Midland Healthcare Limited

Nightingale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 15 and 16 March 2016. Nightingale Care Home provides residential and nursing care, support and treatment for up to 49 people, some of whom are living with dementia. On the day of our inspection 26 people were using the service.

The service had a registered manager at the time of our inspection, but they had left the service in October 2015 and had not completed the process to deregister. A new manager had been appointed in August 2015 and had submitted their application to become registered. 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.

When we last inspected the service in May 2014 we found there were improvements needed in relation to people's safety. This was because not all incidents had been shared with the local authority for consideration under safeguarding procedures as they should have been. During this inspection, we found that systems to ensure that safeguarding referrals were made, when required, were still not robust and referrals had not been made when they should have been.

People felt safe in the service but not all incidents had been shared with the local authority for consideration under their safeguarding procedures prior to the intervention of external agencies.

Staff did not have time to sit with people and at times they did not notice when people required support.

People received their medicines as required and action was being taken in relation to infection control issues to reduce the risk of harm to people.

We found that people were not always protected by legislation designed to ensure that their rights were protected because the principles of the Mental Capacity Act 2005 (MCA) had not been consistently applied.

People were not always provided with the right level of support at mealtimes. Referrals were made to health care professionals for additional support or guidance if people's health changed.

We observed mixed interaction between people who used the service and staff. People's privacy and dignity was respected but people were not always routinely involved in decisions about their care.

Risk assessments and care plans had not always been regularly updated or contain sufficient information about how the risk of harm could be reduced.

People were at risk of receiving support which did not reflect their individual preferences and some people felt that the amount of activities at the service were limited. We saw that information was provided to assist

people in making a complaint and that complaints were responded to.

Improvements were required as to how people's views were gathered on how the service was run. Improvements were required in relation to management systems to ensure they were effective in addressing shortfalls in the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Systems to protect people from the risk of abuse were not fully effective. Risks to people were not always monitored regularly and acted upon.

Staff did not always have time to sit with people and they did not always respond to their needs in a timely way.

People received their medicines as required and action was being taken in relation to protecting people from the risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found that people were not always protected by legislation designed to ensure that their rights were protected because the principles of the Mental Capacity Act 2005 (MCA) had not been consistently applied.

People were not always provided with the right level of support at mealtimes.

Referrals were made to health care professionals for additional support or guidance if people's health changed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed mixed interaction between people who used the service and staff, many of these were caring but some were not.

People's privacy and dignity was respected but people were not always routinely involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's preferences were not always reflected in care plans.

People felt that the activities on offer were limited and we observed at times people received little stimulation.

Information was available about how people could complain about the service and action had been taken in response to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements were required in relation to management systems to ensure they were effective in addressing shortfalls in the service.

Improvements were required in the records kept of people's care.

Improvements were required as to how people's views were gathered on how the service was run and how an overview of the service was formulated.

Nightingale Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We inspected the service on 15 and 16 March 2016. This was an unannounced inspection. The inspection team consisted of one inspector, a specialist advisor, who was a nurse, 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received this information as requested. We also checked the information that we held about the service such as information we had received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the visit we spoke with 11 people who used the service, two relatives, four members of care staff, the cook, one domestic, one nurse, the deputy manager, manager and regional manager. We observed care and support in communal areas. We looked at the care records of five people who used the service, staff training and recruitment records, as well as a range of records relating to the running of the service including audits carried out by the deputy manager and manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service in May 2014 we found there were improvements needed in relation to people's safety. This was because not all incidents had been shared with the local authority for consideration under safeguarding procedures. We found that this remained an area for improvement during this inspection.

People could not be assured that incidents would always be responded to appropriately. Prior to our inspection, an external organisation had visited the service and identified four incidents which should have been reported to the local authority under safeguarding procedures and these had not been. These referrals were made to the local authority by the manager following feedback from the external organisation. During this inspection, we found not all staff were clear on the role of the local authority in investigating safeguarding allegations or whose responsibility it was to report concerns the local authority if the manager was absent. We looked at the service's policy and procedures in relation to safeguarding referrals and found that these were not clear on whose responsibility it was to make a safeguarding referral. This meant that people may not be protected from harm because staff did not know who should take action and report a safeguarding concern to ensure they were kept safe.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not receiving sufficient support to reduce the risk of harm. For example one person required a pressure relieving mattress and cushion to reduce the risk of skin breakdown. When we checked, the equipment was not in place. In addition, some people required regular checks throughout the night and it was not always recorded whether checks were being carried out at the required intervals to ensure that people were receiving the right support. This meant that people may not be protected from harm because systems to ensure the risks to people were reduced were not effectively monitored.

People's independence and freedom within the service was encouraged through the use of mobility aids. We observed that equipment was available and was being used safely to assist people to move around the service. People had plans in place to describe the support they needed to ensure their safety and wellbeing in the event of an emergency situation such as a fire. We saw that any falls people experienced were being recorded along with any action required to reduce the risk of people falling.

Staff told us that they felt people would benefit from increased staffing levels in the morning. Two staff members told us that there were times when people had to wait for support and that people would benefit from staff having more time to sit and spend time with them. We observed that people's requests for support were responded to by staff, but that staff were not always effectively deployed so that they had time to spend with people and recognise when people required support. For example, we witnessed one person who was sat at a table for approximately two hours with a drink. Staff did not approach the person to see if they required assistance to move or offer encouragement for them to drink. We did observe, however, that staff responded to call bells and door alarms in good time.

People could not be assured that recruitment processes were being properly followed because the system for ensuring recruitment was safe was not effectively monitored. We checked the recruitment records for three members of staff. Records showed that Disclosure and Barring Service (DBS) checks had been requested prior to staff commencing employment. The DBS supports providers to make safer recruitment decisions. We found that one person's DBS check had not been fully completed prior to them commencing employment due to an administration error.

People told us that they received support to take their medicines. One person told us, "They are very good. They make sure I have my tablets and they always ask if I've got any pain and if I need anything else." We observed the administration of medicines and saw that staff followed appropriate procedures when giving people their medicines.

We found that some improvements were required to the recording of medicines information. For example we found that the site of application for some medicines was not always recorded to ensure their effectiveness. At the time of our inspection, there was not always guidance for staff when to administer medicines that had been prescribed to be given when required (known as PRN). We received confirmation from the provider following our inspection that PRN protocols had been put into place where required. Other information to aid the safe administration of medicines was recorded, for example each medicines administration record (MAR) contained a photograph of the person to aid identification and there was a record of any allergies and the person's preferences for taking their medicines

We found that medicines were stored safely and stock checks of medicines were carried out regularly. The staff we spoke with were knowledgeable about medicines administration and told us they had received training and had their competency checked during observations by the manager. Training records confirmed that staff responsible for the administration of medicines had received training and all but one member of staff had their competency checked within the last few months.

People told us they felt safe at the service. One person's relative told us, "I am happier knowing [Relation] is safe. The relative told us that their relation had fallen previously in the family home but that, "[Relation] hasn't fallen at all here because the staff make sure [Relation] is alright."

We spoke to staff about their knowledge of infection control and found that they were knowledgeable about the use of safety measures and cleaning requirements to reduce the spread of infection. Records confirmed that staff had received training in infection control. Domestic staff hours had recently been increased following an infection outbreak and external audit which had highlighted concerns which could contribute to the spread of infection. We found that domestic staff were completing cleaning schedules and we saw that the environment and equipment were clean. We reviewed records for a person who had an infection and found that a care plan was in place and was being followed by staff. This meant that the provider was responding to concerns to ensure that people were protected by the prevention and control of infection risks.

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.

We saw people were usually asked for their consent before staff provided them with any care and support, although we observed one occasion where a healthcare professional arrived to see one person and they were told they needed to go down to their room. The person's chair was moved without informing or asking them first so that a care worker could assist them to get up from the chair.

People were at risk of decisions being made on their behalf that they may have been able to make for themselves. If people did not have the capacity to make a specific decision themselves, decisions may have been made without considering the person's best interests. We were informed by the manager prior to accessing people's care plans that the service was in the process of completing mental capacity assessments for people. We found that people did not always have capacity assessments and best interest decisions in place when required. For example, we accessed the care records of one person whose mental health care plan stated that the person's capacity to make decisions was impaired. The person was supported with their medicines by staff and could be resistive towards support with personal care. Capacity assessments and best interest's decisions had not been completed for either decision.

People's future wishes may not be respected because the process to lawfully record these was not correctly followed. People who had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms in place had not had these completed correctly so they applied to people whilst living at this service. We spoke to the regional manager who told us that all DNACPR decisions would be reviewed appropriately with the person's doctor.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were at risk of decisions being made which were not least restrictive of their rights and freedom. People told us that they were not allowed out of the service as the doors were locked to ensure people's safety. One person told us, "Everything is locked and we're not allowed out," whilst another person, when asked if people were escorted to go to the shops said, "It would be lovely but we're not allowed." We spoke to staff and the regional manager about how people were supported to safely maintain their freedom. The staff and regional manager agreed that people should have the opportunity to be supported to go for a walk or access the local shops and a staff member told us that people were supported to do so during the summer months. The manager told us, and records confirmed that applications for DoLS had been made for people who were at risk of being deprived of their liberty.

People were supported by staff who had received relevant training and felt supported by the manager to carry out their roles and responsibilities. A recently recruited member of staff told us that they had received an induction when they started working at the service and further training needs had been identified by the manager. Another member of staff told us that they received supervision on a regular basis and felt that the training provided was "Very good quality" and consisted of "lots of information."

We accessed training records and saw that staff had recently attended a number of training courses relevant to their role. These included health and safety, infection control, moving and handling and fire training. We saw records which confirmed that staff were regularly supervised and that additional supervision sessions had recently been held with staff if required.

People were at risk of not getting the support they required to eat their meals. We observed a mealtime and saw that some people waited a long time for their meal to be served or for their second course to be provided. This resulted in some people getting up and leaving the table and we saw that one person was having difficulty cutting up their meat which was unnoticed by staff.

People told us the food was "really good" and we saw that people were offered a choice of meals. People were provided with drinks frequently throughout the day and people's requests were responded to quickly with a choice of drinks. We witnessed one example of a staff member preparing another hot drink for a person when they realised that their drink had gone cold.

Records showed that advice had been sought from one person's GP when they had lost weight and their food and fluid intake was being monitored in line with their care plan. We saw that people were provided with a specialist diet if required.

People told us that that they were supported with their healthcare and to see healthcare professionals if required. One person told us, "When I'm poorly, they bring the doctor and they let my [relation] know as well."

Staff told us that they felt that the support of external healthcare professionals was sought when required, without delay. A member of staff told us they had recently contacted a community specialist nurse for advice and found them to be very helpful and supportive. We spoke to a visiting healthcare professional who told us that staff were very knowledgeable about the people they were supporting and followed the advice given to them. We saw from care records that staff sought advice from a range of external professionals such as occupational therapists, community and urology nurses and GPs in order to meet people's healthcare needs.

Requires Improvement

Is the service caring?

Our findings

We observed a mixture of interactions between staff and people who used the service, many of them were caring but some of them were not. For example, on one occasion a person was calling out and a member of staff went to them and said quite bluntly, "What is wrong?" When they didn't immediately answer the staff told them it was nearly dinner time and then walked away. We also observed several good interactions between staff and people using the service. One person who lived with dementia was shouting frequently and becoming agitated. The person responded positively when a member of staff talked quietly with a calm and reassuring tone, engaging the person in conversation and asking the person what activities they wished to engage in.

We witnessed that staff did not always respond to people in a timely manner. For example, we witnessed one person stating that they were cold. A member of staff acknowledged this and passed the information on to another member of staff. We observed that neither of the staff members took any action to make the person feel warm.

Some people did not have useful information about their past in included in their care plans to help staff know about them and their likes and interests. When we spoke to staff we found them to be knowledgeable about the people they were supporting, but the lack of information in care plans may mean that new staff would not be provided with important information about the person.

People, or their representatives, may not be involved in decisions about their care or have their choices respected. One person told us, "I don't like showers. I like to have a bath but there is a rota for the bath. I get one probably every couple of weeks and then I have a strip wash on other days." Records showed that the system for ensuring that people were involved in their care planning was not robust or consistently applied. We found that some care plans gave no indication that the person or their relatives, if appropriate, had been involved in decisions.

The manager told us that no-one at the service currently required the support of an advocate and that they would support people to access advocacy if required. Advocates are trained professionals who support, enable and empower people to speak up.

People told us that they thought the staff were caring. One person told us, "Nothing is too much trouble for them. We get everything we want." A relative told us, "This place is amazing. You hear all these horror stories but there's nothing like that here. I have two relatives who are residents here and the staff are brilliant."

People we spoke with told us that staff respected their privacy and dignity. We observed staff respecting people's privacy and dignity when supporting them. For example, taking action to maintain people's dignity when using moving and handling equipment and ensuring that people's clothing was suitably adjusted. We spoke to staff who were able to describe the steps they took to protect people's privacy and maintain their dignity. One staff member told us, "It's about thinking how I would like to be supported" and went on to tell us about ensuring doors were closed when providing personal care, offering people choices and listening to

their wishes.

Requires Improvement

Is the service responsive?

Our findings

People's support needs were not always clearly recorded in their care plans. For example, one person had a medical condition that required medication and monitoring. There was no care plan in place to alert staff who may be unfamiliar with the person about the risks associated with their condition and how to recognise and respond to any changes in their health. We received confirmation from the regional manager following our inspection that the required documentation had been put into place.

One person had a care plan in place in relation to their behaviour. The care plan contained little guidance for staff about how the person should be supported with their behaviour. When we spoke to staff they were knowledgeable about the person and gave good examples about what worked to de-escalate a situation which could cause harm. We observed that the person was supported by staff appropriately. However, there was a risk that new staff would not know about how best to support the person with their behaviour.

Staff told us that the information contained within care plans about the person, their level of independence and preferences could be improved. We found that care plans did not always contain information in sufficient detail about people's preferences about how they wished to be supported. For example, one person required support with personal care tasks. There was limited information about the person's preferences and what the person was able to do themselves and what tasks they required support with.

People were supported to maintain relationships with people who were important to them and relatives felt that the service communicated with them well about their relations. One relative told us, "They keep in touch all the times about how [Relation] is and it's a complete open door. I've come in very early in the mornings sometimes and they don't mind a bit. I've been told that I can come in whenever I want and at any time I want."

People told us that activities on offer at the service were limited. One person told us, "We just sit here. It's boring. A lot of people fall asleep in the afternoon and we are just waiting then for teatime and getting ready for bed. Every day is just the same." Another person showed us an Easter bonnet they had been decorating and told us, "I have done some baking now and again but not very often."

We observed during the morning of the first day of our inspection that several people were sat in one of the lounge areas with the television on. We saw that some people were supported with individual activities in the dining room but that few attempts were made to engage with people in the lounge throughout the morning.

We asked staff whether they felt there was enough for people to do at the service and about the activities available. One staff member said, "Going by their choice, yes there are enough activities." However, they went on to say they felt if there was more time to engage with people and encourage and support them to undertake activities it would be beneficial to their well-being.

An activities co-ordinator was employed at the service three days a week. A weekly activities programme

was in place which showed a variety of activities taking place. However there were no times assigned to activities and the activities we saw taking place on the second day of our inspection did not correspond to those listed on the board. This meant that people were not kept informed about what activities were available for them to take part in and when.

We spoke to the activities co-ordinator about how they gathered ideas and feedback on the activities they offered. They told us that they spoke with people about what they would like but that it depended on the day whether people wished to partake in what was offered. Whilst we observed some activities taking place during our inspection, we observed times when there was little stimulation or interaction with people. The regional manager told us that they had spoken with the activities co-ordinator about how they could be supported to develop their role, through the provision of resources and support to organise residents meetings, to improve activities within the service.

People told us that they had not raised any complaints about the service and could not describe what they would do if they had any, other than one person saying, "I would tell my family. They see to all that kind of thing." People told us that they would feel comfortable approaching the manager if they had any concerns.

We saw that a copy of the complaints procedure was on display in the service along with complaint forms. Staff told us if a person wanted to make a complaint they would listen to the issues, document them, inform the manager and if they could resolve it themselves they would do this. One member of staff gave us an example of an issue a family member had raised and the action they had taken to address the issue immediately. Staff felt that the manager would respond to any complaints raised well.

We reviewed complaints received by the service during the last year. Complaints were recorded on a complaints form which provided information about the response to the complaint and action taken as a result. There had been one complaint over the previous year and we saw that this had been investigated and action taken to prevent recurrence of the issue. However, no record was made whether the complainant had been provided with a response. The regional manager told us that the forms should include a section detailing the feedback given following the complaint and told us that this would be put into place.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in May 2014 we asked the provider to make improvements to ensure that appropriate action was taken in response to allegations or incidents of abuse. During this inspection, we found that the system for ensuring that safeguarding referrals were made when required was not robust.

People could not be assured systems to ensure their safety were robust and effectively monitored by the provider, for example, in relation to recruitment practices. We requested additional information from the manager following our inspection to ensure people were safe. Some of our requests for information to ensure people's safety were not responded to until we contacted the provider. In addition, records we looked at showed that whilst the manager had sent us notifications for certain events in the service they had failed to notify us of allegations of abuse. Providers have a legal obligation to notify us of such incidents to assist with our monitoring of the service.

People's risk assessments were not always regularly updated and care plans did not always contain sufficient information for staff as to how risks could be reduced. We found that measures to reduce the risk to people had not always been implemented or were effectively recorded. We spoke to the regional manager about the lack of information contained in some care plans who agreed that the information in these was not sufficient.

We saw that audits had been completed in the service but these had not always been carried out regularly and the system had proved ineffective in identifying where improvements were needed. For example, a monthly audit of care plans had been completed up until September 2015. The concerns that we and other and external agencies identified with care plans had not been picked up through effective internal monitoring processes.

At the time of our inspection, people were provided with limited opportunities to contribute to the development of the service. We spoke to the regional manager about ensuring that the views of people using the service were captured. They told us that some staff members had been identified to facilitate these meetings and enable people's views to be heard.

All of the above information constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The feedback of people's relatives was sought in monitoring the quality of the service via the use of bi-annual surveys. We saw that the results of the last survey had been collated and action taken in response to people's comments. The surveys showed a high level of satisfaction with the service and all of the relatives who responded felt that they had the opportunity to express their views on the running of the service. A meeting had been held prior to our inspection with people's relatives and external agencies following concerns arising from external audits.

Due to recent concerns raised by external agencies, a regional manager was maintaining a daily presence at

the service during the time of our inspection. The regional manager showed us paperwork being introduced to formalise monthly provider audits at the service. We saw that the provider was responding to recent external audits carried out at the service. For example, an action plan had been developed in response to a recent infection control audit and we saw that progress was being made in addressing areas of concern.

People, and their relatives, were positive about the manager of the service. One person's relative told us, "The manager is amazing. I see them a lot walking around the home and they are very approachable. I wouldn't hesitate to go to them if I was at all worried about anything."

Staff we spoke with told us that the manager was always available, easy to talk to and supportive. One staff member told us, "You can approach [Manager] and [Manager] will get things done." Staff also felt that the regional manager was very approachable and they felt able to raise issues with the regional manager directly if necessary.

Staff told us that they had been kept fully informed of recent issues at the service and we saw that a number of staff meetings and individual staff supervisions had been held to address to provide information and address concerns. Staff practice was being kept under review by the manager, deputy manager and provider via spot checks, and competency assessments which were being introduced.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Maintain securely an accurate, complete and contemporaneous record in respect of each service user,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes must be established and operated effectively to prevent abuse of service users. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegations or evidence of such abuse.