who were in receipt of regular pain medicines had pain assessments completed at least every month or more where required and these were overseen by the GP.

Medicines were delivered on a monthly basis for named individuals by the community pharmacy. These were stored temporarily within a pharmacy room, before being transported to the individual units. Controlled medicines were stored safely for each person in a locked cupboard on the unit and other medicines were stored in people's rooms. However, the temperature of medicines was not monitored in people's rooms to ensure they were being stored at safe levels. The registered manager agreed to look into

this issue.

We looked at the controlled drugs cabinets within three of the units at Nightingale House. We saw that controlled drugs were stored in an appropriately constructed safe in all three units. These medicines were recorded in a separate book and the amounts were checked twice a day by two nurses. We did a physical count of the controlled drugs in each safe and saw the amount recorded tallied with the amount available.

We saw examples of completed medicine administration record (MAR) charts for 16 people for the month of our inspection. We saw that staff had fully completed these. Staff members retrieved medicines from people's rooms with their permission and we counted the amounts stored. We saw these tallied with the records kept.

We observed medicines being administered to people during two separate periods on two different units. We saw that medicines were administered safely, however, we saw one example of medicines being administered unsafely. We reported this to a senior staff member who took appropriate action.

We saw copies of weekly checks that were conducted of medicines which included controlled drugs. This included a physical count of medicines as well as other matters including the amount in stock and expiry dates of medicines. The checks we saw did not identify any issues.

Nurses and other senior staff had completed medicines administration training within the last two years. When we spoke with staff, they were knowledgeable about how to correctly store and administer medicines.

Good

Is the service effective?

Our findings

People were encouraged to eat a healthy and balanced diet. People's care records included information about their dietary requirements which included details about their likes and dislikes. We saw records that detailed people's nutritional needs and allergies. This included specific risk assessments in eating and drinking and a separate swallowing risk assessment was also completed when necessary with evidence of input from their GP and speech and language therapists where required. Referrals to healthcare professionals such as dietitians and speech and language therapists were made when staff had concerns about people and records showed that staff followed advice about how to meet people's needs. Malnutrition Universal Screening tools (MUST) were in place and where people were identified as being at specific risk of malnutrition, we saw management plans were in place to address this. Monthly weight checks were also completed where there were concerns about a person's nutritional intake to ensure that any significant weight loss or gain was identified and responded to promptly to meet any healthcare needs.

People gave mixed feedback about the food available at the service. People told us "Food is always a contentious issue. They [staff] do their best to accommodate, but everyone has their likes and dislikes." "The kitchen staff are very good. They try their best" and 'I think the food is really good. I always have the choice to eat it in the dining room or in my room if I feel like it.'

We spoke with the chef and general manager of the catering company that provided all the meal services. Senior members of the catering team had an active relationship with the home's allocated community dietitian and the Speech and Language Therapy (SALT) team. Catering staff ensured the guidance of health professionals was followed, such as in the provision of pureed or fortified food. The head chef had undertaken specialist training to meet the needs of people in relation to nutrition. For example, they had completed food fortification training to support people to increase their calorie intake when there was a risk of malnutrition. The head chef had also completed training in the adaptation of food preparation for people with dementia to prepare meals that looked more appetising and were more stimulating for people. An example of how this was done was through the addition of beetroot puree to some dishes, which helped to make food more visually stimulating for people.

A pantry was available on each unit, which was re-stocked routinely on Mondays and whenever needed at other times. The pantries included vitamin juice, hot chocolate and fresh sandwiches. Care staff were able to provide people with snacks outside of scheduled mealtimes if needed.

The catering staff conducted 'food forum meetings' every three months to discuss the menu for the season ahead. The chef also altered the menu each month depending on the feedback received directly from people and we saw a copy of the menu for the month of our inspection. Food was seasonal and variations were made according to the season. We saw there was an additional 'diabetic desserts menu' for people whose sugar intake needed to be controlled and an 'afternoon tea cakes' menu which included different cakes each day. There was also an additional menu which included foods that could be prepared quickly for people who did not like anything on the main menu. We observed the lunchtime period on each of the units on the first day of our inspection. People were served their food quickly and politely and staff approached

people to ask for their feedback. One person told the member of staff that they did not like their meal and requested something else. They were brought another freshly prepared meal quickly and the person confirmed they liked it. We sampled the lunch on each day of our inspection. The food was appetising, of a good portion and served at the correct temperature.

Care records contained information about people's health needs. The service had up to date information from healthcare practitioners involved in people's care, and senior staff told us they were in regular contact with people's families to ensure all parties were well informed about peoples' health needs. When questioned, care workers demonstrated they understood people's health needs. For example, all care workers told us how people were feeling on the days of our inspection and if they had any specific health conditions.

The service had an in-house GP service which assigned a GP to each unit. GPs visited each unit every week and were also available to answer emergency calls. The in-house service also employed an advanced nurse practitioner who was the initial contact for emergency requests. There was also an in-house therapy team which included eight occupational therapists (OTs) and physiotherapists. When people first joined the service, they received an initial assessment from both the physiotherapist and occupational therapist to determine their needs and we saw their reports were included in people's care records. Thereafter, people were assessed by the OT and physiotherapist on an annual basis unless they required more input from the team due to having advanced needs. The team provided manual handling training to care workers and responded to direct requests for guidance and support on a daily basis.

Nightingale House also had an in-house pharmacy department and visiting ophthalmologist, optician, audiology and dentist services allocated to them. This meant that healthcare services were available quickly and communication between healthcare professionals, key workers and nurses on individual units was consistent.

People could choose to use alternative healthcare services and we saw evidence of this in people's healthcare files which included contact with alternative chiropodists, opticians and dentists. These professionals conducted visits to the service and we saw records of their visits and advice that was documented and followed.

People told us staff had the appropriate skills and knowledge to meet their needs. People commented that "Staff are extremely competent" and "They are very good." A relative also commented "I've had no concerns about staff whatsoever. They all seem to know exactly what they're doing and they do it with kindness and grace and just make everyone feel like they're at home." The registered manager told us, and care workers confirmed, that they completed training as part of their induction as well as ongoing training. Records confirmed that all staff had completed mandatory training in various topics as part of their induction. These topics included safeguarding adults, moving and handling, infection control and the Mental Capacity Act and DoLS among others. There was also more specialist training available where required, for example courses had been arranged in using enteral feeding pumps for people who could not eat by mouth, diabetes and dementia care mapping which helped people to provide personalised and empathic care for people with dementia. Care staff had also undertaken denture training, which included advice on individual brands of denture products and what staff could do to help people maintain their dentures using these brands. We reviewed staff training records and saw staff had completed mandatory and additional training where required.

Care workers confirmed they could request extra training where they felt this was needed and they felt they received enough training to do their jobs well. Comments included "They try and motivate us to learn more"

and "They give us more specific training when needed. For example we've had training in the holocaust to help us understand some of the experiences of some of the people who live here." Care workers told us they were given protected time for training, which meant they were always up to date with mandatory training sessions. Senior staff had also recognised that those who worked regular night shifts were often at risk of missing organised training sessions. To address this, twilight training sessions had been introduced to ensure night staff would benefit from specialist training.

Staff told us they felt well supported and received regular supervision of their competence to carry out their work. We saw records to indicate that staff supervisions took place every two months. We were told by the registered manager and care workers that they used supervisions to discuss individual people's needs as well as their training and development needs. The registered manager told us annual appraisals were in the process of being conducted for the first time. At the time of our inspection some staff had received annual appraisals and some had not. The registered manager told us and records confirmed that discussions which were arranged for annual appraisal had previously been incorporated within the two monthly supervision sessions. We looked at supervision records for three staff members on one unit and for one person we looked at their supervisions for a year. We saw this person had progressed to a more senior role in the course of the year. We saw all supervision records contained details of people's learning and development needs as well as targets for improvement.

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.

We checked whether the service was working within the principles of the MCA, and found that the provider was meeting the requirements of the MCA. Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent.

Two units within the building were 'closed' units. This meant that people could not leave without being accompanied by a member of staff for their own safety. These units had electronic key pads by the doors which required a code in order to leave. We saw that each person who was living within these units had a Deprivation of Liberty (DoLS) authorisation from the local authority in place which demonstrated that they could legally be deprived of their liberty for their own safety and this was the least restrictive option to ensure this. Where people required additional restrictions on their liberty, for example bed rails, we saw that mental capacity assessments had been conducted which determined that this was the least restrictive option to determine their safety. Where people had bed rails in place we saw additional risk assessments had been conducted to determine that these were safe and these included practical guidance to staff. For example, in two risk assessments we saw evidence of recommendations made to conduct two hourly observations throughout the night to ensure people were safe in their beds. We saw these records were completed and up to date.

Additional DoLS authorisations were not in place for these people, but we spoke with the DoLS lead at the local authority who confirmed that these were not required in addition to the mental capacity assessments for people within these closed units. The DoLS lead confirmed that staff at the service were proactive in their communications with their team and kept them informed of the status of restrictions being placed on people in monthly 'DoLS monitoring' reports. We saw monthly audits were conducted which determined whether the restrictions were still necessary and if DoLS authorisations were still in date.

Where people had their medicines administered covertly, mental capacity assessments were conducted and decisions made by the service GP. We saw decisions were recorded by the GP in people's separate healthcare files.

Good

Is the service caring?

Our findings

People who used the service gave us good feedback about the care workers. Comments included "Staff are caring and kind" and "Staff are excellent. All the carers are extremely good." Relatives also told us they were happy with the care provided. One relative told us "We have seen amazing, person-centred, very tailored care right from the start. We've been amazed by just how naturally [our family member] has settled in because the staff are so kind and so attentive."

Staff demonstrated an excellent understanding of people's life histories. Senior staff and care workers told us they asked questions about people's life histories and people important to them when they first joined the service. We saw email correspondence between staff and people's families which documented the information staff had obtained. People's life histories were documented from their childhood, midlife and working years up to the present day including details of their families and people important to them. Staff members told us details about people's lives and the circumstances which had led them to using the service. For example, staff members told us that one person worried about their children and was comforted when told that their children were safe and well. This comforted the person when they were distressed and reduced their anxiety.

Another person had begun experiencing considerable anxiety as they were struggling to continue their pastime of reading the newspaper which is something they had done independently throughout their lives. In order to alleviate this anxiety, staff had created a specific newspaper reading group which helped them to continue reading the newspaper and discuss the contents to help them understand. This reduced the person's anxiety, but also created an activity that other people enjoyed, creating an additional network for people who enjoyed discussing current affairs.

We spoke with an agency care worker who told us they had been given time to get to know people and build relationships as part of their induction and orientation. During our observations we saw they had developed caring relationships with people. We saw them engaging with one person who was demonstrably comforted by the care worker when they held their hand and walked around the unit talking with them.

Care records included additional person centred documentation. For example, each care record included a document entitled 'my life-style preferences' and this was a record of people's preferred routines, hobbies and preferences regarding food and drink and other matters important to them. Care workers were well acquainted with people's habits and daily routines. For example, they were able to tell us about people's likes and dislikes in relation to activities as well as things that could affect people's moods. For example we observed one person was agitated and we saw care workers encouraged them to get involved with an activities session. We observed their mood to change immediately as they appeared to enjoy themselves immensely.

Attention to detail had also been included in the recording of information around people's end of life care wishes. For example, staff had noted one person wanted to die holding the hand of a loved one and with their relatives in the room. A member of staff who knew the person well told us they had noted the person

was often calmed by gently stroking their forehead. This meant staff had developed an understanding of subtle acts that helped to reduce anxiety in caring for people.

The service had developed a person centred care training programme which had recently become mandatory for staff. This was delivered under the supervision of the 'person centred care facilitator' who had trained in house 'champions' to deliver person centred care. The facilitator explained that it was their role along with the champions to observe staff and advise them in how to deliver care which was individualised and empathic. We asked the facilitator what this meant in practise and they told us "It could involve lots of things. It could be to do with staff's use of language, it could be about challenging staff behaviours. It could also be about understanding the triggers for some of the behaviours of the different people who live here with dementia and providing a service that responds appropriately to them."

We spoke with some of the person centred care champions and other care workers and they confirmed the importance of delivering a person centred service and challenging their own thinking and responses to some of the behaviours of people with dementia. Comments included "They've really gone out of their way to help us look after people with dementia by giving us training to help understand the condition. We have person-centred care training that was really in-depth and showed us how the brain functions when someone has dementia. Once you understand more about the condition, you can start looking after people much better." A nurse said, "The person-centred care training is all about how to offer people choices, even if they find this difficult or they can't understand very well because of dementia."

We saw from care records that the person-centred approach was used to deliver bespoke care in a variety of ways. For example, care workers had identified that one person with a professional legal background responded well to very formal communication whilst a person who had spent a lot of time with children responded more readily to informal, familiar communication. This understanding and adaptation of care enabled staff to treat people as individuals thereby maximising the chances of a positive response from them.

People we spoke with told us they were able to make choices about the care and support provided and told us their wishes were respected. One person said "I was pleased and surprised when I came here. They have tried hard to accommodate my likes and dislikes." Staff told us they respected people's choices and encouraged them to be as independent as possible. Comments included "We break down each task and encourage people to do the parts they are able to do. For example, [one person] can wash her face and comb her hair, but she needs some help with dressing so we help with that" and another care worker told us "We always encourage people to do as much for themselves as possible."

We saw good levels of interaction from care workers during our inspection. Interactions we observed and conversations we overheard demonstrated that staff knew people well and were on friendly and familiar terms. Staff took the time to sit with people, have conversations and laugh together. We observed the lunchtime period on each unit on the first day of our inspection and saw staff helping people with their food and having conversations with people as they were doing so. Mealtimes appeared to be unrushed, sociable events in the day and people appeared to be enjoying themselves. The Chief Executive and General Manager told us and other staff confirmed they too had been on a course called 'Meals Matters'. This helped them to understand the dining experience of people with dementia and how they should help people to enjoy their food. The General Manager told us "I learned that you have to really think about how you're helping people with eating. If you're putting a spoon in someone's mouth you have to think about how you're doing this as I felt how uncomfortable it could be to do this in the wrong way." This helped staff to help people with their meals in an empathic way.

We saw people's relatives visited the service throughout the day and they appeared to be on familiar terms with staff. We met some volunteers to the service and saw they were also on familiar terms with people living at Nightingale House. We observed volunteers engaging people in lively conversations throughout the day, joking and laughing with one another.

People we spoke with told us their privacy was respected. People told us "Staff are very respectful. They will check on you at night, but always knock first" and "Staff are very nice and very respectful." Care workers explained how they promoted people's privacy and dignity. Their comments included "When I'm giving personal care I make sure I only expose the parts that need to be exposed" and "I always respect people's wishes. If they don't want my help, I will leave them alone and check again later to make sure they are alright." We observed staff speaking to people with respect and knocking on doors before entering their rooms.

The registered manager and care workers told us the service had recently employed a Dignity and Safeguarding lead nurse, who they were in the process of replacing. This person worked with staff to identify how caring they were and whether there were any training or cultural practice issues. They had conducted workshops and events for people and staff members to raise awareness about dignity in practise. For example, the service had recently held a 'Dignity Tea' event in which people, their relatives and staff had a party and talked about dignity issues. This helped to keep dignity at the forefront of relatives and staff member's minds and encouraged awareness of staff behaviours thereby improving the care provided to people.

Care records demonstrated that people's cultural and religious requirements were considered when people first started using the service. Nightingale House is a care home for older Jewish people. Therefore all people living at the service belonged to the Jewish faith. We saw initial assessments included details of people's specific cultural and religious requirements and this included details of which branch of the faith they belonged to.

People told us their religious needs were met. For example one person told us "I see the religious adviser regularly." They told us this was important to them and one of the main reasons they chose to live at Nightingale House. The service employed a religious adviser and had an in-house synagogue. We spoke with the religious adviser and he explained that he worked to accommodate people's religious requirements whether they belonged to the orthodox branch of Judaism or belonged to the 'reform' part of the faith. The religious adviser told us "This is an orthodox Jewish home, but we respect that some people are more flexible in how they observe the faith. I help people however I can." The religious adviser explained that he had adapted his services to be more interactive in order to appeal to people with dementia. He told us and people confirmed that he conducted visits and provided religious and informal discussions and guidance on a daily basis. The religious adviser also had oversight of the storage of food within the kitchens to ensure that food was stored and prepared in accordance with Jewish teachings.

Outstanding ☆

Is the service responsive?

Our findings

Relatives we spoke with told us they were involved in decisions about the care provided and that they were aware of their relative's care plan. Comments from relatives included, "I know what is happening in my relative's care" and 'We are always involved in the care planning. We are always updated with any issues or healthcare concerns and they [staff] always get back to us."

People were encouraged to express their views and be involved in decisions regarding their care. People were given information when first joining in the form of a brochure which included details about the service provided and the core values of the service. Residents meetings were held on each unit on a monthly basis. We saw minutes relating to these meetings and saw various topics were discussed and actions had been taken to rectify issues raised. Care records also included details about people's views and staff explained that they prioritised people's choices in relation to their care. For example, care workers gave us numerous examples of how they respected people's choices in their daily lives. They told us people's food preferences, their preferred routines and their preferred activities.

People's needs were assessed before they began using the service and care was planned in response to these. A care planning pre assessment was completed covering various aspects of people's medical, physical and social needs. This also included discussions with people's family members about the type of support they would like to receive where appropriate. Care records included areas of care such as nutrition, continence and moving and handling which had been developed from the assessment of people's individual needs. Care records showed staff prioritised people's views in the assessment of their needs and planning of their care. Care plans included details about people's likes and dislikes in relation to a number of different areas including nutrition and activities. People's progress was reviewed at meetings with their key worker every month. People's views were then used to formulate future goals.

People were encouraged to participate in activities they enjoyed and people's feedback was obtained to determine whether they found activities or events enjoyable or useful. The service had a full time activities coordinator on each unit who implemented an activities programme that spanned seven days a week along with the assistance of numerous volunteers. Volunteer involvement in activities was monitored by a Volunteer Coordinator who kept track of what volunteer's skills were and matched them to people and activities accordingly. Activities were planned for the month in advance and they were displayed on noticeboards in each of the units within the building.

Activities provision within Nightingale House was innovative, creative and bespoke. We saw numerous activities during our inspection. These included concerts which included live music, singing and dancing, pet therapy sessions where people enjoyed holding soft animals, a current affairs discussions group and cookery classes. Sessions were tailored to the individual requirements of people living on each floor. One person told us "I enjoy current affairs" and later that day we saw them involved in a discussion group giving their views on the future EU referendum. We observed other activities which were tailored to people with limited cognitive abilities. We saw a 'garden therapy' session which was an evidence based session to engage people's senses. This involved the use of leaf props and branches, sound effects and videos to create

an indoor garden world. We spoke with the musician who used specific instruments, some of his own design to create sounds that stimulated the senses. We also saw part of a 'namaste' session which involved hand massages in a room with soft lighting, comfortable chairs and music to create a calming and relaxing atmosphere that people appeared to enjoy.

The activities coordinator was also leading a project to create a personalised playlist for each person. This involved talking with each person and finding out the songs that meant the most to them and compiling them together into a playlist. The activities coordinator said, "We noticed that when someone became quite agitated, a certain song would calm them down. So we looked at using music as a preventative tool for aggression and anxiety and found it worked really well. So the music playlists we're putting together are really about maintaining a calm and comforting environment for people as well as reducing instances of complex behaviour." The activities coordinator gave us some examples of when this had worked well and this included playing a song that one person used to sing to their children before putting them to bed in the evening.

The grounds of Nightingale House included large, well maintained gardens which included a bus stop, a decommissioned Morris Minor and a large fish pond. Care workers told us these features helped to make people feel at home and to keep their minds active. The person centred care facilitator further explained the importance of these features. They told us they could assess people's behaviours around these features and use them to learn about people's moods. For example, they said "If people are sat at the bus stop, we ask ourselves why. Do they want to go home? Do they not feel at home here and what can we do about this?"

For people who were not able to get out of bed there were bed therapy and bed based activities on offer on a one to one basis. We saw records of these sessions in people's care records and they included activities such as exercises and discussions. This kept people as active and engaged as they could possibly be.

People told us there were other activities on offer. The service used a mini-bus to transport people to the local shops, or cafes and restaurants within the local area. We overheard one person asking others if anyone wanted to join them to the local shops. One volunteer told us "I've been in every day this week. I went with residents to the Museum of Childhood and I'll be going to the theatre with some people tomorrow." The service also planned trips to the seaside.

People and their relatives commented positively on the activities available. One person said "I like the activities they put on. They take me out to the park. There's a girl who comes in and reads poems and people play the piano. I really enjoy it." A relative told us "So much thought goes into the planning of these and there's something for everyone. I was worried [my family member] wouldn't like organised activities here but there's no pressure to join in and staff have genuinely made sure there is plenty for [my family member] to enjoy. Today we were listening to the music together and we had a dance, it was the first time we've ever done that, it was a very important moment."

The service had a complaints policy which outlined how formal complaints were to be dealt with. People using the service told us they would speak with a staff member if they had reason to complain. We saw records of complaints and saw these were dealt with in line with the provider's policy. We saw evidence of changes made as a result of complaints. In one case we saw extensive planning had been conducted to correctly implement learning from one complaint. This had involved reflective sessions with all staff involved, advice from an external investigator and changes were being planned to risk assessments in order to ensure changes would take place.

Good

Is the service well-led?

Our findings

The service had an open culture that encouraged people's involvement in decisions that affected them. Staff and relatives told us the registered manager was available and listened to what they had to say. Comments from staff included "We have a good relationship with the manager, we can talk to him" and "He is a very approachable man." We observed the registered manager interacting with people using the service throughout the days of our inspection in a friendly manner. People, relatives, care workers and other staff also commented positively on individual unit managers. Comments included "She is fantastic. She always has time for us" and "I can approach the manager about anything that's concerning me."

The registered manager told us various staff meetings were held on a monthly basis and we saw minutes of these. Meetings were held on individual units and between the individual teams, for example the therapy team and management team. We saw records to demonstrate that issues were discussed and action plans were implemented as a result. Progress on action plans were then discussed at follow up meetings. Staff told us they felt able to contribute to these meetings and found the topics discussed were useful to their role. We saw numerous examples of changes made as a result of meetings which improved the quality of care for people. For example during the nutrition and hydration meeting specific people's needs were discussed and then followed up at subsequent meetings to see how they were progressing following the implementation of recommendations made.

We saw evidence that feedback was obtained from people using the service, their relatives and staff. Feedback was received during residents meetings as well as food forum meetings. People told us they found these meetings helpful and felt comfortable speaking in them. We were told by the registered manager that if issues were identified, these would be dealt with individually and we were given an example of when this had happened and how this had improved part of the care provided for people. We saw examples of the changes made to food following feedback from people. We also saw evidence of discussions held during staff meetings to implement learning as a result of identified issues.

We saw records of complaints, and accident and incident records. There was a clear process for reporting and managing these. The registered manager told us they reviewed complaints, accidents and incidents to monitor trends or identify further action required and we saw evidence of this. He told us all accidents and incidents were also reviewed by senior staff at quarterly health and safety committee group meetings. This board level group which was run by one of six directors of the organisation provided overall management and oversight of health and safety matters and we saw their meetings were minuted with follow up actions for review at future meetings. We saw evidence of specific recommendations followed to improve the safety of the building for people living at Nightingale House.

Information was reported to the Care Quality Commission (CQC) as required. We spoke with a member of the local authority and they did not have any concerns about the service.

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. The service had a clear organisational structure

with responsibilities outlined and followed. The service care governance board had oversight of all that happened within the home. There was also a group of 13 trustees. The care governance who consisted of leading professors and clinicians who provided an independent quality assurance system to monitor and review the running of the home. The service had a CEO who was supported by a senior management team of six directors who were responsible for care, HR, facilities, finances, operations and marketing. The director of care was also the registered manager of the organisation and was supported by unit managers for the separate units within Nightingale House. The unit managers were supported in turn by the team leaders, nurses and care workers.

We spoke with the team leaders, nurses and care workers about their responsibilities within the organisation. They explained that their responsibilities were made clear to them when they were first employed. They provided us with explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of staff job descriptions and the details within these tallied with what staff had told us.

The provider had thorough systems to monitor the quality of the care and support people received. We saw evidence of numerous audits covering a range of issues such as medicines, falls, deaths, infection control and pressure ulcers among many others. Audits were reported to committees within the organisation which were run by either the directors or other senior management. For example, falls audits were sent to the therapy team which reviewed the data received through monthly audits. They provided feedback and possible follow up actions to the individual units and also compiled a report which was presented on a quarterly basis to the service care governance board. The board, in turn reviewed all information and provided further feedback and oversight.

The care governance board also conducted a general 'KPI audit' on a quarterly basis. The KPIs (key performance indicators) were based on the requirements stipulated within the Health and Social Care Act 2008 and associated Regulations. We saw the most recent audit which had been conducted in 2015. This showed that improvements were being made and sustained within the organisation, but there was also an action plan for continued improvement. These improvements were further considered in the service '5 year strategy' which included ambitious plans for the future of the home, but also provided clear and practical guidance as to how these ambitions were to be achieved and financed. This ensured the service was forward thinking and continually improving the delivery of care to people.

The health and safety committee reviewed all near misses and accidents and incidents and provided feedback to the individual units or made recommendations to implement further learning. A nutrition and hydration board discussed individual residents and was a forum for discussion and oversight of the treatment being provided to people with complex needs in relation to their nutrition and hydration. This board was also attended by the Wandsworth community dietitian in addition to representatives from each of the units. Records of minutes demonstrated good joint working and implementation of recommendations made.

The service also had a 'person centred care steering group' which was run by the person centred care facilitator. This group met every two months to encourage innovative thinking on how to make the service more person centred. Examples of ideas discussed which were recorded included activities such as the 'namaste' sessions, the work of the 'person centred care champions' to encourage improvements to the service and providing continual training sessions in how to tailor the service to people's individual needs. We observed how these ideas were delivered and how they improved the experience of people receiving care. For example we saw how the Namaste session relaxed people and created a calming environment for them and we spoke to the person centred care champions and heard from them how their training had

improved their delivery of care to people.

The provider worked extensively with numerous other organisations to ensure the service followed best practice. We saw evidence in care records that showed close working with local multi-disciplinary teams, which included the Behaviour and Communication Support Services, community dietitians and other healthcare teams. The service had direct access to some healthcare professionals who provided services on site, but also had good communication links with social services teams and DoLS leads. We saw numerous examples within care records of advice obtained and we saw evidence of this being implemented with positive outcomes achieved as a result.

The service also worked closely with Trinity Hospice in delivering their palliative care training and had also been awarded the 'beacon status' accreditation under the Gold Standard Framework (GSF) which was the highest accreditation available. This meant that the service was in receipt of training and implementing this in order to provide personalised, high quality end of life care. In order to achieve the highest status the service had to demonstrate innovative and established good practice across almost all of the standards. The registered manager was also an ambassador for the GSF and had conducted workshops and a presentation at Westminster under the framework. We spoke with a representative from Trinity Hospice about the end of life care provided at Nightingale House. They explained that they worked with a 'GSF lead nurse' to discuss end of life care and provide feedback and guidance. The representative also worked with 'GSF link nurses' at Nightingale House once a month by attending their monthly palliative care meeting to discuss specific people and how they could improve their end of life care within the GSF framework. The representative told us "Nightingale has worked hard to become and retain its GSF status– they have managed to involve all of the staff in this process and are constantly looking at how they can improve the care/knowledge they offer."

We read feedback from family members whose relatives had received end of life care at Nightingale House. Feedback was almost consistently positive with messages of gratitude to staff. Nightingale House held regular memorial services for people who had passed away which their surviving relatives attended. We spoke with one volunteer whose relative had died at the home. They told us they had developed a strong link to Nightingale House which stemmed from their gratitude for the end of life care they had provided to their relative. Since then, they told us they had volunteered for the home to help them to continue delivering excellent care to people. We spoke with another person whose partner had died at Nightingale House. They told us their partner had received the best care at the end of their lives and they had decided they too wanted to spend their final days at Nightingale House just as their partner had done.

Staff at the service had worked with numerous other organisations. This included Bradford University in the delivery of their person centred care which had delivered numerous positive outcome to people. Staff at the service had also worked with Chelsea and Westminster Hospital and Buckingham University to share and implement knowledge and learning. Staff at the service also worked with St George's Hospital to share training, audits and guidance and managers within the service also sat on external boards to discuss innovations and up to date learning and practice. For example, the head of the therapy team was the co-lead of the care home forum of the specialist section for older people at the College of Occupational Therapy.