Nightingale Group Limited

# Nightingale Group ltd. Trentham Care Centre

## Inspection report

Longton Road
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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

About the service
Nightingale Group ltd. Trentham Care Centre is a care home providing personal and nursing care to 96 people at the time of the inspection, some of whom were living with dementia. The service can support up to 155 people.  People who used the service were both younger and older adults who had mental health needs such as dementia, and physical disabilities. Nightingale Group ltd, Trentham Care Centre accommodates people across 5 different units, each of which had their own purpose-built facilities. At the time of this inspection 4 of the units were in operation.

People's experience of using this service and what we found
People did not receive their medicines safely. Not all staff members followed best practice when administering medicines and not all medicine errors were reported in line with the providers procedures.

There were inconsistencies with the way people were treated by staff. Not everyone received empowering and valuing interactions from the staff supporting them, whilst others reported being supported by caring and kind staff.

The provider did not have effective quality monitoring processes or checks in place to ensure safe care, or to identify or meet inconsistencies in people's experiences.

The provider had assessed the risks associated with people's care and support. Staff members were knowledgeable about these risks. People were supported by enough staff to promptly respond to them when needed. The provider followed safe recruitment practices. The provider had effective infection prevention and control practices in place.

People were protected from the risks of ill-treatment and abuse as staff had been trained to recognise potential signs of abuse and understood what to do if they suspected harm or wrongdoing.

People were supported to have maximum choice and control of their lives and the provider supported them in the least restrictive way possible and in their best interests; the application of the policies and systems supported good practice.

The provider, and management team, had good links with the local communities within which people lived.

The last rated inspection rating was on display at the location and on the providers website.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 23 June 2022). At that inspection there were

breaches of regulation regarding safe care, safeguarding, dignity, staffing and governance processes. The provider completed an action plan after the last inspection to show what they would do and by when to improve. Although improvements were made at this inspection, we found the provider remained in breach of regulations regarding safe care and overall governance. Improvements have been required for 3 consecutive inspections.

This service has been in Special Measures since 23 June 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on actions we told the provider to take at the last inspection. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led.

We looked at infection prevention and control measures (IPC) under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from inadequate to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nightingale Group ltd. Trentham Care Centre on our website at www.cqc.org.uk

Enforcement
We have identified continued breaches in relation to the safe administration of medicines, dignity and overall governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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.

Details are in our safe findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

# Nightingale Group ltd. Trentham Care Centre

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 [the Act] as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection prevention and control measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 5 inspectors, 3 medicines inspectors, 1 specialist nurse and 2 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Nightingale Group ltd. Trentham Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Nightingale Group ltd. Trentham Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.
However, there was a manager who had submitted an application for registration.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people living at Nightingale Group ltd. Trentham Care Centre and 8 relatives. In addition, we spoke with 26 staff members including nurses, nurse support workers, carers, care coordinators, human resource staff, the manager, maintenance staff, an external consultant and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with one visiting healthcare professional.

We spent time in the communal areas, and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at multiple care and support plans and medication records. In addition, we looked at several documents relating to the monitoring of the location including quality assurance audits, health and safety checks, incident and accident reports. We confirmed the recruitment checks of 5 staff members including the safe use of agency staff.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Using medicines safely

● Medicines were not always safely stored. A medication trolley was left unlocked and unattended and a temperature sensitive medicine had been left out overnight and had not been stored safely in a locked cabinet. These issues put people at the risk of harm from accidental or intentional misuse. Fridge temperatures had been recorded on multiple occasions outside of the recommended safe storage range. There was no evidence of action to correct the issue. This potentially compromised the integrity of the medicine putting people at risk of harm from the use of ineffective medicines. In one instance we saw a medication cupboard had not been secured to an internal wall in accordance with the law.

● We observed unsafe administration of medication via a percutaneous gastronomy tube (PEG). The medicines were not administered in line with good practice to avoid the risk of medicines interacting with each other before reaching their intended absorption site in the body which would reduce their efficacy. Poor administration technique also increases the risk of the medicines causing blockage of the PEG tube, putting people at the risk of harm. In one instance a staff member was about to administer the incorrect dosage of medicine and we had to intervene. This staff member was not familiar with the person or the medicine system. We passed this concern to the provider to provide additional guidance to the staff member.

● Staff did not always have sufficient information available to administer medicines covertly (disguised in food or drink,) to people. There was a lack of guidance on how to prepare and administer covert medicine. This put people at risk of inconsistent practice. Staff did not always clean the tablet crusher in between crushing different people's tablets. This meant people were getting the residue of medicines prescribed for somebody else, putting them at risk of harm from medicines not prescribed to them.

● Some people did not have personalised 'when required' (PRN) protocols that stated when they needed their medicines. For example, one medicine protocol stated to give to, 'Alleviate anxiety' but there was no additional information on signs and symptoms of anxiety or what else could be done to support the person.

● Staff were not fully aware about how to use the electronic medication recording system, which put people

at risk of harm from poor medicine administration and practice. Staff could not ascertain where medicated patches had been applied. They could not pull off medicine administration record (MAR) and did not know how to access body maps. Staff had to make a false entry before they could identify where to safely apply the patch.

The provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We passed our concerns to the management team who acted to review all the areas of concern and produced an immediate action plan to mitigate the potential for harm to people.

Learning lessons when things go wrong
● Not all incidents in relation to the safe administration of medicines were reported to, or investigated by, the provider. We found poor staff practice and unsafe storage of medicines which had not been recognised by the provider as part of their lessons learnt process.
● Other than issues relating to medicines, the provider reviewed incidents or accidents to see if any further action was needed and to minimise the risk of reoccurrence. For example, incidents, accidents and near miss incidents were reviewed to ensure appropriate action had been taken.
● The provider had systems in place to address any unsafe staff behaviour. This included retraining or disciplinary procedures if required.

At our last inspection systems were not robust enough to safeguard people from abuse and improper treatment. This placed people at risk of harm. These issues constituted a breach of Regulation 13: Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse
● People were safe from the risks of abuse and ill treatment. One person told us, "If I was worried, I would talk to the manager. I was frightened about coming here at first but not now."
● People were protected from the risk of abuse and ill treatment as staff members had received training on how to recognise and respond to concerns.
● Information was available to people, staff and relatives on how to report any concerns.
● The provider had systems in place to share information about any concerns with the appropriate agency. For example, the local authority, in order to keep people safe.

At our last inspection the provider failed to deploy enough suitably qualified, competent and experienced staff to enable them to effectively and safely meet people's needs. This placed people at risk of harm. These issues constituted a breach of Regulation 18(1): Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 (1).

Staffing and recruitment

● People were supported by enough suitably qualified and experienced staff to meet their needs in a timely way.
● The provider followed safe recruitment processes including seeking a full work history, references and confirmation of the applicants right to work in the UK.
● The provider completed checks with the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks and provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider had measures in place to mitigate the risks associated with COVID-19 related staff pressures.

Assessing risk, safety monitoring and management
● People received support from staff who knew how to safely support them and respond to their needs. One person described their needs to us in detail and how staff safely supported them to remain comfortable and pain free. There were clear instruction in people's care and support plans for staff to follow. Staff were knowledgeable about those they supported, including any risks to health or safety.
● We saw assessments of risks associated with people's care had been completed. These included risks related to diet, nutrition, skin integrity, trips and falls.
● The provider completed regular checks on the physical environment to ensure it was safe for people to live in. This included regular fire safety system checks, any potential trip or fall hazards and legionella checks. Legionnaires' disease is a potentially fatal form of pneumonia caused by the inhalation of small droplets of contaminated water containing Legionella.
● People were supported to identify and mitigate risks associated with their care and support. The provider assessed risks to people and supported them to continue to lead the lives they wanted whilst keeping the risk of harm to a minimum.

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 MCA 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 Mental Capacity Act [MCA]. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards [DoLS]

● People were engaged in decisions about their care and support and staff supported people in the least restrictive way possible. One person described their personal tastes and how staff encourage them to make the choices they wanted.
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
● Staff members had received training in infection prevention and control and knew how to minimise the risks of infectious illnesses. This included updated training in response to the COVID-19 pandemic.
● Staff members had access to personal protection equipment which they used appropriately when supporting people.
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of

infection. Staff understood how to recognise and respond to signs and symptoms of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was making sure infection outbreaks could be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was supporting visits in line with the Government guidance.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At our last inspection people's individual dignity was not respected by those supporting them or those directing care and support. This was a breach of regulation 10, dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

Respecting and promoting people's privacy, dignity and independence. Ensuring people are well treated and supported; respecting equality and diversity

- People received inconsistent support from staff in terms of valuing and positive interactions. Some people received one to one staff support. This was not always personal or engaging. Some people had staff members sat with them, however there was a lack of communication or engagement for prolonged periods of time. Activities which should occur during this time did not always happen. For example, one person should have been supported by staff to do a cooking activity. The staff member updated the person's records to state this had happened when it had not. A staff member told us, "We say it's been done so we don't have a red flag against our names on the records." The provider did not have oversight to ensure one to one support for people occurred as expected. Facilities were not available to do this activity and staff did not have guidance on how to provide engaging and valuing experiences to people.
- People did not always have their personal space decorated or personalised. We saw one person's bedroom was sparsely decorated with no personal possessions. A staff member told us this person had moved in a few years ago but as they had no family, no one has decorated their room or put out personal items for them. We confirmed there was no restriction to staff engaging this person to personalise their room. This did not demonstrate a respectful or dignified approach. However, in other areas of the home we saw people had their personal items in their rooms which had been decorated to their individual tastes.
- Peoples experience of dignity and respect was inconsistent throughout the home. We saw staff entering people's bedrooms when they were present without knocking the door, announcing themselves or engaging with the person who was in the room. This did not demonstrate everyone was treated with respect or their privacy acknowledged.

People's individual dignity was not consistently respected by all those supporting them or those directing care and support. These issues constitute a continued breach of Regulation 10: Dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other areas of the home we saw staff engaging with people in a friendly and valuing way, talking with them when entering their room and seeking permission to go into their personal items of furniture.
● Staff members spoke about those they supported with kindness and respect. One staff member said, "Everyone is different and should be treated as so. Someone may be having an off day, and then they just need some space. Others want you to spend time with them and just have a chat. It has to be personal." We saw this staff member helping one person make an alternative dinner choice as they didn't like what was on offer.
● One person told us, "Staff do their best with real kindness. They're so soft." Another person told us, "They're nice people here and they are good at helping me. The best thing about here is that they are kind."

Supporting people to express their views and be involved in making decisions about their care
● There were inconsistencies in the way people were supported to make decisions. We saw some people had not been engaged in decisions about their bedrooms or activities, where others had been. One person told us they chose the clothes they wore each day and the activities they took part in.
● People made decisions about the food they ate; alternatives were available should they not want what was on offer. One person said, "There's about 10 or 11 different things on the menu to choose from. I'm picky so I might send it back. During the day you can have biscuits, yogurts or fruit."

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to ensure the regulated activity was carried out safely. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Although significant progress had been made by the management team, improvements were still required in quality monitoring to ensure people receive safe and valuing care. The improvements which had been made needed to be embedded in practice. For example, the provider's quality monitoring processes did not correct the missing information in people's medication care plans or the omissions in guidance for the safe administration of PRN or covertly administered medicines. However, the provider had identified issues with the electronic recording system and had acted to seek an alternative recording system.
- The provider did not identify or correct issues relating to the poor administration of medicines or in relation to the unsafe storage of medicines. The provider failed to identify fridge temperatures were repeatedly recorded outside the safe operating range.
- The provider's quality checks had not identified staff recording errors where activities people were engaged in were not accurately recorded.
- The quality checks completed by the provider failed to identify or correct the lack of personal, valuing or interactive contact between some people and staff.

The provider had not embedded their governance systems, including assurance and auditing systems or processes. These issues constitute a continuing breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, significant improvements had been made in terms of staffing, recruitment, risk assessments, safeguarding, notifications of incidents and the effective application of the mental capacity act.
- The provider had appropriately submitted notifications to the CQC. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.

● We saw the last rated inspection was displayed at the home in accordance with the law. The last rating was also displayed on the provider's website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessment. Staff members told us about people's individual characteristics and knew how to best support them. This included people's religious beliefs, gender identification, disability and personal preferences.

● People felt the management team was engaging and approachable. One person said, "If I had a complaint I could say so. [The unit manager] had a dance with us and we all know what they do. I feel I can go to them at any time." They went on to say, "The personal touch is what you get here and it means a lot to me."

● Staff gave us positive feedback about the changes to the management team. One staff member said they felt supported in their role, they had regular support and supervision sessions. Communication had greatly improved with the reintroduction of team meetings. Another staff member told us they felt very supported in their role, there was a great team of staff and everyone was willing to provide help or advice if it was needed.

● Staff understood the policies and procedures that informed their practice including the whistleblowing policy. Staff felt confident raising concerns with the management team and believed they would be supported if they needed to raise a concern.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider was aware of their responsibilities under the duty of candour. The duty of candour is a regulation which all providers must adhere to. Under the duty of candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

● The provider had systems in place to act on concerns raised with them, investigate and feedback to the person the outcome in a timely way. People consistently told us any issues raised were addressed to their satisfaction.

Continuous learning and improving care

● The management team had kept themselves up to date with legislation and best practice used to drive improving care. They received regular updates from the CQC, Local Authority, Clinical Commissioning Groups and provider representation colleagues, in order to keep informed and updated on practice.

Working in partnership with others

● The management team had established links with other health care professionals. For example, the local authority, GP's, and social work teams. Any advice or recommendations were recorded in people's individual care plans.

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<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Not everyone was treated with respect and in a dignified way by those supporting them. |

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 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider did not have systems in place to ensure the safe administration and storage of medicines. |

**The enforcement action we took:**

We have varied a condition to the providers registration with the CQC.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider did not have effective quality monitoring systems in place to drive good care. |

**The enforcement action we took:**

We have varied a condition to the providers registration with the CQC.