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Nightingale House Care Home

Inspection report

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Date of inspection visit: 2 March 2015
Date of publication: 01/05/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We inspected Nightingale House Care Home on 2 March 2015 and the inspection was unannounced. A previous inspection had taken place on 28 August 2013 where the home was found to have complied with the regulations.

Nightingale House Care Home is a care home without nursing providing accommodation and personal care for up to 21 older people. The premises are in the form of a large residential home with ordinary domestic facilities.

The home is managed by a registered 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. The registered manager was not running the home on a day to day basis and delegated this task to the deputy manager.

Although the majority of people thought that the staff were kind, not everyone felt safe at the home. Some

Summary of findings

people felt unsafe due to the way they were assisted by staff, particularly when being physically lifted or moved. One person complained that it hurt when certain members of staff were involved in their moving or lifting and expressed concerns about the way one member of staff spoke to them, which we raised with the manager. The manager began a process to investigate this. Staff records showed that staff had received training in moving and handling and health and safety.

The provider was not fully complying with regulations requiring that providers ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe.

You can see what action we told the provider to take at the back of the full version of the report.

The home environment was mainly safe from hazards and tidy. However, the building was not particularly suited for people who used wheelchairs, and some communal areas, such as the area where the public telephone was located posed a risk to people from being knocked by others.

Risks associated with people's care needs, such as mobility or eyesight, were recorded and staff were aware of these and supported people appropriately. There were sufficient numbers of staff to support the people living in the home and there were adequate recruitment processes to ensure suitable checks were carried out on staff before taking up their post.

People using the service received support with their medicines from trained staff. People received their medicines safely with appropriate records kept. Where people were able to, they were supported in managing their own medicines.

We found care plans to be up to date and people's changing needs were identified and acted upon appropriately. Staff sought people's consent before they took action and people were supported to live as they chose in the home. However, none of the residents we spoke with knew what was meant by care planning or recalled having been spoken with about their needs. We discussed with the manager and Vipin Parkash Nayar, the managing director, the scope for developing people's care records so that they fully involved the person, expressed more explicitly and directly the views and wishes of the people and described the agreed plan of care from their perspective.

People using the service told us that staff treated them with respect and they were happy living at the home. People told us the food was good and we saw that the menu of the day was clearly displayed on the board.

The service had a complaints procedure. However, people were not aware of it and were not clear how they would make a complaint. We observed good professional and friendly relationships between staff and people and staff were knowledgeable about people's needs.

The provider and manager encouraged an open culture in the home and carried out quality assurance checks of the building and equipment. Residents meetings were held monthly, although several people told us that they thought they focussed too much on food and not enough about life inside the home.

People and visitors spoke warmly about the manager and staff and felt they were committed to people and their care. There was a positive ethos and Statement of Purpose which described the values and aims of the service and the rights of people. However, the provider was not doing enough to ensure that people were more aware of the policies and aims that had an impact on them. The provider was also not doing enough to ensure that the methods it used to seek people's views and act on them were most appropriate to the needs of the people who live in the home.

The provider was not fully complying with regulations requiring providers to ensure that they regularly seek the views of people that include descriptions of their experiences of care and

treatment. This meant that the provider was not able to come to an informed view in relation to the standard of care and treatment provided to people.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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

Not all aspects of the service were safe.

There were arrangements in place to protect people from the risk of abuse and harm. People told us staff were kind and the home was free from hazards.

Staff knew people's needs and were aware of any risks and what they needed to do to make sure people were safe. Medicines were managed and administered safely.

However, some people told us they did not feel safe when staff were moving or lifting them and that on some occasions it hurt them.

Is the service effective?

Good

The service was effective.

People had their needs assessed and were supported to live the lives they chose. Several people told us they would like more to do in the home.

People were encouraged and supported to be independent and staff had suitable training in how to care for people.

Staff understood the requirements of the Mental Capacity Act 2005 and applied it appropriately to people in the home.

People had a balanced diet and varied meals and had access to health services for their ongoing healthcare support.

Is the service caring?

Good

The service was caring.

People were positive in their comments about staff and described them as kind and helpful.

Care staff knew people's background, interests and personal preferences well and understood their cultural needs.

Staff promoted an atmosphere of respect towards people and treated people with dignity. However, One person told us that they were concerned about the way in which a member of staff spoke to them.

Is the service responsive?

Good

The service was responsive

The service had care plans for people that described their health care and support needs. Care plans were updated and reviewed at regular intervals. However, people could not recall being involved in their care plan and care plans were clinical rather than holistic and from the person's own perspective.

Summary of findings

The service encouraged people to express their views and make their own decisions on a day to day basis and had systems in place to deal with comments and complaints. However, people did not know these systems or how to use them.

People spoke positively about staff and the manager and told us they were always accessible and happy to help them.

Is the service well-led?

Requires Improvement

The service was not well-led.

The deputy manager was visible on a daily basis at the home and were actively involved in ensuring that the home was led by example and regularly monitored.

There were good internal quality assurance checks and a culture of openness and support.

However, the provider and manager were not able to demonstrate evidence of external quality assurance processes or working in partnership with other agencies that could help their service develop. This meant that the provider was not able to verify that the service was being run along the lines of updated research or best practice.

The provider was not able to demonstrate that the methods used to seek the views of people enabled the provider to come to an informed view in relation to people's opinions and wishes.

Nightingale House 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.

The inspection took place on 2 March 2015 and was unannounced. The inspection team was made up of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had expertise in care for older people and disability.

Before the inspection we reviewed the information we had on the service, including past reports. We also looked at notifications and correspondence received from or about the service, as well as reports by the local Healthwatch team. Healthwatch teams gather the views of people about their needs and experiences of Health and Social Care services and make those views known to commissioners and providers of care and we looked at reports from a visit they had conducted in December 2014.

During the inspection we spoke with 12 people living at Nightingale House Care Home, four visitors, four care staff, the manager and director. We also spoke with a local Community Mental Health Team Occupational Therapist who was visiting one person using the service.

We looked at four care plans, three staff files, policies and procedures of the home, staff training records and medicines records. We observed the interaction between people and staff and looked at how people spent their day. We tracked the care provided to people through their care records and other documents which specified care or activities that people were engaged in.

Requires Improvement

Is the service safe?

Our findings

There were arrangements in place to protect people from the risk of abuse and harm and the home was free from hazards. People told us staff were kind. One person told us, "I like it here, the staff are lovely."

However, two people told us they did not feel safe when staff were moving or lifting them and that on some occasions it hurt them. One person said, "They don't understand how to move me. They say, we'll get the hoist and they know I can't stand it, it really hurts me." Another resident told us, "They get me out of bed for breakfast but I'm not washed or dressed. They say 'Come on, hurry up, and they puff and blow, and say, 'you can try harder.' It makes me cry because I do try."

One person informed us about a particular member of staff whom they felt treated them rudely and roughly. With the person's permission we raised this with the manager and owner with a request that they take this forward as a safeguarding matter with the local authority, which they were happy to do

Staff training records showed that staff had received training in People Handling and Health and Safety. However, there was no record of staff having been trained in the use of hoists and care plans did not illustrate how each person preferred to be assisted. This, together with the experiences of people meant that they had not been protected against the risks of receiving care or treatment that is inappropriate or unsafe.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to tell us confidently what they would do if they were concerned about someone, or if they felt someone was at risk of harm or abuse. They confirmed that they had received safeguarding training as well as other training which kept people safe, such as moving and handling, food hygiene and infection control. We saw that one safeguarding incident was in the process of being investigated by the local authority and that the provider and manager were supporting and assisting the process.

We looked at the home's policies and procedures regarding safety and found that safeguarding policies were in place as well as records of staff training in this area. Staff had also received training in Equality and Diversity which raised awareness of different cultures and faiths and emphasised people's dignity.

People's care plans were mainly in the form of a list of information about the person and their support needs and this included areas where they were most at risk. For example, care plans contained details of whether people were prone to pressure sores and recorded the procedures of turning which would minimise the risk and protect the skin. Other risks that were assessed included hydration and mental capacity. Notes were made as to how these risks could be minimised or managed.

There were no unnecessary restrictions on people's freedom to come and go or to move around the home as they pleased, although the nature of most people's conditions meant that they relied on staff to assist them.

The premises were safe and free from hazards. However, the building was not particularly suited for people who used wheelchairs, for example, a portable ramp was needed to enable wheelchair users to enter and leave the building, and some communal areas, such as the area where the public telephone was located posed a risk to people from being knocked by others. The impact and risk to people was not severe. However, we discussed this with the manager and owner who agreed to look at ways of improving these areas as three people do use wheelchairs at least some of the time. The local Healthwatch visit in December 2014 had raised similar concerns about the suitability of parts of the premises for people who use wheelchairs.

We saw that the home had suitable numbers of appropriately skilled staff for the 15 people living at Nightingale House Care Home. During the inspection there were three care staff, the deputy manager, a cook, with the manager there as an additional person. In the afternoon the same arrangements were in place with the exception of the cook. At night there was one waking night staff with one sleeping-in staff.

Staff rotas for the week showed that this was a typical staffing number. However, this did not include any separate domestic staff, and cleaning of the home was carried out by the evening shift.

Requires Improvement

Is the service safe?

The home had a clear recruitment procedure which included application and interview, reference checks and criminal checks. Induction was provided for new staff and staff were not permitted to administer medication until trained to do so.

Medicines were administered and managed appropriately and records were up to date. We looked at the records of three people and found they had been completed accurately and staff were able to describe clearly the procedures for administering medicines. Where people were able to, they were supported in managing their own medicines.

Good

Is the service effective?

Our findings

People were cared for by staff who knew and understood their needs. One person told us, "They do try to make sure you're comfortable."

The policies, procedures and ethos of the home all expressed the aim of supporting people to live the life they chose and to be as independent as they wished. The home had a statement of purpose which emphasised people's rights.

Care plans contained details of people's support needs and preferences which had been identified through assessment. Assessments included people's abilities such as mobility and communication and identified which other care services people may need, for example, community nursing, dentist or pressure ulcer care. People's care plans were monitored monthly and any changes to people's support needs were logged and discussed with staff.

People's assessed needs were being met by staff with the necessary skills and knowledge. We talked to staff and looked at staff records which confirmed that induction training took place for new starters, and this training included becoming familiar with people's history and support needs as well as the policies and procedures of the home.

In addition to induction training, staff received training in basic mandatory areas of care, including safeguarding, people handling, the mental capacity act, health and safety, food hygiene, infection control, equality and diversity, dementia awareness, nutrition and end-of-life care support. We looked at the training plan for 2014/2015 and saw that there was a system in place to ensure staff who required updated training received it.

This was further supported by a programme of individual staff supervision which took place every two months.

The Mental Capacity Act 2005 (MCA) sets out what must be done to ensure the human rights of people who lack capacity to make decisions are protected. Records confirmed that people's capacity to make decisions was assessed before they moved into the home and on a daily basis thereafter. The manager and staff had been trained in the general requirements of the MCA and the Deprivation of Liberty Safeguards (DoLS) and knew how it applied to people in their care.

People who lacked capacity to make decisions were protected by staff who were aware of the requirements of the MCA and who were able to explain how they supported people to make their own decisions or otherwise act in their best interests.

DoLS requires providers to submit applications to a "Supervisory Body" if they consider a person should be deprived of their liberty in order to get the care and treatment they need. There were appropriate procedures in place to make DoLS applications which staff understood and we saw that they were applied in practice. Several applications had been made by the registered manager.

There was a balanced diet and choice of food at mealtimes and we observed the lunchtime routine and talked with people during lunch. People told us that the food was good. One person said, "The meal is lovely." Another told us, "The food is always well cooked." We saw that people were offered the choice of eating in their rooms or in the main dining area.

Staff supported people to maintain good health. People were registered with a GP and were offered annual health checks. Staff supported people to attend appointments with their GP, hospital consultants, dentists, skin care specialists or other healthcare professionals.

People told us they felt able to see a doctor whenever they wanted. People were also able to tell us that the podiatrist and optician visited regularly. We saw that the home kept records of other professionals' visits to people.

Good

Is the service caring?

Our findings

People told us staff were kind. One person told us, “Staff, yes, they’re wonderful.” Another said, “Staff here are friendly and helpful, I’m very happy”. One resident, who was observed over a period of time and who appeared to have significant memory loss, told us, “They realise there is something there and they know I’m happy. I can walk a little. I don’t want much but I’m happy.”

We also saw feedback from relatives who had responded to a Healthwatch visit in December 2014. One had written, “My aunt is extremely well cared for. The home know my aunt and us very well and treat her with dignity and respect.”

Care plans were up to date and reflected the person's current needs and preferences. Each document addressed important areas such as health, mobility, independent living skills and social needs. Recent events including incidents, accidents, hospital admissions and health appointments were documented and we saw appropriate referrals to other healthcare professionals were being made as people’s needs changed.

People and visitors spoke warmly about the manager and commented on how he was personally accessible and present for most of the week and how he made time for people to answer any questions or receive comments.. Visitors also commented that they felt confident they could always call the home about anything and the manager would return the call.

Throughout the inspection we observed staff treating people kindly and attending to people’s needs in a caring and dignified manner, for example when going to assist someone who had difficulty walking. People told us that staff were kind and caring. One person said, “I feel safe here, and the Manager is very kind. “ One relative told us, “We looked at a number of places and they’ve respected her wishes and she appears content. She’s always clean and her hair nicely cut and washed.’”

People had their privacy respected, for example when they wished to remain in their room. However, staff were aware of people’s support needs and were able to ensure that people were sensitively monitored by carrying out regular checks on rooms.

Good

Is the service responsive?

Our findings

Staff understood people's needs and how they preferred to be supported. People's care records included risk assessments which focussed on the health care needs of people.

People told us that they felt able to make choices about how they spent their time at the home and maintain contact with relatives and visitors. One person said, "I choose what I put on and staff ask me what I'd like to wear". Another told us, "Relatives take me out and there's a lovely care assistant who takes me out when there's time".

During the inspection we found that staff were responsive to people's needs, for example when someone was distressed or anxious.

All residents spoken with, apart from one, felt they would like more activities or opportunities to do things, such as going out. The one resident explained, "We have people come from the church and we sing. That's nice. Graham, the pianist comes once a month, I think, and plays for us. I like that. I don't think there's anything else, but I do go out sometimes. I like a ride, or to go to the shops."

A Healthwatch enter and view visit carried out in December 2014 also found that a need for more activities was identified. At our inspection we saw that there were opportunities for people to carry out ordinary individual activities such watching TV, listening to the radio, reading newspapers, occasionally going out with a staff member or receiving visitors. Two people had their own private telephones with which they could maintain contact with friends and relatives. Most people received regular visits from friends or relatives.

We discussed with the owner and manager how care plans could be improved and developed to reflect the person as a whole and to describe their needs and preferences from their perspective. Although the home's care plans were detailed and up to date, they concentrated on tasks and medical information. None of the people we spoke with could recall having spoken to anyone about their care needs and did not know what a care plan consisted of. Relatives could recall being asked questions when someone was admitted to the home, but could not recall being involved in the care planning process.

The manager and owner agreed to consider ways in which they could develop person-centred care plans, which demonstrated more clearly the active involvement of people and their relatives.

The home had a complaints procedure which had been updated in January 2015. In December 2014 a Healthwatch enter and view visit had identified a need to develop the complaints procedure further and maintain a log of complaints.

The complaints procedure we looked at differentiated between verbal and written complaints. The stated aim was that complaints were seen as a learning opportunity for staff and hopefully could be resolved at the informal, verbal stage. However, there were clear procedures describing how to make a written complaint if that was what people wished to do.

Informal complaints or concerns were logged in handover notes or daily logs. None of the people we spoke with could recall the detail of making a formal complaint. However, people and visitors told us they felt able to complain and express views if they wanted to, and that they would speak to the manager. Visitors told us that the staff and manager always promoted positive relationships, interacted positively with people and provided hospitality. "When we visit we are always given a pot of tea and some biscuits", one visitor told us.

Requires Improvement

Is the service well-led?

Our findings

Whilst there was good day to day management by "walking the floor", there was no formal quality assurance strategy, or one which provided an objective, external analysis of the service.

As a consequence, the owner and manager were unable to demonstrate that the routines of the home, the delivery and management of care and the systems in place to monitor quality were the result of consulting with people or their relatives. There was little evidence that they were based on best practice or guidelines, for example, guidance from Age UK, My Home Life, Social Care Institute for Excellence (SCIE), National Care Association, Skills for Care or others.

This was further evidenced during the inspection of the other key question areas where there was scope for improvement, such as the suitability of premises, the personalisation of care planning, the range of meaningful activities on offer to people based on their life histories and preferences, the level of awareness of people regarding the homes policies and procedures (particularly those which impacted upon their rights, such as making complaints, or of the care planning process), the degree of involvement people had in planning their care or influencing the running of the home.

All of the above were negatively affected because the owner and manager were not able to show that they had quality assurance systems in place that adequately identified issues important to people, or from which they could develop a plan to address them.

This was a breach of Regulation 10) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visitors spoke warmly of the manager and said how kind and helpful he was to them and this was demonstrated in a number of ways through conversation and action during the inspection and from past experiences of people. One person said, "The Manager is good, he'd always help."

The management and quality assurance approach in the home was very much based on direct contact with the manager and clear lines of accountability within the staff team. Staff knew their roles and responsibilities within the structure. They also knew how to communicate concerns and had a good understanding of the service's policies and procedures.

On a day to day basis there was good, open communication between the manager and staff. One staff member told us, "I just love working here". Staff were able to demonstrate the values outlined in the statement of purpose, including dignity, respect and equality for people. There was good day to day leadership and delegation of duties to ensure tasks were completed.

However, there was little evidence that the manager or owner looked to develop their own professional awareness or update their knowledge of best practice in the field of caring for older people. The owner and manager played little part in any association or network, such as local care homes associations or organisations such as Skills For Care (a body that offers workforce learning and development support, sharing best practice and raising quality standards).

We looked at records kept in the home and found these were well maintained and up to date. The home kept policies and procedures relevant to the service, staff records, medication records, logs of checks made to equipment such as radiators in rooms and staff rotas.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services There was no record of staff having been trained in the use of hoists and care plans did not illustrate how each person preferred to be assisted. Regulation 9(1)(b)(ii) and 9(1)(b)(iii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The owner and manager were not able to show that they had quality assurance systems in place that adequately identified issues important to people, or from which they could develop a plan to address them. Regulation 10(2)(e)