Abi Oduyelu

Nightingale House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Nightingale House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 30 people over two floors in an older style adapted building. Twenty-one people were living in the service at the time of this inspection.

People's experience of using this service and what we found
People living in the service were not safe and were at risk of harm. The environment continued to put people at risk, including from the risk of fire. Lessons were not learned, and improvements were not made when things went wrong. Recruitment checks were not robust and failed to keep people safe.

People continued to be restricted from freely moving around the service. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible.

The registered provider failed to provide assurance the service was well-led, that people were safe, and their care and support needs could be met. The registered provider failed to act on serious concerns raised at the last inspection and take immediate action.

The last rating for this service was inadequate (published 6 July 2020) The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
The inspection was prompted following our last inspection of the service on 4 March 2020 where significant concerns were found. We did not receive assurances from the registered provider that enough actions were being taken to ensure people were safe and protected from harm. A decision was made for us to inspect and examine those ongoing risks.

We therefore carried out a focused inspection to review the Key Questions of Safe and Well Led only.

We have identified continued breaches in relation to the environment, oversight, governance, dignity and respect. Following the inspection, all those living at the service were supported by Southend Borough Council to find alternative accommodation and care.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not Well Led

Details are in our Well led findings below.

Nightingale House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Nightingale House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. At the time of inspection, the deputy manager had taken on the role of manager and was being supported by a previous registered manager of the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We continued to receive information about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service who continued to raise concerns about the service and people living in it.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● At the last inspection, we found the environment placed people at immediate risk of harm. We found significant issues requiring immediate action. This included concerns around fire, hot water temperatures and trip hazards around the service. We wrote to the provider and asked for this to be addressed immediately to mitigate any risk posed. The provider confirmed actions would be completed. We returned to the service on the 17 March 2020 and found that whilst some action had been taken to mitigate risks, people remained at risk of harm. There had been a leak from an upstairs bedroom which had led to a ceiling partially collapsing on a bedroom underneath. We identified that access to the bedroom below had not been made secure. This meant people living in the service, including those with a cognitive impairment, had unrestricted access to the area. We immediately raised this with the manager, who told us, "It's been like this for days. We (manager and support manager) raised the concern straight away on Thursday but no one came to look it for 4 days. No one has confirmed if the room was safe."

● People were at risk of harm from hot water outlets. We found temperatures in several bedrooms were extremely hot and not compliant with health and safety guidelines. Older people are often more vulnerable to scalds and burns as they become less sensitive to extreme temperatures. No actions had been taken to monitor this risk or try to reduce it.

● One person experienced an incident where they had choked on food. The person's care plan and risk assessment did not have information available to staff to follow when supporting with food and drink. No information had been updated since the incident. We spoke to the manager and asked for this to be reviewed immediately.

● During the inspection, we spoke to a health professional who was supporting people in the service who were receiving end of life care, including the person who had the choking incident. They told us they had raised previous concerns about the safety of people and the care they received with the management team, but they had not seen any improvements. This included staff competency to recognise and take actions when people's health deteriorated.

Whilst we did not find people had been directly harmed, the risk of harm had not been mitigated to keep people safe. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns and those of the visiting health professional with the manager and made a safeguarding referral to the local authority.

● At the last inspection, risk assessments relating to the environment were not robust enough to mitigate risk to people. This included Personal Emergency Evacuation Plans (PEEP) for use in case of an emergency.

At this return visit, we found that these were now in place and had been updated in line with people's current needs.

Staffing and recruitment

● At the last inspection, there were not enough staff to support people safely. The local authority sourced some support to help with the day to day running of the service. When we returned, we continued to find staffing was not adequate and were informed that staffing had been reduced by the provider having been initially increased. The manager told us, "I explained to him (the provider) about the staffing levels and they need to increase, but he does not want to agree. There was a lot of improvement when the staffing levels went up and the standard of the care improved."

● Since the last inspection, the dependency tool for people to determine their needs and the level of support they required, had not been updated. This meant the provider did not have a clear understanding of people's needs and staffing that was required to support them. We were concerned there were not enough staff with the right skills and competencies to ensure people's needs were being met.

Whilst we did not find people had been directly harmed, people were at risk of being cared for by unsafe staff. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There was a short period of time between this inspection and the last. However, despite support from the local authority and other professionals, no action had been taken by the service to independently ensure people's safety was being maintained. The provider had failed to take appropriate actions to ensure lessons were learnt and improvements were made.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The management team continued to lack oversight on what was happening in the service. We spoke to the manager and support manager about the provider's action plan that had been sent to the commission. This document outlined what actions the provider would be taking to make immediate improvements to the service. It also identified the manager and support manager as having delegated responsibility from the provider to make the required improvements. However, they told us they had not had sight of this. One said "100% we have no action plan with delegated tasks. We use our own initiative but there is no plan at all. We are just trying to make sure that our residents are looked after. Nothing has changed."
- The provider was not proactive about ensuring the quality of care being provided. Despite support from professionals and the local authority, they could not demonstrate the systems in place were keeping people safe and ensuring they got the care they needed. As a result, the local authority made arrangements to support people to move from the service to alternative care and accommodation.

Continuous learning and improving care

- The service continued to be unable to demonstrate that they had learnt lessons when issues were identified.
- Where concerns had been raised by external professionals about people's care, these issues had not been addressed and subsequent concerns were found on our inspection. For example, a visiting health professional told us they had raised concerns about people having dirty hair and being unclean as well as being slumped with no pillows to support them. During the previous inspection, we identified similar concerns, but no action had been taken to make improvements. This meant that the service had not taken opportunities to learn from feedback and improve people's experiences.

Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person was failing to ensure people's safety from the risk of fire, unsafe medicine practice and unsafe staffing levels.

The enforcement action we took:

We have imposed urgent conditions on the providers registration to restrict further admissions to the service