Korcare Limited

Nightingale House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 January 2016 and 8 January 2016 and the first day was unannounced.

Nightingale House is registered to provide care and accommodation for up to 27 people who have an alcohol related brain injury such as Korsakoff's and / or mental health needs. On the day of the inspection 25 people were living at the care home.

The service had a registered manager in post. 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.
Stoke
People told us staff were kind and caring, and most people told us they were treated with dignity and respect. We found staff did not always have time to talk with people, promote their independence and social activities were limited.

People's involvement in the community and social life were not promoted, and some people told us they were bored. People felt staff were competent; however, people were not supported by staff that had the knowledge, skills, experience and training to carry out their role and deliver personalised care. People were protected by safe recruitment procedures.

People were supported to eat and drink enough and maintain a balanced diet. Mealtimes were at set times throughout the day and people told us they did not have a choice of meals. Drinks were also at set times throughout the day and served in the dining room.

Some people felt safe living at Nightingale House, some people felt restricted. The registered manager understood their safeguarding responsibilities.

People were protected from risks but to the extent their independence and freedom was affected. Where staff felt there were risks, risk assessments did not identify these. We found blanket rules in place for everyone rather than individual assessments of people's needs.

People's mental capacity was not always being assessed and regularly reviewed which meant care being provided by staff may not always be in line with people's wishes. People who may be subject to Deprivation of Liberty applications (DoLS) had not been assessed. Staff did not understand how the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) protected people to ensure their freedom was supported and respected.
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People did not always have care plans in place which addressed their individual health and social care needs. People were not involved in the creation of their care plan and ongoing reviews of their care.

Therefore care plans may not have reflected people's needs, wishes and preferences about what care they needed and how they wanted staff to provide it.

People's end of life wishes were not documented and communicated. This meant people's end of life wishes were not known to staff.

People who were living with short term memory difficulties due to their previous alcohol use were not always appropriately supported in an individual way. People's care plans did not address people's cognitive and memory needs or demonstrate how they would like to be supported. People were not always protected by effective infection control procedures.

People knew about the complaints procedure. Staff felt the registered manager was supportive. Staff felt confident about whistleblowing and told us the registered manager would take action to address any concerns.

The registered manager did not have effective systems and processes in place to ensure people received a high quality of care and people's needs were being met.

People's medicines were managed safely.

People's confidential and personal information was stored securely and the registered manager and staff were mindful of the importance of confidentiality when speaking about people's care and support needs in front of others.

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

Requires Improvement

The service was not always safe.

There were not enough staff to meet people's holistic needs at all times.

Some people told us they felt safe, others told us they felt their freedom and ability to be independent was unnecessarily restricted.

People's risk assessments did not reflect their current risks. There were overprotective measures in place to protect people when their individual risk assessments had not highlighted concerns in these areas. People were not involved in planning how to manage and mitigate potential risks.

There were not robust infection control measures in place.

Staff had completed safeguarding training and would refer any concerns to the registered manager.

Staff were recruited safely.

Medicines were managed safely.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

People were not being assessed in line with the Mental Capacity Act 2005 and conditions on authorisations to deprive people of their liberty were not being met.

People were supported to eat and drink enough and maintain a balanced diet, however, a choice of meals was not evident and mealtimes were regimented and not always personalised.

Staff had received training and there was a system in place to monitor staff training.

People's health needs were met.

Is the service caring?

Requires Improvement

Aspects of the service were not always caring.

People were not always able to maintain and develop their independence, because the routines were rigid and people's choices limited.

Aspects of people's dignity were not respected people's independence was not always promoted.

People's choices and wishes for the end of their life had not been considered, communicated to staff or care planned.

People's confidentiality and privacy were respected.

Staff spoke to people kindly and we observed staff treating people with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not personalised and did not evidence people were involved in the design and implementation of their own care plan.

Care plans were out of date and did not always give guidance and direction to staff about how to meet people's care needs.

People were not provided with opportunities to engage in personalised activities. Structured activities were in place but people had little to occupy their time outside of these events.

There was a policy in place for dealing with complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was insular and not familiar with the latest developments in care for people with memory loss.

People did not receive a high standard of quality care because the systems and processes for quality monitoring were ineffective in ensuring people's needs were met.

There was a management structure in place and staff told us they felt supported by the registered manager.

Nightingale House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the home unannounced on 2 January and announced on 8 January 2016. The inspection team consisted of two inspectors for adult social care on 2 January 2016 and two inspectors for adult social care on 8 January 2016.

During our inspection, we spoke with 15 people living at the home, four members of care staff, the registered manager and the finance manager. We carried out a Short Observational Framework Inspection (SOFI) in the lounge on 2 January 2016. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how people were supported at lunch, and watched how staff interacted with people during this time.

We observed care and support in the lounge, spoke with people in private and looked at seven care plans and associated care documentation. We also looked at records that related to medicines as well as documentation relating to the management of the service. These included policies and procedures, staffing rotas, residents' meeting minutes, staff recruitment files, training records and quality assurance and monitoring paperwork.

Before our inspection we reviewed the information we held about the home and spoke to a relative of one person who had lived at the home. We reviewed notifications of incidents the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law.

After the inspection we contacted the local authority service improvement team. We also made contact with the local GP practice.

Requires Improvement

Is the service safe?

Our findings

The complexities of people's health conditions meant they were not always able to accurately express their views verbally. For this reason, we used observation to ascertain people's well-being in addition to talking to those who were able. Four out of 10 people who were able to talk to us said they felt safe but restricted.

People told us "This place is safe"; "I am confined to my room and can only go out on the veranda when it is open"; "I feel penned in" and "Life is not moving on and has no upward curve because I am not allowed to go out"; "I exist"; "I'm locked in here, I think they think if I go outside, I'll do a runner"; "I can't even go out for a coffee, they'd probably get me arrested and send me to a secure unit." and "It feels very restricted."

Most people we spoke to were negative about their life at Nightingale House and the restrictions imposed on them. People told us "It is too regimented"; "Staff attitude has improved but there is no relaxing of authority for the day to day rules." We spoke to staff and the registered manager about the routines at the home and why there were blanket rules in place for all people. Due to people's previous alcohol dependency there were agreements in place that people would not drink alcohol at Nightingale House. The registered manager and staff told us that routine and structure were important for people at Nightingale House but they were unable to tell us what good practice research they had based these views on. We asked one person who told us they were unhappy at Nightingale House what would make them happier. They replied "A little more independence, I can't even make a coffee; I have to wait to be called."

People were supported in some areas to take everyday risks to enhance their feelings of autonomy, for example their personal care. People who liked to wash independently but needed some staff support to reach areas such as their backs, were supported. However, we found there were overprotective measures in place to protect all people at the home when their individual risk assessments had not highlighted concerns in these areas. For example, no one at the home was able to access the kitchen or drink making facilities, people had access to water in their bedrooms. One person told us, "We can't make our own drink because it's a health and safety risk, they say I'll scald myself." At designated tea and coffee times all people were called and went downstairs to the dining room where they had a drink. We asked staff why people were not able to make a drink for themselves or have their drinks in the lounge whilst they watched TV. Staff advised it was because people had previously thrown drinks at others, they were worried about people walking with hot drinks and there had been disagreements over the drinks. The registered manager told us "these things have to be controlled". The registered manager said they would be willing to try again to provide a more homely routine with drinks.

We reviewed people's care plans but were unable to see evidence related to these specific restrictions. All the care plans we reviewed said people were safe in these areas. One person told us they were unable to ask for tea or coffee outside of the set drinks times. They went on to tell us they liked the garden but staff didn't like them going in to the garden. Four other people also told us staff did not like them using the garden with one telling us they had been told watering the plants was a health and safety risk. Another person said "I think they (the staff) like the power over us." Staff told us people confabulated, that is gave fictitious accounts of past events, believing they were true, as part of their illness and that people were able to use

and enjoy the garden at all times. We found people were not individually assessed regarding any potential risks prior to controls over their independence being in place.

Two people told us they would like to go out but weren't allowed to. Staff confirmed this was the case. One person said they thought they would be put in a secure unit if they tried to leave. They wanted to go into town for a coffee. Staff told us most people would get lost and the police would have to be called to return them. The service had not evidenced trying to work alongside people in the least restrictive way or supporting people to learn the way home.

The home was secure to prevent unknown people entering. People had their identity checked and were asked to sign in when they arrived. Keypads were on external doors which prevented those at risk from leaving but the correct legal processes had not been followed to restrict people's movement in this way.

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

One person we spoke with had the ability to clean their own room and wished to do so. They told us they weren't allowed to use the vacuum cleaner due to health and safety. Another person told us they were not allowed to have their own hairdryer and had asked repeatedly for one. Staff told us they were not safe using a hairdryer but could not tell us what the specific reasons were and we were unable to see anything recorded in the care records which identified any concerns. This person also told us they were not allowed their denture adhesive in their room. One staff member told us they would put it "everywhere" however, the person's care plan said they were independent in their dental care with no risks identified.

Where people had identified risks and behaviours that challenged the service, there was not clear guidance in place on how any incidents could be diffused and what might help to calm or distract people. Where staff had identified risks, some these were out of date, based on historical information in different circumstances, and not reflective of people's current situation.

Risk assessments were not always in place as necessary, updated, and reviewed. Risk assessments were not always reflective of people's individual needs.

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

Infection control procedures did not always ensure people were protected from the possibility of cross infection. There was no infection control risk assessment and no infection control audit in place. The meant the service could not be confident staff were following safe infection control practices and the service was meeting current guidance. Staff told us they had undertaken infection control training and wore personal, protective equipment when providing personal care to reduce the risk of cross infection. However, during the inspection we found two communal toilets had no hand gel or paper towels. Staff told us they had not undertaken their morning checks yet. We checked at the end of the first day of the inspection and hand gel was still not present in these bathrooms. This meant people using these bathrooms did not have access to soap to wash their hands after using the toilet. We found many bedrooms did not have soap or hand gel either. Handwashing helps reduce the risk of cross infection. On examination of one person's bedroom, a clean sheet had been placed over their fabric mattress which was saturated with urine. There was a large dip in this person's mattress where the springs had been worn over time and damaged. The urine had soaked through the mattress to the bed slats. This person's waterproof duvet, which smelled strongly of urine, had been hung over a chair to dry and their damp pillow, which also smelled of urine, was hung out of the

window. We brought this to the attention of staff who replaced the person's mattress and provided them with clean, dry bedding and a new mattress so they would be comfortable. Following the inspection the registered manager sent us a cleaning checklist they planned to implement within the service.

Good infection control practice was not followed. Adequate procedures were not in place to assess the risk of, and prevent the risk of infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people told us they were locked out of their bedrooms during the day. We found one of these bedrooms locked when we checked. We returned later after we asked staff about this and it had been unlocked. People told us the smoking room was also locked but during the inspection we found it unlocked. Staff told us these people were not locked out of their rooms or the smoking room. The registered manager told us people had requested their room be locked so other people did not go in it. Three people who lived in a house adjacent to the home spent the day at the main house in the lounge. Staff held the keys to this house and told us people were able to return in the day to their bedrooms if they wished, but they chose not to and preferred the company of others in the main house lounge.

People were protected by staff that had received training in safeguarding and knew how to recognise some of the signs of possible abuse. Staff commented "If someone was horrible to another person or touched them inappropriately I'd report it to the manager." Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Training records showed that staff had completed safeguarding training in 2014 and most staff accurately talked us through the action they would take if they identified potential abuse had taken place.

Staff at the home were responsible for caring for people, cooking, cleaning and laundry. On the first day of the inspection there were two staff on duty when we arrived. We were told a third staff member was running late and coming in to cook lunch as the cook did not work weekends. Staff called the registered manager who came in to support the inspection. On the second day of the inspection we were told by the registered manager there had been another staff member on duty on 2 January 2016 but we did not see them. We asked to see the staffing rota for the first week of January 2016 but it could not be found.

We were told the staff rota was not always an accurate reflection of the staff working. For example, one senior care staff on duty during the morning of the second day of the inspection had worked part of the previous night shift due to staffing issues but this was not recorded on the duty rota. We spoke to the registered manager about how staffing levels at the home had been decided as the staff on duty did not have time to engage with people in meaningful activity or take them out if they wanted to go out. The service's website said "We maintain a very heavy staff/client ratio and will extend our resources that 'extra mile'". We did not see evidence of this during the inspection.

Staff told us they felt two staff were sufficient to meet the needs of 25 people however we observed little individual interaction with people throughout the day. During a two hour SOFI observation staff spent fewer than five minutes in the lounge with people. Most people (18 during the observation period) spent the entire day in the lounge. A few watched television, one did a cross word, one read their newspaper but most slept or were sitting quietly. Recruitment was in progress to fill current vacancies. Staff told us in the event of short term absence they worked flexibly as a team. This meant agency staff were not required ensuring consistency and continuity of care was maintained for people by staff who knew them well.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Staff confirmed these checks had been applied for and obtained prior to

commencing their employment with the service.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Medicine administration records were accurate and fully completed. Staff were trained and confirmed they understood the importance of safe administration and management of medicines. One staff member told us "I watch people until they take their medicines, they're as good as gold." Regular medicine audits were undertaken.

People's needs with regards to administration of medicines had been met in line with the Mental Capacity Act 2005 (MCA). The MCA states that if a person lacks the capacity to make a particular decision, then whoever is making that decision must do so in their best interests. For example, according to staff some people were unable to consent to their medicine. Staff informed us people's doctors had been involved in the decision that continuing to take the prescribed medicines was in people's best interests.

People's needs were considered and met in the event of an emergency situation such as a fire. People had personal evacuation plans in place which detailed their specific needs in relation to mobility and equipment they might require. These plans helped to ensure people's individual needs were known to staff and to emergency services, so they could be supported and evacuated from the building in a safe way. Staff at the home had participated in fire safety training and regular fire drills took place.

Regular health and safety checks had been undertaken and equipment was regularly serviced ensuring it was safe and fit for purpose. Most routine maintenance was carried out by an external contractor. Staff confirmed faulty items were reported and repaired promptly.

Staff told us they kept people safe through numerous methods. For example they described checks they undertook on people's wheelchairs to ensure they were safe, and the environmental checks they did to ensure there were no trip hazards and obstacles. Staff told us "It is basic common sense. I check floors aren't slippery, there are no mats or rugs to trip on." Staff confirmed those who required two people to assist with their mobility always had this and we observed this during the inspection. Staff ensured people had the right equipment in the right place, for example their frames to help them walk safely. We heard staff giving clear, precise directions to one person as they helped them to manoeuvre from their chair to their wheelchair.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had received training in the MCA. The registered manager and staff however did not understand the MCA and their responsibilities in relation to this legislation and associated Deprivation of Liberty Safeguards (DoLS).

The 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 at Nightingale House were not being routinely assessed in respect of their mental capacity when required. This was despite people being noted as having conditions, such as Alcohol Related Brain Damage and Korsakoff's, which may mean they were less able to make decisions about their care and treatment. There were no capacity assessments in place to ensure people's right to consent was being respected. Records did not demonstrate who had been involved in any decision making in respect of people's care and treatment.

We found there was an assumption by staff that people did not have mental capacity which had not always been assessed or reviewed as people's health improved. Staff told us "No one here is able to make a decision for themselves, they would forget." However, although staff told us people did not have capacity we found some people's care records stated they did. For example, for one person's care plan stated they relied on others to make decisions for them; however, there was no evidence of how this person's mental capacity had been assessed to reach this conclusion.

Care plans lacked detail about what decisions people were able to make for themselves, or with support, and which decisions needed to be made in people's best interests involving those who knew them well. Staff told us however, where people did not have mental capacity, best interests meetings had been held for larger decisions, for example hospital operations people needed and to discuss people who were looking to move on from Nightingale House .

We spoke with people who said they did not want to be living at Nightingale House. One person took our hands and said "Can I just say I'd like to leave here". We asked them if they would be comfortable if we approached social services, (the people who arranged and paid for them to be at the home) on their behalf, and they said, "yes, please". Although initially they had been moved to the service in their best interests, their ability to make decisions about their life and where they lived had improved over time and a review was required. We spoke to the registered manager about asking people's funding authorities to reassess these people. Following the inspection, the registered manager confirmed requests for reviews had been made.

Not all people who may be subject to Derivation of Liberty Safeguards (DoLS) had been assessed. DoLS

provide legal protection for those vulnerable people who are, or may become, deprived of their liberty to protect their safety. Restrictions were in place on people at Nightingale House which meant people were possibly being deprived of their liberty without lawful authority.

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

Some staff had a limited understanding about the principles of the MCA and DoLS and had not undertaken training in the Mental Capacity Act. Some staff told us they were aware and understood the MCA and DoLS. Staff were unable to give us an explanation of why people had not been referred to the supervisory body in a reasonable timescale where there were restrictions in place on their liberty and they not able to leave the home. Staff told us "The law has changed, we are catching up." We were told one person had a DoLS in place but their care records did not reflect this. This person's capacity assessment stated they might make inappropriate decisions but there was no guidance in place of how to support the person to make decisions. Their care record stated it was not in their best interests to be deprived of their liberty.

We spoke to the registered manager about the change in law and the process required for a DoLS assessment. We requested those people who were under constant supervision and control, not free to leave the home and who staff felt did not have capacity were assessed. We were told this would be prioritised.

The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed. Not acting in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nightingale House had an in-house induction programme for new staff but the registered manager was not aware of the Care Certificate. The new care certificate was recommended following the 'Cavendish Review'. The outcome of the review was to improve consistency in the training health care assistants and support workers receive in social care settings. The registered manager arranged training on this following the first day of the inspection.

People had their nutritional needs met. Staff told us people were involved in the menu planning in residents' meetings. We were unable to see a menu displaying what was for lunch or tea and heard people asking staff what was for lunch. For people who live with memory difficulties, a menu may be helpful as people may forget what they had been told. People were provided with a balanced diet. People told us the food was fine but there was little choice. Staff told us if people did not like the main meal on offer, they were able to ask for something else such as a jacket potato. Staff told us people were all happy to have the same food as each other. The registered manager told us an information board with the menu was displayed following the inspection to support people's memory difficulties and they would know what was for lunch.

Meal times and tea and coffee times were set and spaced throughout the day. We were told by staff this provided structure and routine to people's day which was important for them. The first day of the inspection was a Saturday and everyone had eaten breakfast before we arrived (before 9am). We asked staff if everyone had wanted to have their breakfast at the weekend between 7 and 7.30am, we were told all the people in the home were early risers. However, one person told us they would like a lie in sometimes.

Most people ate and had their drinks in the dining room downstairs. This was a small room with artificial lighting as there were no windows. We were told there were plans in place for an extension of the dining room to improve this space. We sat with people downstairs during coffee time and people were relaxed and enjoyed the social interaction during this time. People told us if they were hungry outside of the set

mealtimes, snacks were available on request. Staff told us people had cereals or toast for breakfast; the registered manager told us people could request a cooked breakfast if they wished. People's preferences were sought, although we were told these sometimes changed due to their memory issues. Food and fluid diaries were kept where people's nutritional intake required monitoring due to their health conditions or because they had been neglecting themselves. However, people's risk assessments and care plans did not reflect why these measures were in place. For example one person whose diet was monitored was not identified as a risk and their weight was stable. People's weight was monitored where required.

People were encouraged to come to the dining room for their meals if they were physically able, and all drinks were served in this area. Those who were unable to come to the dining room due to health needs or mobility problems had their meals and drinks served in their rooms or in the lounge (there was no lift to enable people to go to the dining room). Staff informed us people did not have drinks in the lounge due to health and safety risks with hot drinks. Other staff told us this was so they could monitor what people ate and drank, as some people would say they had eaten when they had not. Staff informed us drinks were observed in this way so people had the eight drinks a day the service aimed for. We did not see individual risk assessments or protective measures to mitigate these risks for those people prior to a rule being put in place which may not be everyone's choice. However, we observed people were so familiar with the routines that when staff called them for drinks or meals, they all went without question to the dining room regardless of whether they wished to finish watching a programme on the television. Those who were unable to access the dining area had drinks and food brought to them by staff. Staff told us they had previously tried having drinks in the lounge area but no one asked for a drink as they were used to being cared for by staff.

People confirmed they had access to external health professionals, such as GPs, dentists and opticians and documentation confirmed this. The registered manager told us people would rarely come to them with a health problem but because they knew people so well and the staff team was so stable, they identified changes in people's health quickly and responded promptly. The registered manager told us they had a good relationship with the GP surgery who always responded in a timely manner when requested. We found however when people's needs had changed and people had improved, social services were not contacted in a timely way to review people's needs and placement. This meant some people's placement in residential care may no longer have been required.

Staff said they felt well supported. Staff had not received formal one to one supervision, but the registered manager told us appraisals were in place. We were informed staff received regular informal supervision and staff told us the registered manager was always available for advice and support.

Staff training records showed they completed a variety of courses including food hygiene, health and safety, emergency first aid, infection control, medicine management, safeguarding and DoLS.

Requires Improvement

Is the service caring?

Our findings

People could not recall being involved in the creation or review of their care plan to ensure it was reflective of how they wanted their health and social care needs to be met. The registered manager told us people were encouraged to discuss and be involved in their care planning and sign care records if they were able to. Many people living at Nightingale House did not have family or friends involved in their care. People living at Nightingale House were from different areas of the country, some people were reviewed annually by their local authority. This meant people relied on staff to have their care and support needs met and ensure they had access to advocacy.

The routines and structure in place at Nightingale House and lack of personalised care planning and positive risk taking meant people's potential for recovery may be limited. People were not encouraged and supported to be as independent as they could be. One staff member told us it was sometimes quicker to do things for people. Many people had lived at the service for a long time and were used to the routines, the loss of independence and they were compliant with the rules in place.

People's end of life wishes were not recorded in their care plans. This meant people were at risk of not having their choices and preferences for the end of their life met because there was no written information for staff to follow.

We found care was not always person-centred or reflective of people's their personal preferences for care. We found care plans did not include how people could be supported to maintain their independence. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity and privacy were sometimes upheld. Staff told us they maintained people's privacy when providing personal care, always knocked on people's doors and ensured people were appropriately dressed when returning from the bathroom to their room. If people had particular requests for gender specific staff or a favourite member of staff, if they were on duty, this was made possible. One staff member said "Most like us to go in the bathroom with them but I'll turn my back, hand them their towels." Other staff gave examples of how they supported people in a kind way to choose clothing which maintained their dignity and was appropriate for the weather. One person we met however had holes in their shoes. We spoke to the registered manager about this and were told several pairs were bought for the person at the same time which they liked, so they were able to have a new pair.

We were told by staff people were able to lock their rooms if they wished, however, some people told us they were locked out of their room during the day. Staff said this was not the case and rooms were only locked at people's requests. One person told us they did not always feel they were cared for in a respectful way. One person said staff come in early every morning, opened the curtains and woke them up. They said "would rather sleep in" and indicated this by putting their head back down on the pillow. They told us, "it's OK but all the time is too much".

People told us some staff were kind. One person said "One or two staff are good, others' bad, bad, bad" and

indicated this by putting their thumbs down. They were unable to verbally explain to us why they felt staff were not kind.

We observed staff were kind and caring when they interacted with people. Staff told us they felt people were well cared for and happy. Staff were also happy and had worked at the service for many years. We were told there was a good atmosphere within the service. Staff said "I always have a laugh with them; they all call us by our first names." They communicated with people in ways which suited their needs and staff demonstrated familiarity and knowledge of people's likes and dislikes. Staff called people by their preferred name. For example staff said they were patient with people who could be forgetful, spoke slowly and repeated information as needed. Another staff member told us they engaged people with tales of their cat and they liked this. The nature of people's health needs meant people lacked motivation and spontaneous conversation was difficult for some people. During our observation when staff did engage with people in the lounge and discussed the football score, their faces lit up. People responded positively to conversation and enjoyed staff company.

Staff told us people looked out for each other too and helped one another, for example two people who sat next to each other would nudge the other if they were falling asleep. We also saw people holding their hands out to one person as they moved across the lounge to the door. Staff said "It is like one large family."

Special occasions such as birthdays were celebrated. Staff told us people made a cake, there was a sing song with people and they received a birthday card. Staff confirmed Christmas had been a special occasion with lots of food and crackers and everyone was due to go for a meal in January to continue celebrating.

People's records were kept securely and staff understood the importance of confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not guide and direct staff to deliver consistent, personalised care which met their needs and reflected their personal preferences. For example, one person told us they liked the peace and quiet of their room away from everybody but they said this was discouraged by staff and they were told they were isolating themselves. We did not see any concerns regarding this in their care plan and why their preference for remaining in their room was not acceptable.

Care plans lacked detail that was essential for staff in respect of caring for people with particular health needs. For example one person's care plan stated they had no history of falls and there were no problems with their skin but staff informed us they had tripped, fallen and sustained a fracture last year. They had required surgery following the fall. Staff told us the person was having on-going problems related to the fracture, their skin was poor and was creamed daily and they now had an infection in their leg. A further person had continence needs, their care records said there were no urinary or continence needs. Staff told us some people had behavioural problems but care plans did not detail what these were or how staff should support people with particular needs.

Not maintaining accurate, complete and contemporaneous records in respect of each service user is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there was not enough to do. Comments included, "People all just sit in the lounge, every day the same"; "The lounge is surreal, everybody sits all day, the atmosphere is surreal; there is no conversation. Now and again staff will come and sit down for a chat."

People's care plans included a personal history so staff were aware of what a person achieved in life prior to into Nightingale House but this information was not always used to support people's care at Nightingale House. A person's history can help staff to have meaningful conversations with people and tailor social activities to people's past interests and memories. This is particularly important when supporting people who have cognitive and memory difficulties. One person we met had previously been an artist. They showed us their unopened drawing pads and pencils. They told us they weren't allowed to do art at present as there wasn't enough space. We asked staff about this who told us the person did not have the motivation to do their drawing and they were looking to create an activity area. We spoke with the registered manager about helping staff engage and motivate people as a lack of motivation can be a symptom of Alcohol Related Brain Damage (ARBD).

On the first day of our inspection there were no planned activities, on the second day an external entertainer visited during the afternoon. For the majority of the first day and the morning of the second day, people sat in the lounge with the TV on, a few chose to stay in their bedrooms. Staff told us they had time to sit and chat to people and play games in the afternoon but we did not see this during the two inspection days. People were left in the lounge for long periods with little stimulation or interaction. The television was on constantly with few people watching. One staff member tried to suggest snakes and ladders or cards, one person said they'd prefer to play monopoly or scrabble, they were told by the staff member they didn't have

scrabble and no further effort was made to engage in person in any activity. People with Korsakoff's can have difficulties with motivation so staff require skill engaging and involving people in activities.

People told us activities were not individualised or meaningful and "We get fed up of bingo" and "I'm summoned for a shower just after 7am, have breakfast and then sit around like a moron for the rest of the day, in the summer we go outside and sometimes we are taken out, it feels institutionalised." We read in a care plan that one person liked quizzes, musical entertainment, trips out and reading. The care records between 14 October 2015 and 7 January 2016 showed this person had not left the home. We read another person liked to go for coffee three times a week. Their care records indicated they had not done this for two months. The registered manager told us this was a recording issue; the person was unable to recall when they had last been out for a coffee.

Staff told us people didn't really have any goals and people didn't say what they wanted for their future. In the care records we reviewed most people had no recorded life goals in this section of their care plan. However, one person's goal was to start their life again and have a little house. We saw no evidence that this had been listened to and a plan put in place to enable the person to work towards this goal.

We were told some people enjoyed holidaying in America each year and staff supported and enabled this to happen for them. The registered manager told us that although people had similar diagnoses, they were all very different, displaying different symptoms, reacting in different ways. The stable staff team meant people's individuality was known. People however told us there were things they would like to do – art, gardening, go to the shops and going out for coffee. We did not see these people having their individual activity needs met.

Staff told us there were regular set activities which occurred throughout the week. We were told there were external musicians who visited and brought drums, karaoke singing, bingo and people were taken bowling. Outings external to the home were also enjoyed for example trips to the pub, out for a Chinese meal and people were supported to plan and go on holidays. There was a cinema club being looked into and people could participate in an in-house lunch club.

People did not know about the formal complaints procedure, we did not see this visibly displayed or in any of the rooms we visited. Most people told us they would complain to the staff but two people told us they did not feel able to. The service had a system in place to respond to people's formal complaints.

People who were referred to the service underwent a thorough assessment process to ensure the service could meet their needs. People came on a three month trial basis initially to see how they adjusted to Nightingale House. The registered manager confirmed the owners were supportive of a thorough assessment to ensure the mix of people in the house remained as stable and safe as possible. The registered manager told us assessments were discussed in team meetings and people's needs incorporated in care plans.

Staff knew people well so they knew how people liked to be supported with their care needs, they knew who preferred and bath to a shower and who didn't like staff in the bathroom with them. People told us they were supported each day with their personal care and were able to have a bath or shower.

Requires Improvement

Is the service well-led?

Our findings

Nightingale House is run by Korcare Limited. This is the company's only service.

People did not receive a high standard of quality care in all areas. The provider did not have systems and processes in place to assess, monitor and improve the quality of the services provided in respect of the planning of people's care, meeting people's individual needs, record keeping, and implementation of the legislative framework the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS).

The statement of purpose and the service's website detailed the philosophy the service aimed to provide "Person-centred care and a comprehensively trained care team, extra one to one input for therapeutic activity." We did not see this, or find any evidence that this occurred, during our inspection.

The values of the service were "autonomy, attainment, citizenship, individuality, diversity, well-being and inclusion." The people we spoke with and the people whose care we looked at told us they did not feel autonomous or that their individuality was respected. We found no evidence to show these values in practice during our inspection.

The systems in place to assess, monitor and improve the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider how they stayed up to date with current practice. We were informed they had the CQC newsletters, attended residential team updates, read best practice guidance and they knew the people at the home and what worked. We found the registered manager was not aware of changes and recommendations for improving the quality of care; for example the care certificate and changes to the law which affected the people living at Nightingale House had not been embedded into practice. Our observations during the inspection indicated the methods for learning and staying abreast of changes and implementing this in practice had not been effective.

Staff all felt the service was well-led, organised and everything ran smoothly. Staff told us "People are well cared for, there is plenty of food, the manager always makes time for people and they are generally happy."

Staff confirmed they were happy. Many staff had worked for the provider for many years. They told us the atmosphere was good. They confirmed there were regular staff meetings where things were discussed, for example, aspects of people's care so everyone was doing the same thing. Staff said they work as a team; all supported each other and worked together.

Staff knew where the policies were in relation to whistleblowing should they require this to raise concerns over people's welfare.

We reviewed the minutes of the last residents' meeting in September 2015. This detailed information of the building work and noted people were looking forward to enjoying the conservatory. No one was enjoying the new conservatory during this inspection. The registered manager told us furniture was due to be purchased to make this area more enticing to people. Outings and activities were discussed in these meetings and people's menu requests asked for.

We provided feedback to the registered manager throughout the inspection and found them responsive and agreeable to looking at ways to change the culture and support people to have an improved quality of life. Additional training for staff was arranged promptly following the inspection and the registered manager arranged for people who told us they were unhappy to be reviewed by their funding authorities. We were told that where people lacked capacity, were restricted and under constant supervision and control, an assessment would be requested by their supervisory body.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not person centred Care plans were not reflective of care provided There was not sufficient evidence people had been supported to understand care and treatment choices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always in place as necessary, updated, and reviewed. Risk assessments were not always reflective of people's individual needs. There was no evidence that the service and staff had done all that was reasonably practical to mitigate potential risks to people. Good infection control practice was not always followed to assess, detect, prevent and control the risk of infection.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided with consent as the registered person was not acting in accordance with the MCA 2005 for people who were unable to consent because they lacked mental capacity to make particular decisions for themselves.

The enforcement action we took:

WN against provider and manger

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 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (4) (b) (5) (7) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must not be provided in a way which intends to control a service user that is not necessary to prevent, or not a proportionate response to, a risk of harm posed to a service user. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful auth

The enforcement action we took:

WN against provider and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance Regulation 17(1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes were not established to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate the risk to the health, safety and welfare of service users Records of people's care were not always accurate, complete and contemporaneous.

The enforcement action we took:

Warning notice against manager and provider