MAPS Properties Limited

Nightingale Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6 March 2018 and was unannounced. We also returned on the 8 and 12 March 2018. The provider and manager were given notice of the other dates, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information. This inspection was prompted in part by information shared with CQC about the potential concerns around the management of people's care needs. This inspection examined those risks.

Prior to this inspection we carried out an unannounced focussed inspection of this service on 11 July 2017, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had been alerted to an incident where, on the advice of a healthcare professional, one person's controlled drugs had been given to another person. This was not in line with the provider's own medication policy. This incident had placed the person at risk of harm and prompted our responsive inspection. We concluded that, not all medicines were managed safely. We also found audits had not identified the errors we found. Some audits could not be located and the registered manager at that time did not have clear oversight of all the issues related to the safe management of medicines.

Previous to the focused inspection we completed an unannounced comprehensive inspection of this service on 16 March 2017 and found the provider to be fully compliant with the Regulations. We rated the key questions is the service safe, effective, caring, responsive and well led as good.

At this inspection we found that insufficient improvements had been made following our previous focused inspection. We identified a continuing breach in the Health and Social Care Act regulations relating to medication and found additional breaches of Regulation.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Nightingale is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates people in one adapted building. Nightingale care home accommodates 47 people, some were living with dementia. At the time of the inspection there were 31 people living at the home.

A recently appointed manager was in post and had submitted their application to register with CQC. 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 previous registered manager continued to work at Nightingale Care Home under the supervision of the new manager. Their role and responsibilities had not yet been agreed at the time of our visit.

Risks to people's health and wellbeing were not appropriately assessed and reviewed. Care plans were not sufficiently detailed to provide an accurate description of people's care and support needs.

Although the provider had systems in place to protect people from harm, we found these were not always effective. The majority of staff were trained in safeguarding adults yet the training was not always implemented in practice whilst supporting people. Staff told us they were aware of their responsibility to keep people safe however, they failed to identify some of the practices within the home which were abusive and breached people's rights to receive safe, respectful and dignified care. At the time of our visit, we requested the manager to complete a safeguarding referral to Norfolk local authority safeguarding team reporting our findings. Following our visit, we also contacted the local authority to share our concerns.

People were supported by staff who had not been safely recruited. The previous registered manager had not completed all the appropriate and standard safety recruitment checks to ensure staff were safe to provide care to people. We found insufficient staffing levels to support people's needs and people did not always receive care and support when required. The manager agreed with our findings at the time of inspection and following our inspection, had reassessed the needs of people, resulting in the staffing levels being increased by an additional 7.5 hours per day. This also meant the service was enabled to be more flexible to meet people's needs.

Staff had completed training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Applications had been made to the local authority for DoLS however, thorough assessments had not been carried out on people's mental capacity prior to the applications being made. We found staff lacked understanding about the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, and obtaining consent and carrying out care and support in people's best interests. There were restrictions and interventions being used, imposed on people that did not consider their ability to make individual decisions for themselves, as required under the MCA Code of Practice. At the time of our inspection, the manager agreed with our findings and had started the process of reassessing people's needs.

We identified gaps in training provided to staff. In spite of staff's best efforts and hard work to provide care in a supportive and friendly way, they lacked experience and training. This had resulted in negative outcomes for people being cared for. Some staff had received an appraisal of their work performance but most had

not received regular support and supervision. There was also a lack of team meetings and opportunities for staff to learn and discuss best practice. Resulting in staff feeling unsupported and opportunities missed in identifying inconsistencies in staff knowledge and practice.

We found that people's privacy, dignity and independence were not always respected and promoted. We had to intervene on several occasions to ensure people received safe and appropriate care. Staff did not always engage with people when given the opportunity. People, who used the service, or their representatives, were not always encouraged to contribute to the planning of their care.

People who remained in their bedrooms lacked social stimulation and few opportunities to engage in activities were recorded.

Although processes were in place to deal with people's complaints and concerns if received, we were not satisfied the provider operated an effective accessible system for identifying complaints. There had been no documented complaints since June 2011. We found no evidence the provider sought and acted on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they can continually evaluate the service and drive improvement.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred care was embedded. Systems in the service that were meant to monitor and identify improvements were not effective and records were not always maintained and completed in full. This lack of effective governance led to all people not receiving safe and consistent care. The care plans for people using the service were incomplete or did not contain up to date and regularly reviewed information. This meant staff were not able to perform their duties efficiently.

People were provided with a variety of meals and the menu catered for any specialist dietary needs or preferences. People were supported to maintain a healthy balanced diet through the provision of nutritious food and drink by staff who understood their dietary preferences. We observed communal mealtimes where people ate together.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks. People's rooms were decorated in line with their personal preferences.

For people who were mobile and able to access the lounge, there was a strong emphasis on meeting people's emotional well-being through the provision of meaningful social activities and opportunities. These people were offered a wide range of individual activities, which met their needs and preferences.

At the time of our visit, the manager and provider acknowledged and agreed with the shortfalls identified. The manager and provider demonstrated a willingness to change practice and drive improvement. The manager took immediate action to improve people's safety and quality of care delivery. The provider agreed to voluntarily suspend all new admissions until our next inspection visit. We received further assurances since the inspection and continue to be in regular contact with the provider to ensure standards improve imminently.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

People were not protected by the systems, processes and practices to safeguard them from abuse.

Whilst some people said that they felt safe, we found that the provider did not have effective arrangements to ensure risks were assessed, monitored and mitigated. This meant there were risks to people's safety, health and welfare.

Staffing levels were not sufficient and were not effective to maintain people's safety and meet their needs. Staff had not undergone all the recruitment checks, to ensure they were safe to work in care.

Medicines were not managed in accordance with best-practice guidelines.

People were not protected by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not always follow the requirements of the Mental Capacity Act when people lacked the capacity to give consent to care and treatment. Best interest principles were not adhered to.

Staff had not always received appropriate training and supervision to ensure they could perform their roles and responsibilities effectively.

People were provided with a choice of quality meals, which met their personal preferences and supported them to maintain a balanced diet and adequate hydration.

People had access to healthcare professionals to maintain good health.

People's needs were met by the adaptation, design and

decoration of premises.

Is the service caring?

Inadequate

The service was not always caring.

Staff did not engage socially with people when they had the opportunity.

Staffing arrangements meant care was task focused and not focused on people.

People were not always treated respectfully. People's privacy and dignity was not always protected.

People were not always involved in making decisions about their care.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no effective system in place for identifying complaints.

People did not always receive personalised care that was responsive to their needs.

People who were able and mobile were offered the opportunity to pursue their hobbies and interests and to take part in a range of social activities.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Inadequate

The service was not well led.

Prior to the newly appointed manager, there had been a serious lack of managerial oversight of the service as a whole. There was a reactive rather than proactive approach by the provider, which meant that people did not receive a consistent safe and appropriate service.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred care was embedded.

The service lacked appropriate governance and risk management frameworks, which resulted in poor outcomes for people who used the service.	

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.

This inspection took place on 6 March 2018 and was unannounced. We also returned on the 8 and 12 March 2018. The provider and manager were given notice of the other dates, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

On the first day the inspection team consisted of one inspector and one expert by experience. An expert by experience is a person who has personal experience of using this type of service. On the second and third day one inspector completed the inspection.

Before the inspection, the provider 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. We also reviewed notifications received from the provider before the inspection. A notification is information about important events, which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the breakfast and lunchtime meal, medicines administration and activities.

We spoke with five people who lived in the service and with five relatives. We spoke with the provider, newly appointed manager and previous registered manager. We also spoke with the chef, five members of care staff and one activity coordinator. We looked at the care plans and associated records for five people. We looked at five people's medication records. We reviewed other records, including the provider's internal

checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for five staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Inadequate

Is the service safe?

Our findings

At our last focused inspection in July 2017 we rated this key question as 'requires improvement'. We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had continued to fail in ensuring the proper and safe management of medicines. We also found the provider had failed to comply with other parts of Regulation 12.

We reviewed the procedures for the ordering, storage, administration, stocktaking and safe disposal of medicines to establish if systems were now safe. We found both good and poor practice with regard to the management of medicines.

We found continued concerns regarding medicines which were only given occasionally or were only recently prescribed were not always well managed. For example, buccal midazolam had been prescribed for two people. There was limited information about how and when to administer this medicine and no protocols to guide staff. This medicine can be used in the event of a person having an epileptic seizure and is administered between the cheek and the gum via a syringe. The care plans for epilepsy did not offer clear information of when and how to also take the medication, which meant there was a risk that people would not receive the prescribed medicine correctly and promptly. Records confirmed that although some staff had received training in administering medicines, not all staff had received training regarding this particular medicine. Following our inspection the manager confirmed to us that all staff were being trained to administer this medication. However, at the time of our inspection staff were not trained and the provider had not identified this lack of training as a potential risk.

Risks to people's wellbeing and safety had not always been effectively mitigated. We looked at how risks were managed. We found individual risks had been assessed and recorded in people's care plans. Examples of risk assessments relating to personal care included moving and handling, nutrition and hydration, falls and continence information. However, we found gaps within care records with poor or missing information to safely manage risks.

We found two people remained in bed and an assessment of their needs had not been thoroughly completed. For some people assessments identified if they could or could not use a call bell to alert staff, but had not identified for those that could not, how their wellbeing was going to be met. Some care plans indicated staff would check on people hourly or two hourly, but there was no guidance on what staff were checking. Records were also incomplete which did not give us assurances that checks were taking place as stipulated. We spoke with the manager who told us they would update people's care plans to ensure that more guidance was given to staff regarding what a well being check was and these were to be documented. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

We visited three people who were in bed, and found all three to be in a distressed state. One person told us, they were hungry and thirsty and another person was tearful and confused. We asked staff to attend to them and support each person with their needs. Due to these observations we asked to visit each bedroom with

the manager to check on people's wellbeing. We found a further eight people at risk due to not being able to reach their call bell, call bells not being in place or sensor mats not working which would alert staff if a person at risk of falls was mobile. For one person they had to step over a mattress on the floor to reach their call bell. The person had already been assessed as at risk of falls. We shared our concerns regarding this with the manager on the first day of our visit; they purchased new call bells for these people. On the third day of our visit, we observed them in use. They were much larger and required less physical effort to press. We observed one person using their new bell frequently, we asked them why they were doing this. The person told us "I can't believe I have this, it's amazing. It gets the girls [carers] attention and they come to me. They actually come to me. I don't have to shout anymore."

People were supported with specialist equipment such as pressure relieving mattresses to reduce the risk of pressure areas developing on their skin. We identified three mattresses' that should be set, according to the person's weight. Having the mattress set too firm or too soft could result in pressure damage occurring. Weight records indicated that these people had not been weighed since November 2017 due to not being able to weight bear any longer. The previous registered manager had not considered other ways of weighing people. There was also no guidance in people's care plans as to the correct setting. Staff we spoke with were not aware of the correct settings for the mattress. The previous registered manager told us, the district nurses checked these settings on their weekly visits. We asked the previous registered manager how they knew this, to which she told us, she did not and had assumed this. Therefore we could not be assured that all people had their mattresses at the correct setting, which could result in pressure areas developing on people's skin.

We told the manager of our findings, who ordered a set of scales that would support people who could no longer weight bear. We were shown evidence of this purchase. They had not arrived by the third day of our visit, but the manager provided assurances that people would be supported to be weighed once they arrived and she would review the mattress checking system, linking weight to pressure relieving mattress settings as described in the guidance for the different manufacturers. However, had this not been identified by the inspector people would have continued to use equipment that was not set correctly for its intended purpose to protect people from the risk of pressure sores.

People had mattresses on the floor due to being at risk of falls. There was no additional evidence that the risks associated with these had been fully explored. One person who we heard shouting out from their bedroom, was ignored by three staff passing the room. We asked the manager to check on the person, we entered the bedroom and found the person had fallen half out of bed, lying in an awkward position. The persons care plan stated they should be checked two hourly, however notes had not been completed as to when the person was last checked. We could not identify how long the person had been left in this position. The person was tearful, stated they were in pain and confused. We asked the manager why the person had not been assessed for the use of bedrails, which would prevent the person from falling from the bed. The manager told us, bedrails were not used by the home. We explained to the manager people's needs should be assessed individually and then appropriate measures put in place to safeguard those risks.

On our third day of inspection the manager had identified three people who needed the use of bed rails. These were in place on our third day. However, the previous registered manager was asked to complete the risk assessments for their use. These were incorrectly completed and the previous registered manager needed further guidance on how to complete them to ensure people were safe. We found bumpers had been put in place to prevent entrapment.

Moving and handling assessments did not give staff clear guidance on how to support people when moving them. We noted suitable equipment such as hoists and wheelchairs were available for staff to use, however

staff were guessing what sling size to use for people as they did not have slings for each person's individual use. We observed staff using a medium sized sling for one person, when the care plan stated they required a small sized sling. This could potentially cause injury if a person slipped through the sling, but also if the person was too large for the sling, it could rub and cause a skin injury.

We observed three people unable to comfortably turn from their wheelchair back to a seated position in their chair. One person said, "I don't like the twisting bit, this is the bit I really don't like." Once the person had dropped into the chair they repeated, "Oh, I really don't like that bit." People's mobility care plans had also not been reviewed since March 2017 in accordance with their changing needs or in accordance with the way staff had developed to cope with their inability to swivel from standing position to their wheelchair / chair.

The previous registered manager had stopped assessing risks to people's health and safety in December 2017. Individual accidents and incidents that had been recorded had not been analysed to identify any patterns or trends to help prevent them from happening again. For example, although staff logged incidents, the previous manager did not review or use the information to improve people's safety.

We asked the previous registered manager why they had stopped reviewing peoples care plans, risk assessments, accidents and incidents, to which they could not give an answer, other than, "I just stopped". The manager was present at this conversation and acknowledged this practice was not safe and provided assurances those assessments would now continue as part of her auditing.

The home was not clean and was poorly maintained. There was evidence of poor cleanliness throughout the building. Carpets were not thoroughly cleaned and soft furnishings were stained and dirty in places. We found 10 armchairs that did not have removable covers that had stains and unpleasant odours. The baths in both bathrooms were stained and chipped. We observed toilets and toilet brushes heavily stained and were rusty. Floors in bathrooms were water stained and in places mouldy. The ground floor had a malodour throughout. We shared our concerns about the cleanliness and safety of the premises with Environmental Health.

Following our visit, we raised our concerns about the suitability of the home to meet the needs of particular people with the local social services department and they carried out reviews of people who lived at the home.

The above concerns constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the service were not always protected from the risk of potential abuse or neglect. Training records showed some staff had not completed training to help them recognise and respond to possible abuse. This meant we were not confident all staff would know how to respond if they encountered any concerns.

Staff were able to tell us different types of abuse and stated they would raise concerns to their immediate line manager. However they were not aware of how to share their concerns with external agencies such as the local authority safeguarding team, the police or the Care Quality Commission. This meant there might be times when issues regarding people's safety would not be reported and acted upon robustly.

The provider used the local authority's safeguarding policy, which was out of date and had not been reviewed since 2013; it therefore did not incorporate significant changes in the safeguarding legislation that

came into practice in April 2015, which had also been reviewed and amended in March 2017. The manager gave assurances this would be reviewed and updated. We will not be able to confirm this until our next visit.

Although staff told us they were aware of their responsibility to keep people safe, they failed to identify some of the practices within the home were abusive and breached people's rights to receive safe, respectful and dignified care.

We observed staff move one person from their wheelchair to a chair against their will. The person repeatedly told staff to leave them alone. The person said, "Before you start, I am not wearing that (referring to the sling)." Two staff continued to put a sling on the person and hoist the person even though the person screamed, cried and shouted for them to stop. We observed the person say, "Please stop it. I want my mum. Shut it off, please, please, please, please." A staff member told the person, "If you want to stay in here (the lounge) then you have to sit in a chair." While in the process of being hoisted the person told the staff they had soiled themselves. Both staff continued to hoist the person into the armchair. We intervened and told the carers, the person had informed them they were soiled. A staff member told us, without checking the person, they were not soiled. The person was distressed and crying. Both staff left the room and did not return. We immediately shared our observations and concerns with the manager who checked the person's wellbeing and to see if they were comfortable.

We interviewed the two staff observed. We asked them why it was so important to move the person from their wheelchair, against their will, one staff member told us, "The senior told us to do this. I will always do what the senior tells me to do; otherwise I will be accused of moaning." We asked both staff would they still carry out a task, if told to do so by a more senior staff member, even if it was detrimental to the person. Both staff indicated they would.

Staff demonstrated a lack of awareness and knowledge about responding to the hygiene needs of people. We observed some people's bodily odour to be malodorous. One person spent the day in their dressing gown with no other clothing underneath. We observed the person unintentionally expose themselves in front of other people, in staff presence. Two staff ignored this behaviour. This demonstrated a standard of care and treatment which significantly disregarded the needs of people and did not protect them from the risk of neglect or self-neglect. We shared our observations with the manager who found a staff member to support the person with getting dressed.

We spoke to the manager and provider at the time of our observations who provided assurances that all staff would be retrained and competency assessed in safeguarding by the end of April 2018. The manager also provided assurances that staff would be met with at a team meeting to discuss themes and topics including safeguarding reporting, moving and handling best practice, assessed risks and how to keep people safe. We were told these meetings would occur monthly.

Failure to establish systems and processes to prevent abuse of people is a breach of Regulation 13 of the Health and Social Care Act 2014.

On the third day of our visit, we observed better moving and handling practice. People were safely supported to move from their chairs to wheelchairs and to sit at the dining table for their meals. We observed staff communicating with people during transfers to check people felt safe and comfortable.

At the time of our visit, we requested the manager to complete a safeguarding referral to the local authority safeguarding team as part of their duty to keep people safe from harm. The manager said this would be done without delay. Following our visit we contacted the local authority who had acknowledged the referral

and was going to investigate the concerns raised.

We found that there was an insufficient number of suitably trained and competent staff on duty in the home to meet the needs of the 31 people who were resident there on the day. The staff rota showed that there were a total of six care workers rostered on duty from 7.30am to 8pm including the senior care assistant and care assistants. The previous registered manager also worked in addition to these hours, and as yet had not been given a specific job role. We have reported on this in the key question, is the service well-led?

We asked the manager whether staffing levels had been identified via a staffing needs analysis. They told us the current staffing ratio had been calculated by the previous registered manager and had not yet completed a staffing needs analysis tool.

The provider's website states, they are, 'Committed to the delivery of exemplary levels of care for our residents, always ensuring that around the clock access to care assistance for their wellbeing is provided for.' We found the provider had not delivered this.

The manager told us; staffing levels were not adequate but had not identified where in the day it needed to be increased. We could see that there had been no consideration given to the complex needs presented by many of the people who were resident at the home.

One person told us, "I don't think there is enough staff. It seems to be a long time between seeing carers and that means I have to wait longer if I need something."

Staff also told us they did not feel there were sufficient numbers. Staff we spoke with said they had challenged the staffing levels but had been told by the management team they were correct. They gave examples of how they were unable to meet people's needs safely, for example not being able to support people to shower or bathe regularly due to the time being spent on supporting people in two's with hoisting.

Staff could not monitor people living in the home effectively and they were over stretched with the workload. Throughout the inspection, we noted people were left in the lounge areas unattended for long periods. People with needs related to dementia and mobility were unable to get the support they required. We observed a person drop their drink on the floor in front of them, in attempting to pick this up there was a risk of falling and no staff to respond to this. Other people appeared confused and distressed and there were no staff available to provide reassurance or support. The staffing levels were not effective in ensuring people received the support they needed in a timely way.

Failure to ensure that there are sufficient numbers of staff to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about the lack of staff with the provider and manager on our third day. They agreed with our concerns and arranged for an additional staff member to work 8am to 3.30pm on duty with immediate effect. Following our inspection, the manager had reassessed the needs of people at Nightingale Care Home and gave assurances that the increased staffing level would remain. The manager told us, the additional increase would mean people who spent most of their time in bed, would be better supported emotionally and physically. This also meant the service was enabled to be more flexible to meet people's needs.

Safe recruitment practices were not always followed when appointing staff. We looked at five staff

recruitment files and found two references were obtained from previous employers and there were records to show staff were interviewed to check their suitability to work in a care setting. However three of the five members of staff did not have completed Disclosure and Barring Service (DBS) checks, when they started employment at Nightingale Care Home.

A DBS check enables employers to carry out safer recruitment decisions. It also prevents unsuitable people from working with vulnerable groups. The staff had started working without a completed and confirmed DBS. The manager said they had confidence that all these members of staff would promote and protect people's safety. However, the previous registered manager had not done everything possible to ensure these safety checks had been completed. Staff that had commenced employment since the new manager commenced four weeks prior to our visit, had ensured DBS checks had been applied for.

We asked the manager to ensure these members of staff had completed DBS checks before they supported people on their own. The manager confirmed that they would do this. The manager also offered assurances that she would check the rest of the staff employed.

Failure to carry out relevant and robust recruitment checks of staff is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The good practice we found with regard to the management of medicines was the reliable arrangements for ordering, administering and disposing of medicines. There was a sufficient supply of medicines. We observed staff correctly following the provider's written guidance to make sure that people were given the right medicines at the right times. We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire.

The service maintained a safe environment for people because regular checks of the building and fire evacuation procedures were in place. Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. These checks included the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff in how to support people to evacuate the premises in an emergency.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in March 2017 we rated this key question as 'good'. Following this inspection this question is now rated as 'requires improvement'.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. We found the previous registered manager had not recorded steps taken to reach a decision about a person's capacity. The MCA states that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We identified that for certain decisions this had not been considered or referred for a best interest meeting and best interest decisions were not consistently in place. We spoke to the previous registered manager and current manager regarding the MCA who both demonstrated sound knowledge of the MCA, however the previous registered manager told us, they had not adhered to it in practice.

We saw that before people moved to the service, a pre-assessment form included information about whether people had capacity to make decisions for themselves and whether another person had the legal power to consent on their behalf. We saw that the provider had assessed some people's capacity to make decisions about their care, although these were not regularly reviewed.

Care files also included conflicting information regarding who had an authorised lasting power of attorney (LPoA). When a person is a legally authorised LPoA this relates to care and welfare and/or finances. Information regarding a person's LPoA must be clear to inform staff who is legally entitled to be involved in specific decisions regarding that person's care. Two peoples care plans indicated there were no LPoA in place and staff were to make best interest decisions on persons behalf, however we found that both people had a LPoA in place with the legal documents included at the front of the folder. We found for one person who was unable to consent to their care; the care plan had been signed as consented to by their relative. We checked and the relative did not have a lasting power of attorney to make that decision. Other people's plans, relatives had signed on behalf of the person without any explanation as to whether they had the legal power to do so.

When people were in their bedrooms not everyone had been given their call bells. Staff told us and care

plans indicated that not everyone was able to use them; however there was no information to show how this decision had been assessed or what alternative methods had been considered. Some people had pressure mats in their rooms. These are used to alert staff if a person is moving around their room, however, there was no rationale for why pressure mats were considered the most suitable and appropriate method to ensure peoples safety. Risk assessments had not been completed to demonstrate the mats had been assessed as necessary.

There had been no consideration regarding each person's capacity or consultation with the person or their legal representatives. Staff told us the mats alerted them to when a person stood up from their chair or got out of bed so that they could go to the room and sit them back down or help them return to bed. People were at risk of restrictive practice by staff as appropriate checks and reviews had not been completed. The above issues meant that the provider had not ensured care and treatment was provided with the consent and involvement of relevant persons.

Do not attempt cardio-pulmonary resuscitation (DNACPR) documents were in most people's files we looked at. These recorded decisions regarding the agreement to provide resuscitation to a person at times of medical emergency. Where these had accompanied the person on a hospital discharge the provider had not arranged for them to be reviewed as part of the handover of medical responsibility as advised as best practice on the form. We found the forms we looked at were incomplete and they had not been checked for accuracy. We discussed these concerns with the manager who was unaware of the checks required to ensure DNACPR forms were robustly completed and agreed by the relevant individuals and professionals involved with their care and support.

We discussed practice in relation to the MCA and DoLS with the new manager and provider. They advised us they would take steps to immediately clarify the situation in terms of DoLS applications, authorisations and mental capacity assessments and ensure the necessary steps were taken.

The above concerns constituted a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider maintained a spreadsheet record of training in courses completed by staff which the provider considered as mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people, care planning and the Mental Capacity Act (MCA).

Additional training was available to staff in specific conditions such as end of life care, fluids and nutrition, and dementia. In addition, they had also received on-going refresher training to keep their knowledge and skills up to date.

However we found, staff had not always completed their training when requested which had not been followed up until the new manager started. This meant in spite of staff's best efforts and hard work to provide care in a supportive and friendly way, they lacked experience and training. This had resulted in negative outcomes for people being cared for.

Staff were supporting multiple people who was experiencing heightened anxieties. Some staff told us they felt ill equipped to deal with the more complex challenging behaviours that the people experienced and their training did not cover all the areas they required. Although most staff had completed training in dementia, the training provided was a short course, online and not adequate for the staff to understand how to support the large number of individuals living with dementia. This was evident in the way people were

supported and spoken to during our visit.

Following our visit the manager emailed us and said, "The E-Learning is not good and staff have been given until 23rd March to complete units that they have." The manager also offered assurances that more face to face training would be organised. The manager also told us, additional moving and handling training for all staff was booked for 26 March and enhanced dementia training for all staff with a dementia care nurse was arranged for 5 April.

Some staff had received an appraisal of their work performance but most had not received regular support and supervision. There was also a lack of team meetings and opportunities for staff to learn and discuss best practice. This had resulted in staff feeling unsupported and opportunities missed in identifying inconsistencies in staff knowledge and practice.

The provider had failed to support and supervise staff, resulting in them being unable to carry out their role and responsibilities. Not ensuring staff fully understood the training they received and carried out their duties in a competent way was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures.

Staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

People enjoyed the food at the service. The chef explained that they used a four-week menu, which consisted of two main meal choices and changed with the seasons. In addition, there were special menus for celebrations such as Christmas and St. Patrick's Day. We observed that people were asked for their choice of meal during the morning and that this list was then passed to the kitchen.

We were present at lunch time and we noted that the meal time was mostly relaxed and a pleasant occasion. We observed three meal times during our inspection, one of which was not as well managed which we have covered in the key question, is the service caring?

The dining tables were neatly laid, people were offered a choice of dishes again at meal time in case they had changed their mind or were unable to remember what they had ordered and the meals were attractively presented.

People were being supported to eat and drink enough to maintain a balanced diet. For people who were able to weight bear, we found they had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The previous registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff.

The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included care staff readily having to hand important information about a persons' care so that this could be given to ambulance staff if someone needed to be admitted to hospital.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians.

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. People were able to move about their home safely because there were no internal steps and there was a passenger lift between the two floors. There was sufficient communal space in the dining room and in the lounges. In addition, there was enough signage around the accommodation to help people find their way around.

Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

Inadequate

Is the service caring?

Our findings

At our last comprehensive inspection in March 2017 we rated this key question as 'good'. Following this inspection this question is now rated as 'inadequate'.

Our observations showed a wide variation in the level of care provided by staff. Some staff demonstrated the ability to support people in a caring and dignified way and others did not. For example we observed a staff member talking to people in the lounge asking if they were warm enough, if they wanted particular music on and if they were comfortable. The staff member was kind and gentle when communicating with people. However this approach was not consistent throughout our observations. We found examples where staff did not treat people with dignity and respect and had not upheld their privacy.

The provider's website states, 'Every one of our residents receives the high level of care that they need.' We found where people were at risk of being socially isolated because they received care in their rooms, there was little interaction or support observed to reduce this risk and treat them with dignity. The majority of staff had a brisk and directive approach when speaking to people and did not demonstrate warmth and respect.

We observed there were occasions when there were opportunities for staff to engage socially with people that were not acted upon. This was not solely due to demands placed on staff or staffing levels. We saw staff standing in the lounge area and dining area not engaging with the people in the room.

We observed lunch being served in the dining room. The management of the meal was at times noisy and disorganised. Staff talked over people's heads loudly to each other. People's reactions to this implied they were not happy. This mealtime experience lacked the air of sociability for the people in the room and had a negative impact on their dining experience.

On three occasions we observed a member of staff assisting someone to eat in bed. The member of staff did not interact with them verbally throughout and the person could only communicate their desire for more food by opening their mouth.

On the third day of our visit at 10.08am we observed 14 people in the dining room who had finished their breakfast. People were becoming upset and had nothing to do. One person said, "This place is [expletive]. I am fed up living here. No one listens to me." At 10.40am 12 people were still in the dining room. At 11.52am four of the 14 people were still in the dining room. The curtains were closed and there was no music or stimulation being offered. When people saw us, two of them asked us to open the curtains. One person said, "Can I at least see the light." Another person told us, "They [staff] shut the curtains without asking, I was looking out the garden." The person had been placed at a table, directly opposite the garden, and was now looking at closed curtains. All four people were in wheelchairs and depended on staff to manoeuvre them. At 11.58am a domestic staff member came in the dining room and confirmed people had been left. The staff member removed each of their aprons from breakfast. There had been a complete disregard for the four remaining people, with no interaction or activity.

Two of the five people were able to share how they felt. One person told us, "I can't complain, I have had a good life. The carers try, I get my food and I have a bed. I am grateful." Another person told us, "I have just been left; I am treated like an animal, washed and fed. I do not like it here." The remaining two were unable to communicate with us.

There were three instances during our visit we had to ask staff to adjust people's clothing to ensure they were appropriately covered. Whilst staff responded quickly to our requests, they had not been addressed without our intervention. We observed staff interactions throughout the inspection and there was very little social interaction, staff routinely walked past people and carried out tasks without speaking to them.

A person had requested to speak with us in their bedroom, they had the blind drawn and had no lights on so the room was quite dim. They told us the light hurt their eyes so they did not like it too bright. While we were in conversation, a carer entered the bedroom, turned on the lights, opened the curtains, and then left the room. The carer did not knock, did not explain why they did what they did and had no regard for the choices made by the person.

We observed two people walking around the home with no shoes or socks on. We observed their toe nails to be very long, on some toes, curling over and covered in brown dirt, indicating they had not been washed and had been neglected for some time. We shared our observations with the manager who provided assurances they would address these concerns.

We observed staff assisting people to move with the use of a sling and hoist. There were occasions we observed staff speak with the person throughout the manoeuvre and reassured people, using phrases such as, "You're going up now [name]," and "You're okay." However overall we observed these manoeuvres carried out in silence, with little regard to the persons comfort. There was no explanation or reassurance given. For people wearing skirts and dresses staff did not wrap anything around the person, or pull the person's clothes down to protect the person's dignity.

Three people on a daily basis urinated on the floor of their bedroom and for one person against their curtains. All three individuals had some level of memory impairment and each of their ensuite toilets looked like a wardrobe / cupboard. The door to their toilets was not identifiable as a toilet. We showed the manager our findings and they were not able to confirm whether health care professionals had been referred to for advice. There was no assessment conducted to establish why this was happening and no proactive measures put in place to support this behaviour. We visited these rooms and found them not to be fit for use due to the powerful odours and in a state of very poor hygiene. The dampness this had caused had gone through to the person's floorboards; attempts to deep clean the area had been unsuccessful. The provider agreed to replace the flooring and curtains for these three people without delay. On the third day of our visit, we saw that this had been actioned.

We observed one person in the lounge approached by three staff and a visiting G.P. The GP indicated to a staff member she wanted to check the person's breathing. The carer offered to get a screen to protect the person's dignity but the GP said no. Staff and the GP did not explain to the person they was being seen by the GP, the GP did not introduce herself and staff did not offer this either. The GP asked the staff member to help lean the person forward so she could listen to the person's chest; both the carer and GP took hold of the person's shoulders and lent the person forward. As they lent them forward, the person became tearful and shouted out. The person was asking why they were being touched and what was happening. All three staff members present and the GP ignored the person and continued assessing the persons health needs in the lounge, without the persons consent, in front of five other people in the lounge. The persons care plan did not specify whether they were happy to have their health appointments take place in a communal area

with other people present.

Failure in ensuring people using the service are treated with respect and dignity at all times while they are receiving care and treatment is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us they were able to express their views and make day-to-day decisions about their care. However, we could not find any further evidence that people or their relatives were involved with planning their care. None of the five care plans sampled recorded people's involvement to their content. As a result, there was no evidence that people or those who knew them best had been involved in planning or reviewing people's care.

People did not have an opportunity to comment on their care planning or whether their needs were accurately reflected. The previous registered manager told us they evaluated the care plans monthly. However, that stopped in between March and November 2017. There was no evidence of how people were asked to be involved or what steps had taken to try different ways of involving people.

People who used the service were provided with some information. There were notice boards containing information about who was on duty, what activities were planned and what the meals were for the day. There was a service user guide, which described the services available and how people could raise concerns. These measures helped to keep people informed and enabled them to make decisions about their daily living activities.

Staff maintained confidentiality. Conversations about personal issues or phone calls made with professionals were carried out in the office. Staff files were held securely in the main administration office. Care files were held securely in lockable cabinets and cupboards.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection in March 2017 we rated this key question as 'good'. Following this inspection this question is now rated as 'requires improvement'.

We identified three people being at risk of social isolation. Not all of these people had care plans that stated they were at risk of social isolation and should be included in activities. We observed these people were left alone in their room for many hours during all three days of our inspection. Their daily records completed by care staff was brief and could not evidence that any meaningful interaction had taken place for these people. Therefore, we were not assured this need was being met consistently and in line with their care plan, for those that had one.

Care plans provided advice and guidance to staff about people's care, however there was a lack of evidence regarding how people had been involved in their care planning and how they wished to be supported. We fed this back to the new manager on our first day who agreed they could be more personalised reflecting peoples individual personal choices. This was in regards to people's personal care, health care, mobility, social care, communication, religious and cultural preferences, dietary needs and medication.

The provider had failed to ensure people's care and treatment met their needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider managed complaints. There was a policy in place for dealing with complaints and a procedure setting out how to make a complaint. However, this was not in a format that would be accessible to people living in the service.

People that we spoke to about this did not know how to access the policy or who to speak to if they had a complaint. There was no evidence that people were spoken to about how they could make a complaint and multiple people confirmed that this was not discussed at residents meetings or on a one to one basis.

The last documented complaint was made in June 2011. The manager offered assurances that she would personally meet with each person living at Nightingale Care Home to go through the complaints procedure and offer each person an accessible format of that procedure. The manager stated she would also offer each person the opportunity to express how they feel about living at Nightingale Care Home and from that, establish if there is anything else the provider needs to respond to.

For people who were able to access the communal area, the service placed a strong emphasis on meeting people's emotional well-being needs through the provision of meaningful social activities and opportunities. People were offered a wide range of individual activities, which met their needs and preferences. There was an activity coordinator who worked in the home Monday to Friday each week and had developed a daily programme of entertainment including music, quizzes, memory games and having nails painted. In addition, visiting entertainers had been booked to deliver musical entertainment, an

exercise class and a hairdresser visited each week. On the day of our visit, approximately 12 people remained between two lounges. The radio was on in one room and the TV in the other. People were knitting and doing puzzles. There were blankets on chairs in case people got cold.

During our visit, we observed people have their nails painted, participate in board games, take part in a memory quiz and a hairdresser visited. On our third day we observed an external music entertainer visit, which 17 people attended, all of which played instruments, sang and danced.

People were supported to maintain relationships with their families. Details of contact numbers and key dates such as birthdays for relatives and important people in each individual's life were kept in their care plan file. People told us staff helped them to keep in contact with their friends and relatives.

There were several visitors during the inspection and the front door was always answered promptly by staff that welcomed people and ensured that they signed in the visitor's book before entering the service.

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how their individual needs could be met. The assessments completed prior to an individual moving into the service formed the basis of each person's care plan.

Handover records sampled showed entries were completed by staff twice a day between 8am and 8pm. Handover records demonstrated that when staffing teams changed shift, people's needs were discussed such as their health and their mood. This helped ensure people's needs were monitored and that all staff were aware of any changing needs. At the handover meeting, a nominated staff member on each shift recorded what each person had done that day. It detailed what else was planned, a reminder for staff to read the house diary for appointments and the name of the senior who was nominated to administer medication. Daily records compiled by staff detailed the support people had received throughout the day and this followed the plan of care.

While we were on site, two people had been identified as being at risk of developing pressure sores. We noted risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration and their diabetic state. Pressure sores are graded between one and four, one being the mildest form. The district nurse had visited on our second day and confirmed staff were following instructions from the district nursing team and the two people identified as at risk of developing pressure sores had not developed past grade one. On the third day of our visit two pressure relieving mattress's had arrived for their use to ensure the areas were well supported.

Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. The daily records gave clear information about how people were so that staff on each shift would know what was happening. Staff were responsive to changes in need and referred people to appropriate health professionals in a timely way.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that the management team had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. We also noted that care staff had supported relatives at this difficult time by making them welcome so that they could stay with their family

member during their last hours in order to provide comfort and reassurance.

Inadequate

Is the service well-led?

Our findings

At our last focused inspection in July 2017 we rated this key question as 'requires improvement'. We had concerns about the quality of the medication audits the service carried out. We concluded that these had not been robust as some of the issues we identified during this inspection dated back several weeks. The service's own audits and external audits identified issues but action was not always taken to address them. The registered manager at that time did not have an effective system to review the quality of the audits.

At this inspection, we found the previous registered manager and provider had continued to fail in ensuring the proper and safe management of medicines. We also found the provider had not ensured that they operated effective systems and processes to make sure they assessed and monitored their service against the regulations. Since our last visit, we found the provider lacked complete oversight and responsibility for Nightingale Care Home, resulting in a systematic failure in meeting the regulations.

Despite the concerns raised at our previous visit there had been an absence of formal support and development to the registered manager at that time. Consequently, we found inadequate monitoring of the quality and safety of the service provided.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred care was embedded. Systems in the service that were meant to monitor and identify improvements were not effective and records were not always maintained and completed in full. This lack of effective governance led to all people not receiving safe and consistent care. The care plans for people using the service were incomplete or did not contain up to date and regularly reviewed information. This meant staff was not able to perform their duties efficiently and that people were at risk of receiving care not appropriate to their needs.

The provider's failure to have an effective system in place to monitor, check, identify and address risk had resulted in people's wellbeing and safety not always being mitigated. We also found shortfalls in peoples' care related to peoples' lack of access to stimulation, meaningful occupation and activities. The provider had not reviewed staffing levels in response to peoples' changing needs to ensure that these were sufficient.

We identified inconsistencies in the quality of care with documentation and care delivery of variable quality dependent on the area of the home. For example we identified some issues with risk management, MCA compliance not being adhered to, care documentation and a lack of assessment of people's needs, as well as observing some good areas of practice in these same areas. Therefore, the quality and outcomes for people were inconsistent.

Accidents and incidents were recorded, including falls. There was no evidence of audit or review of incidents and accidents to identify patterns to inform care planning or flag up concerns. The evidence above shows that the provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person's care and treatment.

We found serious concerns with care and support delivery at the home that necessitated a referral to the local authority safeguarding team to ensure people's safety. These shortfalls had not been identified by the current management team.

We reviewed the infection control audit carried out by the local authority infection control lead on 10 November 2016. They had identified areas of the home that was coded as red (low compliance and needing urgent attention) and yellow (medium compliance, further consideration and actions needed). We noted three actions in relation to chairs needing replacement due to fabric stains and odours and cleaning of equipment including the stained flooring in the bathrooms were identified as priority areas. We found the provider had not acted on these recommended actions. We shared our findings with the local authority.

People told us they found the management and staff at the home to be approachable and helpful. However, we found the staff lacked effective leadership and management support and their morale was low. Our findings from this inspection demonstrated that the provider had failed to provide good quality and safe care to people and had not acted upon known risks and shortfalls.

Since 2016, we found no evidence the provider sought and acted on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they could continually evaluate the service and drive improvement.

There were inadequate processes for assessing and monitoring the quality and safety of the service provided for the purposes of continuing development. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new manager had commenced employment four weeks prior to our visit. They had submitted their application to register with CQC. One person told us, "I've met the new manager, she's very nice." The new manager told us they knew the home was going to be a challenge as the provider had been honest with them from the onset that standards had fallen and systems were not in place as they were. The manager told us they were committed to the future of Nightingale Care Home.

The previous registered manager continued to work at Nightingale Care Home under the supervision of the new manager. Their role and responsibilities had not yet been agreed at the time of our visit. During the three days of our visit, the previous registered manager acknowledged the short falls that had occurred and told us, all monitoring of the service had stopped in October 2017.

The provider confirmed they had not ensured systems continued and recognised this was a serious failure. The provider told us, they had waited until the new manager commenced for the systems to be reintroduced and implemented. One relative told us, "Well I only found out (regarding the management change) because of another visitor, a relative, knew about it and told me, I had no idea that the old manager was no longer in charge."

Each time we informed the new manager of our findings, she immediately responded by ensuring shortfalls were addressed. This included informing the safeguarding team of concerns, carrying out spot checks on staff practice, increasing staffing levels with immediate effect, arranging monthly staff meetings and staff supervision to offer additional support and guidance. The manager updated the services audit tool to ensure the areas we identified would be included.

Following the inspection the manager offered assurances they would also audit the service on a weekly basis and had advertised a deputy manager post which would be full time, which would offer more of a

management structure to the home who would be part of the quality monitoring system to improve practices in the home. At our next inspection, we will assess how changes to their quality assurances processes have been embedded to ensure improvements are made and sustained.

The new manager provided sufficient evidence that all training needs were booked and planned for to ensure staff had the knowledge and skills to meet people's needs. The provider agreed to voluntarily suspend all new admissions until our next inspection visit. We received further assurances since the inspection and continue to be in regular contact with the provider to ensure standards improve imminently.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's care and treatment met their needs and reflected their preferences. (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Failure in ensuring people using the service are treated with respect and dignity at all times while they are receiving care and treatment is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. The provider had not done all that was possible to ensure consent was being obtained lawfully and that the person who obtains the consent had the necessary knowledge and understanding of the care and/or treatment that they are asking consent for.

(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to mitigate risks to people's safety because care records lacked detail and monitoring was not always effective. The provider had continued not protecting people against the risks associated with the unsafe handling and recording of medicines. (1) (2) (a) (b) (g) (h)

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 Failure to establish systems and processes to prevent abuse of people is a breach of Regulation 13 of the Health and Social Care Act 2014. (1) (2) (3) (4) (c) (6) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate processes for assessing and monitoring the quality and safety of the service provided for the purposes of continuing development. (1) (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failure to carry out relevant and robust

recruitment checks of staff is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

(2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff to meet peoples needs. The provider failed to support and supervise staff, resulting in them being unable to carry out their role and responsibilities. Not ensuring staff fully understood the training they received and carried out their duties in a competent way was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. (1) (2) (a)