Joy Care Service Limited

Nightingales Residential 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection site visit took place on 11 and 12 April 2018 and was unannounced.

Nightingales Residential Care Home is registered to provide accommodation for persons who require nursing or personal care, for a maximum of 22 people. At the time of the inspection 14 people were living at Nightingales Residential Care Home, some of whom were living with dementia.

Nightingales Residential Care Home 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.

There was a registered manager in post at the time of the inspection. However, the registered manager was absent from the service due to maternity leave, of which we had been notified. An acting manager was covering the role, with support from one deputy manager and one acting deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the management was not clear and robust in the absence of the registered manager. We saw that staff did not always follow policies and procedures and that the systems of audit and quality assurance did not always identify and address all the areas that required improvement.

From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

We have made a recommendation that the provider seeks advice and guidance from a reputable source about Accessible Information Standard (AIS) to ensure staff are aware of their responsibilities.

Staff knowledge and understanding around Deprivation of Liberty Safeguards (DoLS) was not consistent, and staff had not received training in this area. We found that this had impact for at least one person during the inspection.

Staff had not received training to understand the needs of all the people living at the service. For example, one person had a diagnosis of epilepsy, yet staff had not received training on this and were not aware of the type of seizure the person would be likely to experience.
Medicines were not always managed safely in line with current regulations and guidance and the systems to administer medicines were not robust or always followed by staff. We found that administration records

were not always correct, that medicines were not always given on time and there were not always guidance documents.

Records were not consistent with the support people were assessed as needing, or that staff told us they had provided. For example, the records for a person who needed support to turn regularly did not match the frequency the turns were assessed to have been needed. People's care plans were not always updated when their needs changed.

We found that activities were not tailored to people's interests or past experiences and activity support was not offered consistently to all people living at the service.

People and staff told us there were enough staff on shift. We saw that staff knew people well and had good relationships with people. People told us they enjoyed time with the staff. People knew who to talk to if they had any concerns and we found that concerns and complaints were monitored and complaints acted upon in a timely manner.

People, relatives and staff spoke well of the service. Meetings and other methods, such as resident surveys, were in place to gain feedback from staff and people. People and their relatives told us they were involved in their care planning. People had regular access to healthcare and other professionals.

We found that the atmosphere at Nightingales Residential Care Home was homely, people told us they felt safe and their visitors were welcomed.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe.

Safeguarding, accidents and incidents were not always recognised and responded to appropriately.

Medicines were not always managed safely.

There were sufficient staff available to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Health conditions were not always recognised and monitored for people living at the service.

Staff did not always have the right training and skills to support people's needs.

People had regular access to healthcare and other professionals.

Is the service caring?

Good

The service was caring.

People told us they enjoyed time with the staff.

Staff knew people well and had good relationships with people.

Visitors were made welcome at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities were not tailored to people's interests or past experiences and not offered to all people living at the service.

People's care plans had not always been updated when their needs changed.

People and their relatives were involved in their care planning.

Concerns and complaints were monitored and complaints acted upon in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The leadership was not clear and robust in the absence of the registered manager.

Systems of audit and quality assurance did not always identify areas that required improvement.

Records did not always reflect what we were told about people or things that had happened.

Nightingales Residential 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 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.

This inspection took place on 11 and 12 April 2018 and was unannounced.

The inspection team included two Inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used the information in the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted local authority commissioners of adult social care services and asked them for their views of the service provided.

During the inspection we observed the support that people received in the communal lounge and dining area of the service. Some people could not fully communicate with us due to their condition; however, we spoke with six people, three relatives, one visitor, six care staff, the cook, the acting manager, deputy manager, the acting deputy manager and the provider. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, including four people's care records, four staff files and other records

relating to the management of the service, such as policies and procedures, accident/incident recording and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

The provider had safeguarding procedures in place. Staff had received training and knew how to report instances of concern within the service, though they were not all clear about reporting concerns externally. An incident had not been recognised by staff as a potential safeguarding, in part because there were differences between what staff recognised as an accident or an incident. This meant a referral to the local authority had not been made; there were no records to indicate how they had managed the incident and what the outcome had been for the people concerned. This placed people at potential risk of harm or injury. Staff were aware of a previous safeguarding enquiry in relation to skin integrity and managing pressure areas, and documentation seen demonstrated learning had taken place and actions that were taken included improved communication with other professionals.

There were systems in place to manage medicines, but these were not consistently safe and people may not have been given the medicines they needed. For example, medicines were not always given in the morning as prescribed. Staff did not accurately record what time medicines were given. This meant there may not have been sufficient time between doses of the same medicines, which were prescribed three or four times a day. This may have meant they were not as effective or people could have had the next dose too soon. People that needed to take medicine only when required (such as pain relief) had guidance in place to provide staff with information about when the medicine was to be given. However, these had not been completed for all those medicines. In addition, staff had not consistently recorded when these medicines had been given; what they had been given for and if they had worked. Homely remedies (medicines that are not prescribed but are bought over the counter) were also given, for pain relief, upset stomach and diarrhoea. These had been agreed by the GP and there was a signed record to support their use but, there was no specific guidance in place for each person living in the home. In particular, this is important for people living with dementia, who may not be able to tell people if they feel unwell.

The provider had a system in place for checking medicine administration record (MAR) charts for any errors or gaps. Staff said they followed this and there were records to show that additional support and competency assessments had been used, to ensure staff had the skills to give out medicines safely when errors had been identified. However, we found this had not been followed; staff had signed a MAR retrospectively for a colleague using that person's initials and had recorded on the checking form that there had been no gaps. The person responsible for giving out the medicines was not allocated specific time to do this and they had to juggle different tasks, such as preparing breakfast trays at the same time as dispensing medicines. Staff told us that because of this, medicines were sometimes given to another member of staff to give to the person if they were busy, but an accurate record of this was not kept in line with good practice.

People were prescribed topical creams, these were recorded on the MAR as being received, but staff had not signed the MAR to show that the creams had been applied. This was discussed during the inspection. Staff discussed alternative ways of keeping a record in the future to ensure an accurate record of application would be kept.

The provider had not ensured the proper and safe management of medicines. Therefore, the above areas

are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were ordered, received and stored safely and only senior staff held the keys to access them. A fridge was available for staff to store medicines that needed to be kept within a certain temperature range and records showed that the temperature of the cupboards and fridge were checked daily to ensure medicines were safe to use. Staff told us that they had training about medicines and would then be watched giving medicines on three occasions before being considered competent to administer medicines without observation. This was then reviewed annually.

Recruitment procedures were in place to assess the suitability of prospective staff. These included completed application forms, two references and evidence of being able to work in the UK. A Disclosure and Barring System check had also been completed, which identifies if they had a criminal record or were barred from working with children or adults. However, gaps in employment history had not always been checked and references had not been consistently requested from previous employers. This meant that people were potentially at risk as the provider had not fully assessed the suitability of all staff.

Risks to people were assessed using recognised tools for nutrition and risk of skin breakdown. This risk information was shared with staff, with guidance on how to support the person to further reduce the risk. Risks around people's mobility were also considered and we saw that people had suitable aids available to support their independence when moving around.

Staff told us the number of staff on shift was sufficient for the number of people living at the service. A member of staff commented, "Yes there are enough staff, if we were full I think we would be really busy, but it is good at the moment." People were encouraged to use technology, such as call bells, to attract the attention of staff when needed. We saw that these were in reach of people as we went around the service. People told us, "As a rule they answer the bell pretty quick", "They're not too bad at answering the bell" though "Sometimes when they're busy they can be slow at answering the bell." Staff told us that the management team would support them to provide care, if this was needed. We noted that staff responded to people quickly when they needed support during the inspection. People told us staff helped them feel safe and one person said, "They look after me."

Risks around the spread of infection were well managed. For example, staff used personal protective equipment (PPE) such as aprons and gloves when supporting people with personal care. Risks relating to the environment were managed with regular safety checks of gas, electricity and water. Specialist equipment, such as hoists and stair lifts were regularly serviced. Individual environmental risk was looked at for each person with their care planning. Staff had been trained on what to do in the event of a fire. There were regular checks of fire alarms, firefighting equipment and emergency lighting.

Requires Improvement

Is the service effective?

Our findings

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. We saw that people were offered choices and staff understood how to support people to make choices. Staff had received training on the MCA and told us that they supported people to make their own decisions and would, "Always ask them what they would like for lunch and dinner," as staff, "Can't make decisions for them."

CQC monitors the operation of the DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The provider had not fully considered DoLS for people. There was no one subject to DoLS living at the home during the inspection, however staff were not clear who DoLS had and had not been applied for. Following discussion with the management team we were not confident with their knowledge and application of DoLS. For example, the front door was alarmed, so that staff knew who was entering or leaving the building. Staff said this was also to support one person who was at risk if they left the building on their own and may not tell staff they were leaving. Some staff told us they thought this person was subject to DoLS, however, we found that a valid application had not been made at the time of the inspection. We observed there were occasions when the door was opened by visitors and for deliveries and staff had not responded to the alarm going off. We also found an external door, which led out from the room where the medicines were stored to the garden, was open on occasions during the inspection. This meant people could be at risk, if they left the building without staff support and from unknown visitors to the home.

The provider had not arranged appropriate training for staff to enable them to understand people's needs and develop the skills to meet them. For example, one person was diagnosed with epilepsy and the type of seizure they experienced was described within their care planning information. However, on discussion staff were not aware of the type of seizure this person experienced although they told us they had observed this person having seizures. They had not recorded these, which meant that patterns or increases in the seizure activity could not be tracked and monitored and the person may not have received the support they needed.

The provider had used a recruitment agency to employ care staff and two agency staff had started to work at the home on a three-month trial basis. There was evidence from the agency that staff had completed relevant training but, the provider had not interviewed the staff before they commenced work and had not ensured they completed induction training. Staff told us new staff always worked with more experienced staff until they were competent to provide support on their own. However, there was no system in place to

assess the competency of the agency staff and therefore there was no evidence that they had an understanding of people's needs and the skills to provide the right support and care for people.

Records around the daily support provided to people were focussed on tasks completed. We were told that staff had not received any training on how to write these.

The provider had not ensured that staff had the appropriate support and training to enable them to carry out their duties. Therefore, the above areas are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who were employed directly by the service told us that they received induction training, which involved completing online training, reading people's care plans and shadowing established members of staff. Staff told us that the management team, "Show and teach you all you need to know." We saw that the management team had asked staff about their training, and changes were made when it was felt the training delivered had not met expectations. Records about the training staff had completed showed the staff had received training on essential subjects like fire safety and first aid. They had also had some specialist training on dementia awareness and brain injury.

Staff told us that they had regular supervision with the management team and were able to talk about their work and share ideas and feedback. Staff gave us examples of suggestions they had made to improve the service and how these were put in place such as the use of reflective tape on the turning to the home to make the turning clearer when it was dark. Staff meetings were also held, to allow discussion within the staff team.

People had guidelines in place around eating and drinking written by Speech and Language Therapists (SaLT). Staff knew about people's guidelines for eating and drinking and any food allergies they had. However, the evening meal was not fully considered for those on a pureed diet, as they may have been getting fewer calories than others. People who required a pureed diet were receiving a soup for an evening meal during the inspection, and others were offered soup and sandwiches or cheese on toast. We raised this for staff to consider. Some people had been diagnosed with health conditions that were managed through their diet, for example diabetes. The management of this condition had not been considered by staff, who responded more to people's appetites.

People were offered two main choices at mealtimes and staff said alternatives were available if they did not like the choices or had changed their mind. People had mixed views on the food, telling us, "The food is good.", "The food on the whole is excellent, the lady cook is brilliant" and, "The food is not a good as it was, we get a choice of two." A visitor said, "I think the meals are very good, aren't they. Residents can have what they want." We observed lunchtime during the inspection and saw that people were offered choice and second helpings, if they wished. People were able to eat where they wanted to, including the dining room, lounge or their own rooms, and staff assisted people with their meals if required. Tables were laid out with condiments and napkins, a range of cold drinks was offered and it was a sociable time for people.

Staff recorded what people ate and drank if they had any concerns and regularly weighed people to ensure they were having sufficient food and drink. Staff said referrals to the GP were made when there were concerns.

People told us they had access to healthcare services, "We have a nice lady doctor who visits", and "I see the nurse on a Thursday and the doctor is very good." Relatives told us that people's healthcare needs were responded to and that people's wishes were respected. A range of other professionals regularly visited

people at the service including hairdressing, chiropody and a manicurist. We contacted healthcare professionals for comments and were advised by the local medical practice, "We find the care at Nightingales to be excellent. In our experience they are helpful and competent colleagues and provide a caring, safe environment for their residents."

The service told us through their provider information return (PIR) that they were planning building works and an extension to the service. This would include additional rooms with en-suite showers, lift access to the ground and first floors and refurbishment to the kitchen. Some people and families were aware of this, however, the planning was still at an early stage and work had not yet begun.

Good

Is the service caring?

Our findings

People told us they were comfortable and liked their rooms. One person told us, "The staff are excellent. I have everything I want and need." Although some people did not feel they had as much time with staff as they'd like and one person said, "They will talk to me if they can but they're so busy. It would be nice to have a chat now and again but they can't manage it." Conversations we saw between people and staff were respectful and relaxed.

Staff clearly knew people very well, most had worked at the home for number of years and had supported people as their needs had changed and some were now living with dementia. When one person became distressed, staff clearly understood the reason for their distress and spent time reassuring them. We saw conversations between staff and people were about their families and past experiences. Staff told us they enjoyed making people's lives happier and, "Showing them that you care."

Staff clearly cared about people's wellbeing and were monitoring how they were, we saw that one person was very quiet and sleepy during the first day of the inspection. Staff told us about whether this was usual for them, and how they supported them on those days.

Throughout the inspection we saw that staff respected the privacy and dignity. They knocked on bedroom doors and asked if they could enter and were discrete when they asked people in the lounge if they wanted to use the bathroom. People's care plans included detail on how people liked to be supported during intimate care and included their level of independence so this could be promoted by staff. A member of staff and a person living at the service had a shared first language and they were able to talk together in this, benefitting them both. People's cultural and religious needs were respected and supported by the service.

We saw that people had good relationships with staff and were encouraged and their independence and right to choose was respected. For example, one person was encouraged by staff to elevate their legs and loosen their shoes. The person accepted a foot stool to elevate their legs, but did not feel that loosening their shoes was required, and this was respected by the member of staff.

Visitors to the service told us they were made to feel welcome and people said, "There's no set visiting time." They said they were involved with their relatives care and updated when things changed.

Requires Improvement

Is the service responsive?

Our findings

People were not all supported to follow their interests and take part in relevant activities tailored to their interests. Staff told us that an art teacher visited fortnightly and we saw pictures produced by people were displayed in the lounge. Other visiting entertainments were musical and exercise based. People told us they chose not to take part in the activities. One person said "I don't really want to join in. I prefer not to go downstairs." Another person said, "I don't take part in any of the activities." We observed personalised interaction between staff and people, however, this was limited and there were long periods when people were sat in communal areas with little stimulation.

An entertainments officer was employed for eight hours a week. Records indicated that this was predominantly in support to one person and not all people we spoke with had met this person or were clear on their role.

During the inspection the Commonwealth Games were on the television. Staff told us told that the registered manager would normally arrange things around various themes, "The manager has organised different things in the lounge, like when Wimbledon was on, there were tennis balls hanging on the walls and residents had afternoon cream tea." However, this had not happened in their absence. This is an area that requires improvement.

Staff told us, "We support residents to go out if they want to. Most don't because they are not as mobile as they were and need support, but we can walk with them around the garden at any time." We saw this happen during the inspection, that staff were taking people to walk around the garden, however, we also saw this denied to one person with no explanation by a member of staff. This person was then offered an opportunity to go out with another member of staff shortly afterwards.

Staff commented, "We are here to support people, it is their home and they decide what they want to do." and that, "Residents really decide what they want to do and how we should support them, it is their choice." Care plans detailed people's preferences about when they like to get up and how they like to spend their day. Staff told us that when people changed, they would advise the management team who would update their documentation.

People had been assessed before they moved into Nightingales; these assessments involved the person and those important to them and looked at any risks, such as a history of falls, and also the person's preferences with their diet and social interests. This assessment was then used as the basis of the person's care plans. Care plans had not always been updated when people's needs had changed, for example one person, who required food to be fork mashable, did not have this information reflected in their care plan, though this information was available in the kitchen. People and their relatives had been involved in the writing of their care plans. Care plans included information on people's previous life histories and we saw that staff had knowledge of this when interacting with people.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the

Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff said they had not received this training, although they had a good understanding of people's communication needs. People's care plans included information on the way that they communicated and any aids they might use, such as glasses or hearing aids. We saw that staff knew people well and tailored their communication to the person.

We recommend that the service seek advice and guidance from a reputable source, about Accessible Information Standards (AIS) to ensure staff are aware of their responsibilities.

People told us they would speak to the acting manager or their own family if they had a complaint, but they had not needed to do so. Information about the concerns and complaints procedure was displayed in the hallway. There was also a suggestions box so that comments could be made anonymously. Records of complaints were kept, and these detailed the action taken to resolve the issue.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was on maternity leave from the service and people told us that things were "different". Whilst some spoke positively of the management team, others told us, "It's been a bit upside down and not so good" and, "It's not quite the same whilst [the manager] has been on leave." People told us that the current management team were approachable, however, a relative told us, "Communication is not so good."

Staff who had been appointed to manage the service on a day to day basis, in the registered manager's absence, were not aware of their roles and responsibilities and this affected the service provided. This meant that although quality assurance audits had been completed regularly, these audits had not assisted in the recognition of all the areas of risk we found during the inspection. For example, there were six monthly checks on recruitment files, yet we found missing information in staff files. The management team had not kept up with developments with legislation and practice such as Deprivation of Liberty Safeguards and Accessible Information Standard.

Interactions between care staff and people were good when they happened, but opportunities to do so were lost. Staff took coffee breaks together and therefore not leaving sufficient staff to engage with people who were falling asleep in front of the television due to the lack of engagement. When we walked around the service, we noted that people's clean laundry was left on railings outside of their bedrooms, including undergarments. This impacted on people's privacy and dignity and we raised it with the staff during the inspection. The management team had not considered this as an issue until discussed during this inspection.

Opportunities to continuously learn and improve were not always recognised and taken forward, especially around the records kept by the service. For example, discussions with staff indicated that action had been taken following most incidents, however, this was not recorded. Records did not evidence that medical attention had been sought consistently when people were complaining of pain after a fall, though discussions with staff indicated that this medical support had been sought. A fall history document was compiled quarterly for each person, this indicated whether the number of falls people had experienced had increased or decreased. Staff told us, and we could see with the equipment that was in place for people that action was taken following falls; however, the records did not evidence this. Risk assessments were in place for people, but they were not monitored effectively. For example, one person had been assessed as needing support to turn at regular intervals, to reduce the risk of their skin breaking down. Records did not show this had happened as regularly as the assessment advised.

The provider had not ensured good governance had been maintained. Therefore, the above areas are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider of the service changed in 2017. Some people and relatives told us they had met the new provider, though some had not. The management team told us the provider visited weekly and had also compiled a quality monitoring report in December 2017, which we viewed. This had highlighted some areas

for improvement within the service, the provider told us these audits were planned to be carried out every six months.

There had been a survey sent out to residents and some family members in February 2018. We saw that the provider had written a report about the results. The provider had acknowledged people's feedback and planned to offer an outing to a local park. Staff were aware of these plans and spoke about plans to go to parks and garden centres. The provider had held regular residents' meetings to discuss the services provided, ask for feedback about changes that had been made and discuss any concerns.

People and their relatives told us the staff worked in partnership with other agencies such as district nursing, to ensure people received the right support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured good governance had been maintained. Appropriate systems and processes were not in place to fully assess, monitor and improve the quality and safety of the service provided. 17(1) (2a) (2c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff had the appropriate support and training to enable them to carry out their duties. 18 (2a)

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 provider had not ensured the proper and safe management of medicines. 12 (2g)

The enforcement action we took:

Warning notice