CAS Care Services Limited

Nightingale

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 1 and 7 September 2017. The first day was unannounced. It was our first inspection of the service since it was re-registered following a change of ownership in October 2016.

Nightingale is a care home for adults living with conditions on the autistic spectrum and who have complex needs associated with this, including learning disabilities, communication difficulties and behaviours that challenge. Nursing care is not provided. The service is registered to accommodate up to 12 people, but managers have decided to limit this to 10 people. At the time of the inspection there were nine young adults living there.

Accommodation is provided in individual bedrooms on the ground, first and second floors in the two wings of the building. Each room has an ensuite shower room. Communal areas include two lounges, two kitchen dining rooms, a sensory room and an activities room. The upstairs floors are accessed by stairs only; there are no lifts. There is a secure garden at the back of the building with a lawn, plants, garden furniture and shelters. There is onsite parking for the service's own vehicles and it is possible to park on the street near the house.

The service has a registered manager, as required by its conditions of registration. 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.

People were treated as individuals, receiving person-centred care and support from staff who knew them and had a good understanding of them as people. There was an emphasis on meaningful activity and creative ways were found to support people to live as full a life as possible. The whole staff team, managers, support workers and ancillary staff, were trained and supported to do so. People were encouraged to access services and events in the wider community.

People told us they liked the food and were able to make choices about what they had to eat. Cultural and dietary needs were known and catered for. People's weights were monitored on a regular basis and unplanned weight changes were referred to the GP with a view to a dietician referral.

Health Action Plans were in place and people had the support they needed to maintain their health. People's care records showed relevant health and social care professionals were involved with their care.

People's consent was obtained to their care, where they were able to give this. If they lacked the mental capacity to consent to particular aspects of their care, staff worked according to the principles of the Mental Capacity Act 2005. Where necessary there were Deprivation of Liberty Safeguards (DoLS) authorisations in

place or these had been applied for.

People were protected against abuse. Staff treated people with dignity and respect. They had the knowledge and confidence to identify safeguarding concerns and knew how to act on these to keep people safe. When staff had raised concerns about poor practice by colleagues, the registered manager had taken the necessary action.

People were protected against avoidable harm. Risks to people's personal safety had been assessed and plans were in place to manage these risks in the least restrictive way possible. People had positive behaviour support plans that identified what they might be communicating through behaviours that challenged, set out strategies for avoiding such behaviours in the first place and explained how people should be supported when the behaviours arose. People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. The premises were well maintained, with the appropriate certification for fire, gas and electricity in place.

There were safe medication administration systems in place and people received their medicines when required.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Safe recruitment practices were followed before new staff were employed to ensure staff were suitable to work in a care setting. Staff were supported and developed to perform their roles through regular training, supervision and appraisal.

People and staff had confidence in the management of the service. The service had a positive, open, person-centred culture, with a motivated and confident staff team. People were involved in decisions about how the service was run. For example, they participated in staff recruitment. House meetings took place most months. There were regular staff meetings. The registered manager valued staff feedback and acted on their suggestions.

Quality assurance and governance systems were in place to monitor the quality of service being delivered and the running of the home. There was regular oversight from the provider's management team, at local, regional and national level. A programme of audits fed into the provider's ongoing improvement action plan. Action was taken where any shortfalls were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from avoidable harm and potential abuse.

Risks, including behaviour that challenged, were managed in a way that protected people with the minimum necessary restriction on their freedom.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had the training and support they needed to be able to perform their roles effectively.

Wherever possible, people's consent was sought. Where people lacked mental capacity in relation to particular aspects of their care, best interests decisions were made to ensure this care was only provided where this was in the person's best interests.

People had the support they needed to manage their health.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew and understood them.

Staff treated people with compassion and respect.

People were supported to express their views and make decisions.

Is the service responsive?

Good

The service was responsive.

The service was flexible and responsive to people's individual needs and preferences, finding creative ways to help them live as full a life as possible.

People were supported to engage with services and events in the wider community.

People's care and support was planned in partnership with them and, where appropriate, their families.

Is the service well-led?

Good

The service was well led.

Staff had the confidence to question practice and report any concerns. When this happened, appropriate action was taken.

Staff morale was good. Staff understood their role and what was expected of them.

Quality assurance arrangements were robust. Processes were in place for managers to account for actions, behaviours and the performance of staff.

Nightingale

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 1 and 7 September 2017. The first day was unannounced. It was conducted by an adult social care inspector.

Prior to the inspection we reviewed the information we held about the service. This included notifications of significant events that the service is required by law to send to the Care Quality Commission (CQC). It also included information from stakeholders such as families of people who live at the service and the local authority safeguarding team. Before the inspection the provider had completed 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.

During the inspection we met people who lived at the service. One person chose to speak with us at some length about their experience there and another told us about it briefly. We also spoke with six support workers and supervisory staff, three ancillary staff, the registered manager, the regional manager who was also the service's nominated individual, the provider's head of quality and compliance, one of the provider's clinicians and an external advocate who regularly visited the service. We made general observations around the service. We reviewed two people's care records, nine people's medicines records, three staff recruitment and supervision files and other records relating to the management of the service, such as complaints and quality assurance audits.

Following the inspection we spoke with a health and social care professional who has contact with the service.

Good

Is the service safe?

Our findings

A person we spoke with at length told us they felt safe living at Nightingale. They said of the staff, "They're nice, make me happy". People looked relaxed and comfortable in the presence of staff.

People were protected against the risks of potential abuse. Staff had the knowledge and confidence to identify safeguarding concerns and knew how to act on these to keep people safe. Staff had training about this during their induction, with annual refresher training thereafter. Staff received supervision and training about professional boundaries to help them maintain safe and effective working relationships with people. Safeguarding was discussed at team meetings. Staff knew where to find information about outside organisations concerned with safeguarding people. Records were kept of cash that staff looked after on people's behalf. There were frequent checks to ensure these tallied with the amount of cash held and any discrepancies were investigated promptly. Inventories were kept of people's personal belongings.

Occasionally people became upset or anxious and might exhibit behaviours that could challenge others. Someone told us how staff helped them to calm down when they were angry. Risks from behaviour that challenged others were assessed. People had positive behaviour support plans that identified what people might be communicating through such behaviours. The plans set out proactive support measures to help prevent the behaviours in the first place, and strategies for supporting the person in the least restrictive way possible when the behaviours occurred. Staff had regular refresher training in managing aggression and behaviours that challenged, including a system of physical intervention that was accredited by a national learning disability organisation. Each occasion where physical intervention was used was recorded in a physical intervention log with details about the incident and was reviewed by the service's management to ensure it had been the least restrictive intervention possible. Additionally, the provider's management team monitored the frequency of physical intervention in its services.

Risks to people's personal safety had been assessed. Care plans addressed how to minimise these risks whilst supporting people to develop their independence. Risk assessments were individualised and covered areas such as activities, choking, nutrition, and the risk from others.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. When people had accidents, incidents or near misses these were recorded and monitored by the registered manager and by the provider to look for developing trends.

The premises were well maintained, with the appropriate certification for fire, gas and electricity in place. There were regular health and safety checks that included the state of repair of the premises, water temperature checks and shower head cleaning to help prevent the growth of legionella bacteria, and fire safety checks and tests. Any breakages or defects in the building were reported and attended to. There was a programme for redecoration and some communal areas had recently been redecorated. The registered manager and their deputy walked around the premises daily, checking bedrooms and communal areas were clean and in good order.

The service's business continuity plan set out the arrangements to keep people safe in different kinds of emergency, such as utilities or IT failure, fire or flooding. The plan contained contact details for the relevant people to be contacted. This information was readily available for staff.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. People told us staff were on hand to provide the support they needed. Staff confirmed that staffing levels were usually sufficient for them to perform their roles safely and effectively. For example, a support worker said staffing levels were sufficient "99 per cent of the time". They said that staffing levels enabled them to take people out into the community. On occasions where staffing levels were short due to sickness or leave, the activities organiser, cook or domestic stepped in to a support worker role, as they knew people well and had received the necessary training.

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were of good character and suitable to work at Nightingale. These included criminal records checks with the Disclosure and Barring Service during the recruitment process and at intervals thereafter. Other recruitment checks included reviewing a candidate's employment history and obtaining an explanation of any gaps, taking references from previous employers and getting proof of their right to work in the UK.

There were safe medication administration systems in place and people received their medicines when required. Medicines were stored securely and there were regular checks to ensure the quantities held tallied with medicines records. Following an incident where someone ran out of one of their medicines, procedures had been tightened to ensure stock levels were regularly checked and sufficient replacements ordered promptly. Staff who handled medicines had regular refresher training in this and their competency was reassessed each year by staff who had the skills to do this.

Good

Is the service effective?

Our findings

The people we spoke with were positive about the staff.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. The staff we met had a good understanding of the challenges faced by people living with autism. Staff told us they had the training they needed when they started working at the service, and were expected to refresh their training. Core staff training was updated at intervals and included safeguarding, mental capacity, fire safety, health and safety, and food hygiene. Staff had regular training in recognised and accredited strategies for managing behaviour that challenges, including physical intervention. They had also completed, or were working on, an autism workbook. Staff were also encouraged to work towards qualifications appropriate to their role. One member of staff said that whilst the training they needed was readily available, they wished more of it was delivered face to face.

New staff had a two week induction, where they shadowed existing staff and learnt about what their role would involve. Staff who were new to care were expected to complete the Care Certificate, a nationally recognised set of standards that should be covered as part of the training of new care staff. A new member of staff who had not previously worked in care told us, "I don't feel out of my depth. Everyone's there to help everyone out."

Staff told us they felt supported by the registered manager and other staff. They had regular one-to-one supervision meetings and twice yearly appraisals with their line manager to discuss their work and any training needs or concerns they had. Comments included: "Sitting down and having allocated time to talk about it definitely helps", "Absolutely massively [well supported]", "There's so much support" and "It's the best job I've ever had and I've had many."

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 so that they can 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had identified people who they believed were being deprived of their liberty. They had made DoLS applications to the appropriate supervisory body and had a system for applying to renew DoLS authorisations when these were due to expire. For one person, there was a DoLS authorisation with a condition set by the supervisory body. This condition had been met.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. Where there was concern that people might not be able to consent to particular aspects of care, their mental capacity to do so had been assessed. People were supported as far as possible to decide this for themselves. However, where they lacked capacity to make this decision, the registered manager ensured a best interests decision was made and recorded so that staff could provide the care and support the person needed in the least restrictive way. Others important to the person were consulted, such as family members, health and social care professionals and advocates. Examples of best interests decisions seen related to contact with particular family members, managing finances, medicines, healthy food choices, the use of physical intervention and having keypad locks on external doors.

People told us they liked the food and were able to make choices about what they had to eat. Two menu options were given for lunch and dinner, on a three week rolling menu. People were asked what they wanted to eat. There was also a pictorial menu choice board, where people stuck their photo alongside a picture of their preferred meal. The menus had recently changed and the cook was in the process of updating the menu pictures.

People's weights were monitored on a regular basis and unplanned weight changes were referred to the GP with a view to a dietician referral. One of the people whose care we tracked had seen a dietician for advice regarding weight loss and continued to lose weight gradually according to their plan. The provider's speech and language therapist had assessed two people who had swallowing difficulties that put them at risk of choking.

People's dietary needs and preferences were documented and known by the cook and staff. Staff were aware of people who were at risk of choking and suitable food was provided in line with their safe swallow plans. The home's cook kept a record of people's dietary needs, likes and dislikes. The cook also kept records of what people had eaten, for people whose diet was being monitored.

Care records showed relevant health and social care professionals were involved with people's care. The provider had their own visiting team of clinicians including psychiatrists, psychologists, nurses and speech and language therapists. One of the speech and language therapists visited during the inspection and told us about work they had done with different people who lived at the service, including developing safe swallow plans for two people and training staff in particular communication strategies to use with people. The service also maintained contact with local NHS and local authority learning disability services. Health Action Plans were in place describing the support the person needed to maintain their health. People's health needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Good

Is the service caring?

Our findings

People told us they liked the staff, who treated them with respect. A professional told us people who lived at the service talked about it as their home.

People were treated with kindness and compassion in their day-to-day care. Throughout the inspection people looked settled and contented in the company of staff, who treated them respectfully and with dignity. When people showed signs of distress, staff responded quickly and calmly to clarify what was wrong and offer support.

People's privacy was maintained. Staff were conscious of their duty of confidentiality. People often had one-to-one staffing to maintain their safety and wellbeing, but this was managed sensitively to minimise intrusion. Staff were engaged with people when they wanted this, for example supporting them in an activity. People could also spend private time alone in their rooms and staff respected this, whilst enabling them to remain safe.

People's bedrooms were decorated to their taste and personalised with their own items. When people moved in their rooms were decorated in a neutral colour but once they had moved in they were able to have their room painted in their preferred colour. A person told us how they liked whereabouts in the house their room was and that it was decorated in their favourite colours.

People chose where they spent their time, whether in their rooms or in communal areas. They moved freely around the house, and staff supported them accordingly.

People received care and support from staff who had got to know them well. People's records included information about their personal histories, others who were important to them and their preferences regarding their care and support. There were a number of staff who had joined in recent months, but they had already got to know and understand people. Staff were knowledgeable about things people found difficult and how they preferred to be supported. They understood how people communicated, including people who did not communicate verbally. Some staff also told us about the close working relationships they had developed with people's families.

Written information was provided in clear language, and using easy-to-read symbols. This included, for example, fire evacuation procedures and meeting minutes. People were given information and explanations when they needed them. Staff explained to people what they were doing and what would be happening next.

Information about advocacy services was available to people. There was a poster about an independent advocacy service in the downstairs hallway. An independent advocate visited the service at least monthly, and was there during part of the inspection.

Good

Is the service responsive?

Our findings

People told us they got the support they needed and were involved in a range of activities at the service and in the wider community.

Staff had an excellent understanding of people's needs, which were assessed in detail before they moved in. The registered manager and deputy led this, supported by one of the provider's nurse assessors and sometimes its wider multi-disciplinary team, for psychology input for example. Information was sought from the person, their relatives and other professionals involved in their care. There followed a transition process, where people were gradually introduced to the service so they and their circle of support could decide whether it would be suitable and to minimise upheaval as they moved in. The registered manager felt this had resulted in "a lovely mix of residents" who were settled at the service.

Information was gathered at assessment about people's cultural and spiritual needs. One person had come from abroad to use the service. A representative from the provider flew out to visit the person and their family to undertake the assessment. This was filmed for the registered manager and deputy to see. To respect the family's culture, it was agreed with the family member that no other staff would have access to this video footage. The person's cultural and religious needs had been considered during the assessment and their care plan set out clearly how staff should support them with these.

These assessments of need were used to develop people's care plans, which were thorough and personalised, reflecting people's choices and preferences. Each person's file contained information about their likes, dislikes and people important to them. Care plans addressed issues such as personal care routines, communication, nutrition, activities and daily living tasks. They emphasised what the person was able to do independently, and set out clearly the support required from staff. There were communication passports that set out things staff must know about the person, how the person preferred to communicate, and signs they were or were not OK. Staff were able to tell us about the care and support people needed.

An external professional and one of the provider's clinical team who visited the service during the inspection both emphasised that the service provided person-centred care and supported people to progress with their lives. A person who had historically behaved in a way that challenged the service told us at some length how staff had helped them make progress: "I'm so happy now. I don't want to run away any more."

People's needs and care plans were reviewed regularly and as required. A person who lived at the service told us staff were aware they wanted eventually to move to their own flat. Their current goals were to hoover and cook their own meals, which staff were helping them to meet. They also told us how they had gradually lost weight, as they had wanted, as they had been supported to eat more healthily and to be active. People and their relatives and health and social care professionals, as appropriate, were involved in this process. The service used an autism assessment tool to monitor how people had progressed with managing their symptoms and give an indication of particular support that was needed.

The service was flexible and responsive to people's individual needs and preferences, finding creative ways

for people to lead as full a life as possible. Arrangements for social, work and leisure activities were innovative and met people's individual needs. Support workers and ancillary staff worked together, all building relationships with people and getting involved in regular activities with them on and off site. The ancillary staff had training to support people and two of them were working towards the Care Certificate, which is a national qualification for staff new to health and social care. They supported people both with household tasks and to pursue their interests.

People were encouraged and supported to engage with services and events outside of the service. Nightingale had a dedicated activities organiser who was building and extending links with the wider community. They had supported people to take on voluntary work with a local animal rescue charity and with community farms. They had also developed links with leisure centres and clubs. People were able to choose what activities they took part in and suggest other activities they would like to complete. One person had managed their condition such that they now worked part time in one of the provider's other services. Someone else told us how they had taken part in a particular activity but did not like it as much anymore and so staff were helping them with ideas of what they might like to try next.

People spent much time during the inspection out with staff. A professional who visited regularly told us there were "always outside activities going on". A support worker told us that a significant part of their job was taking people out to their organised activities such as drama, riding or swimming. They said, "They like being out". They explained how they and their colleagues often supported people to go out on walks on the beach and in the local countryside.

People were encouraged to get involved with activities that were meaningful to them at Nightingale as well as in the wider community. There was an activities room, which people used frequently during the inspection: we saw people using a computer, painting and writing with staff. There was also a sensory room, which people used as they chose. People were also encouraged to get involved with day-to-day tasks such as cleaning their rooms or preparing meals. We saw someone working alongside the cook to prepare a light lunch for people. They told us they enjoyed cooking and often participated in this.

Input from people's support networks was encouraged and sustained. People were supported to develop and maintain relationships with people that mattered to them. Most people's families lived some distance away. Staff helped them to keep in contact in a way that suited them, for example, by making video calls or facilitating visits to or from families. One person's family member who lived a couple of hours away had health conditions that made it difficult for them to use public transport, so the registered manager arranged for staff to fetch them to visit and take them back home afterwards. A room with a small kitchenette was set up as a family room so people and their families could have privacy during visits without having to use the person's bedroom.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There were eight complaints recorded since November 2016. Most of these had been investigated thoroughly and people and their relatives were satisfied with their responses. Other investigations were ongoing and the outcomes yet to be determined, although interim action had already been taken to address the concerns.

Good

Is the service well-led?

Our findings

The service had a positive, open, person-centred culture. The atmosphere at the service was relaxed and homely, with a sense that both residents and staff were purposefully occupied and calm. Music and laughter were often to be heard. There was a sense of both people and staff taking pride in the service and being supportive of each other, despite there having been a turnover in staff during 2017. Staff came across as motivated and confident in their work. For example, a member of staff told us they were "very happy" working at Nightingale. Another said, "I really enjoy my job" and commented on how some challenging situations over the year had strengthened the staff team. A further member of staff said, "We're very supportive of each other and help each other out a lot more [than previously]."

People were involved in decisions about how the service was run. For example, they participated in staff recruitment, with people who wanted to sitting on interview panels and others spending informal time with candidates as part of the selection process. People were also consulted about the decoration of communal areas; the lounges had been redecorated after people had been asked how they would like them to look. House meetings took place most months, where news was shared about staff changes and forthcoming events and people had an opportunity to say what they thought. Minutes were produced in an easy read symbol format.

People and staff had confidence the registered manager would listen to their concerns, which would be received openly and dealt with appropriately. The service had a whistleblowing policy. When staff had raised concerns about poor practice by colleagues, the registered manager had taken the necessary action, including making a safeguarding adults referral to the local authority. A member of staff expressed their confidence in the management of the service thus: "If ever I ask for help, even if it's just witnessing meds, it's 'Yes, no problem'."

The registered manager valued staff feedback and acted on their suggestions. There were regular staff meetings to discuss people who lived at the service and what was going on there in general. A member of staff commented that at the meetings staff contributed freely, were listened to and their suggestions acted upon where appropriate: "Everyone says what they think… It makes you feel important and part of the team."

The service worked in partnership with local health and social care organisations. The registered manager confirmed they had maintained links with learning disability community services. One of the healthcare professionals had done a talk for staff about how best to support someone who had been in the process of moving into the service.

Quality assurance and governance systems were in place to monitor the quality of service being delivered and the running of the home. The registered manager told us they and the deputy worked very closely together. They said that since Nightingale had transferred to the current provider they had had more autonomy in running and developing the service. There was regular oversight from the provider's management team, at local, regional and national level. The registered manager made a weekly report to

the regional manager, who visited at least weekly and passed the report to the provider's board with updates on any concerns. The regional manager attended quality governance meetings with the provider's senior management team, where they gave account of the service's performance. This included the monitoring of accidents and incidents, the use of physical intervention and complaints and compliments. The provider's operations director also visited the service, every month or so.

There was a programme of audits, which fed into the provider's ongoing improvement action plan. Action was taken where any shortfalls were identified. The provider's quality team audited the service quarterly; the most recent audit had taken place the previous week. It had highlighted the need to improve food labelling and menu information. This had been addressed by the time of the inspection. The registered manager also conducted and oversaw audits within the service, including monthly health and safety and medicines checks, and unannounced visits at night. The provider's regional estates manager made periodic quality checks on the maintenance of the premises.

People and those important to them had opportunities to feed back their views about Nightingale and the quality of the service they received. This happened through ad hoc discussions with the registered manager, at 'family day' events, and through an annual quality assurance survey. The most recent survey had been undertaken in December 2016.

The registered manager had notified CQC about significant events. CQC uses such information to monitor the service and ensure they respond appropriately to keep people safe.