

## Nightingale Hammerson

# Nightingale House

### Inspection report

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### Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

# Summary of findings

## Overall summary

This was an unannounced comprehensive inspection carried out on 29 and 31 May 2018.

Nightingale House is a 'care home'. People living in the care home receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home can accommodate up to 215 older Jewish people across six self-contained units, each with separate adapted facilities. Three of the units known as Ronson, Sampson and Wohl specialised in providing nursing care to people, while the units known as Sherman, Wine and Osha were residential and provided people with personal care. At the time of our inspection 180 older people resided at the care home, the majority of whom were living with dementia.

At our last inspection of the service in February 2016 we rated them 'Good' overall and for four five key questions, 'Is the service safe, effective, caring and well-led?' and 'Outstanding' for the key question, 'Is the service responsive?'

At this inspection we have increased their overall rating from 'Good' to 'Outstanding' and for the two key questions, 'Is the service caring and well-led?' The service remains 'Outstanding' for the key question, 'Is the service responsive?' and 'Good' for the two key questions, 'Is the service safe and effective?' This was because we found the provider continued to drive improvement, particularly in relation to the service being caring and well-led.

The service continued to have a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We received extremely positive feedback about the standard of care provided at the home from people living there and their visiting relatives and professional health and social care representatives. We observed staff continued to be compassionate and kind throughout our two-day inspection.

People nearing the end of their life received compassionate and supportive care at Nightingale House. The service retains their Gold Standards Framework (GSF) award with 'Beacon' status. The Gold Standards Framework is a professional accreditation awarded to care homes in recognition of their high-quality end of life care practices. Beacon status is awarded to those services who have maintained best end of life care practices. The provider worked closely with all the relevant community health and palliative care professionals and respected the wishes of people nearing the end of their life. Staff received end of life care and bereavement training, which included a specific module on understanding death and dying from the perspective of the Jewish faith.

The service had built up strong links with the wider community. Since the last inspection, the service had embarked upon an innovative inter-generational project which had led to the opening of an on-site nursery to bring children and people living in the home together on a daily basis to participate in shared social activities. The service also had good links with other local community groups and institutions. For example, entertainers, drama groups, musicians and a mother and toddler group regularly visited the home to perform or just interact with people living at the home. The service also employed a community outreach worker who kept people updated about what was happening in the local Jewish community.

Activities provision within Nightingale House remained person-centred and innovative, which enabled people to live active and fulfilling lives. The service had its own concert room, well-equipped activity centre with pottery kiln, cooking facilities and internet-café, a library, cafe, well-kept gardens and a pet's corner with rabbits, guinea pigs and an aviary. People who preferred or needed to stay in their bedroom were also protected from social isolation. People regularly participated in outings and activities in the local community. Furthermore, the service had introduced the Namaste programme which was designed to improve the quality of life for people living with dementia. Each unit had designated Namaste trained staff and a purpose-built Namaste sensory room which was a calm space for people to relax in.

People, relatives, community health and social care professionals and staff were very complimentary about the service's management team. They said managers and senior staff were all highly regarded by everyone and worked well together as a team, which had a positive impact on the quality of the service provided at the home. People and staff said managers were ever present on the units, approachable and always interested to what they had to say.

The provider continued to work closely with numerous other professional agencies and academic institutions to review joint working arrangements and to share best practice including, Springfield University Hospitals team of psychiatrists who Furthermore, several university students were in the process of carrying out PhD research projects at the home, looking specifically at dementia, bowel and bladder care, end of life care, spirituality and staff interaction with people.

Managers at all levels ensured the company's values and vision for the home were fully embedded in the service's systems and processes and demonstrated by staff through their behaviours and actions. There was clear oversight and scrutiny of the service. They used well-established quality assurance systems to ensure all aspects of the service were routinely monitored and could be improved for people. This helped them to check that people were consistently experiencing good quality care and support. Any shortfalls or gaps identified through these checks were promptly addressed.

Managers encouraged and supported staff to deliver high quality care and recognised and rewarded them when they demonstrated excellence in the work place. Staff told us Nightingale House was an excellent place to work, were very proud of the high standard of care they provided there and felt well-supported by their line managers and co-workers. People and their relatives felt there was a strong commitment within the staff team to continuously improve and develop their working practices. This ensured staff continued to deliver high quality personalised care to people living in the home.

People and their relatives told us the provider understood their Jewish Faith and culture. The service had their own religious co-ordinator and on-site synagogue. Staff completed equality and diversity training, which included a module about understanding what it meant to be Jewish, and the Jewish faith and culture in general. In addition, specially trained volunteers regularly presented seminars to people living in the home, their relatives and staff on Jewish history and specifically the Holocaust. The catering staff also demonstrated a good understanding of how to prepare kosher food to conform with Jewish dietary law and

practices.

The provider used imaginative ways to meet the needs and wishes of people living with dementia at the home. We saw an old Morris Minor car had been put in the garden specifically for a person who had expressed a fondness for this type of car, an office had been created for another person who missed working and a former architect was encouraged to participate in planning meetings about building projects at the home. The service also used new technology well to support people living in the home. For example, people had been provided with their own iPod and headphones so they could listen to personalised playlists of music of their choosing, and access email, Skype and the internet.

People received person-centred care which was responsive to their specific needs and wishes. Each person had an up to date, personalised care plan, which set out how their care and support needs should be met by staff. Assessments were regularly undertaken to review people's needs and any changes in the support they required. Staff continued to receive regular and relevant training and supervision to help them to meet people's needs. Staff were aware of people's communication methods and provided them with any support they required to communicate to ensure their wishes were identified and they were enabled to make informed decisions and choices about the care and support they received. People were also supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People were supported to maintain relationships with those that mattered to them and relatives and visitors were warmly welcomed when they came to the home. Staff had developed caring relationships with people and their relatives, and ensured people received the right levels of care and support in a dignified and respectful way.

Staff were aware of their duties under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent before providing any care and support and followed legal requirements when people did not have the capacity to do so. People were supported to eat and drink enough to meet their dietary needs and preferences. Staff ensured mealtimes were an enjoyable and personalised experience. Staff regularly monitored people's general health and wellbeing. Where there were any issues or concerns about a person's health, they ensured they received prompt care and attention from the relevant health care professionals, which included the five on-site GP's and eight occupational therapists and physiotherapists. People said Nightingale House was a homely and comfortable place to live.

People said they felt safe at the home. Staff knew how to recognise and report suspected abuse and neglect to protect people from the risk of harm. The provider had arrangements in place for checking the suitability and fitness of new staff employed to work at the service. There were enough staff deployed in the home to keep people safe. Staff followed appropriate guidance to minimise identified risks to people's health, safety and welfare. The premises and equipment were safe for people and staff to use because managers and the relevant professionals regularly carried out health and safety maintenance and servicing checks on these. We observed the environment was kept hygienically clean and staff demonstrated good awareness of their role and responsibilities in relation to infection control and food hygiene. Medicines were managed safely and suitably trained staff ensured people received their medicines as intended.

The service had appropriate arrangements in place for dealing with people's complaints if they were unhappy with any aspect of the support provided at the home. People and their relatives said they were confident any concerns they might have about the home would be appropriately dealt with by the managers. The service had received numerous compliments about the staff and the care and support provided at the home.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service remains safe and continues to be rated 'Good' for this key question.

There continued to be robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse. Risks people might face were identified and managed appropriately at both an individual and service level. The provider had suitable systems to monitor accidents and incidents and learn from these.

Staff recruitment procedures continued to prevent people from being cared for by unsuitable staff. There were sufficient numbers of suitable staff deployed to keep people safe and respond promptly to their needs.

Medicines were managed safely and people received them as prescribed.

The provider had suitably robust infection prevention and control and basic good hygiene arrangements in place. The home was clean, free from odours and was appropriately maintained.

Good ●

### Is the service effective?

The service remains effective and continues to be rated 'Good' for this key question.

Staff were equipped with the knowledge and skills they needed to provide effective care, through training, support and information sharing.

Staff sought people's consent before providing care. The registered manager and staff were knowledgeable about and adhered to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

The service supported people's nutrition, hydration and health care needs by providing a variety of balanced meal choices, monitoring people's intake if they were at risk of malnutrition or dehydration.

Good ●

People also received the support they needed to stay healthy and to access health care services. Staff involved the relevant health care professionals as and when required with whom they regularly discussed good practice.

### **Is the service caring?**

The service provides excellent care and this is reflected in their new improved 'Outstanding' rating for this key question.

This is because people, their relatives and health care professionals were extremely complimentary about the care and support provided at the home. Staff consistently demonstrated warmth, respect and empathy in their interactions with people and their relatives. They ensured people's right to privacy and to be treated with dignity was maintained, particularly when receiving personal care.

People had positive relationships with staff, who took time to get to know them and the things that were important to them. People were involved in decisions about their care.

Staff used a variety of communication methods to ensure people understood the information they needed to express their views and make choices.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

**Outstanding** 

### **Is the service responsive?**

The service remains responsive and continues to be rated 'Outstanding' for this key question.

Relatives told us their family members who had passed away at the home had received compassionate and supportive care from staff. The provider continually sought and implemented guidance on best practice in caring for people at the end of their lives. They worked alongside relevant health and palliative care professionals and respected the wishes of people nearing the end of their life.

People were supported to live an active and fulfilling life within the home and the wider community. The provider ensured people had access to a wide range of stimulating and meaningful activities and events.

People were supported to maintain relationships with people

**Outstanding** 

that mattered to them. People had an up to date, personalised care plan, which set out how staff should meet their care and support needs. This meant people were supported by staff who knew them well and understood their individual needs, preferences and choices.

People were involved in discussions and decisions about their care and support needs.

People and relatives knew how to make a complaint if they were dissatisfied with the service they received. The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

### **Is the service well-led?**

The service provided excellent leadership and management and this is reflected in their new improved rating for this key question of 'Outstanding'.

The management team were highly regarded by people, relatives, health and social care professionals and staff. People felt they led by example, were accessible and approachable and remained committed to providing high quality care in line with best practice.

There was a strong organisational commitment to the provider's vision and values, which were outcome based and put people at the heart of the service. The provider's values and behaviours underpinned their governance framework and there were robust procedures in place to assess, monitor and improve the quality of service delivery.

People, their relatives and staff were involved in developing the service. Their feedback was continually sought and used to drive improvement. The provider encouraged staff to reflect on their practice and learn together as a team. Staff were proud of the quality of service they delivered.

The provider also worked in close partnership with external health and social professionals, agencies and bodies.

**Outstanding** 

# 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.

This inspection was conducted over two-days on 29 and 31 May 2018. The first day of our inspection was unannounced and we told the provider we would be returning on the second day. The inspection team on the first day consisted of four inspectors, a specialist advisor who was a registered nurse and an expert-by-experience. Only the lead inspector returned to the service on the second day. The expert-by-experience had personal experience of caring for someone who lived with dementia.

Before the inspection, we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During this two-day inspection we spoke in-person to 15 people who lived at Nightingale House, two relatives, four visiting community nurses, the registered manager and director of care, the chief executive officer (CEO), four registered nurses, 20 health care assistance, a pharmacist technician, two occupational therapists, the director of human resources, two catering managers, the head of activities and the maintenance manager.

We also undertook general observations in relation to the way staff interacted with people living in the home. On the first day of our inspection we used the Short Observational Framework for Inspection (SOFI) to observe lunch being served on five units. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we looked at included 12 people's care plans, 17 staff files and other documents that related to the overall management of the service including quality assurance audits, medicines records, complaints and



accidents and incident reports.

In addition, we received written comments about this service from four external health and social care professionals. This included the head teacher of the nursery school located in the grounds of the home, a local authority Mental Capacity and Deprivation of Liberty Safeguards (DoLS) manager, an independent consultant and the Director of the National Activity Providers Association (NAPA). NAPA is an organisation that trains activity coordinators to develop person-centred social activities for people living in a care home.

## Is the service safe?

### Our findings

People and their relatives told us Nightingale House was a safe place to live. Typical comments we received included, "I am safe and well looked after here", "My [family member] has always felt very safe living at the home" and "My mind is at rest when I leave here as I know he [family member] is well looked after by genuinely caring staff."

The provider continued to have robust systems in place to report and act on signs or allegations of abuse or neglect. There were safeguarding adults and staff whistle blowing policies and procedures in place. The provider had a safeguarding lead who was responsible for liaising with the local authority on all safeguarding matters and providing staff with their annual child protection and safeguarding adults at risk training. Managers and staff were aware of their responsibilities to safeguard people from harm and demonstrated a good understanding of the reporting procedures to follow if they had any concerns about people's safety. Staff told us managers continually encouraged and supported them to speak out if they were ever concerned about poor working practices or behaviours that could pose a risk to people. One member of staff said, "If I had concerns about a person I would make sure they were safe, then report it to the unit manager... There is also a whistleblowing number I can ring if I need to", while another member of staff informed us, "If I suspect abuse I have a duty to report it... It's my job."

We were assured the provider had taken appropriate action to mitigate the risks in relation to all the safeguarding incidents involving people living in the home that had occurred since we last inspected Nightingale House. The provider's safeguarding lead had alerted the local authority's safeguarding adults team and the CQC without delay about these safeguarding incidents and continued to work closely with the relevant safeguarding authorities to deal with them. At the time of our inspection no safeguarding investigations were on-going.

Measures were still in place to reduce identified risks to people's health, safety and welfare. People's care plans included detailed risk management plans for staff to follow, which were routinely reviewed and updated. Risks that were assessed included falls, malnutrition and dehydration, choking, pressure sores, behaviours that challenged the service and social isolation. It was clear from discussions we had with staff and working practices we observed staff understood the risks specific individuals might face and what action they needed to take to prevent or mitigate them. For example, throughout our inspection we saw several instances of two staff correctly using mobile hoists to transfer people safely from one place to another. Staff confirmed they had completed their practical and theoretical lifting and manual handling training, which was refreshed annually.

In addition, we found people whose behaviour might challenge the service had appropriate risk management plans in place. A relative told us, "The staff understand my [family member's] needs and know exactly how to keep him calm if his behaviour becomes rather unruly." We observed staff on three separate occasions react promptly and appropriately to de-escalate and redirect people whose behaviour challenged the service and other people living in the home.

The provider had suitable arrangements in place to deal with foreseeable emergencies. Records showed the service had developed a range of contingency and business plans to help staff deal with such events quickly. We saw fire exit signage conspicuously displayed on doors and walls throughout the premises and fire evacuation ski-pads were available in stairwells to help people with physical disabilities navigate the stairs. People's care plans contained a personal emergency evacuation plan (PEEP), which explained the help people would need to safely evacuate the building in an emergency. Records showed staff routinely participated in fire evacuation drills at the home and received on-going fire safety training. Staff demonstrated a good understanding of their fire safety roles and responsibilities.

The environment was well-maintained, which contributed to people's safety. Maintenance records showed environmental health and safety, and equipment checks were routinely undertaken by suitably qualified external contractors in accordance with the manufacturers guidelines. This included checks in relation to the service's gas safety and electrical installations, portable electrical appliances; fire equipment, including fire extinguishers, fire alarms; heating and ventilation systems; water hygiene and monitoring of water temperatures; passenger lifts; and, the routine servicing of mobility aids, pressure relieving mattresses, bed rails and window restrictors. We also saw radiators were suitably covered throughout the home.

The provider's recruitment processes remained robust. The provider's human resources department obtained at least two employment references from new staff's previous employers and carried out checks on their criminal records, proof of identify, eligibility to work in the UK, full employment history and explanations for any breaks in employment and health.

In addition, as discussed with the provider at their last CQC inspection they now carrying out criminal records checks at three yearly intervals on all existing staff. This enables the provider to assess the on-going suitability of staff to work in the home. The pre-employment checks described above were also carried out on the 230 volunteers who worked in the care home. We also saw the provider checked the personal identification number of all nurses employed to working the home to confirm they were registered with the Nursing and Midwifery Council (NMC) and therefore authorised to practice as nurses.

The home was adequately staffed. People told us there were always plenty of staff working at Nightingale House. One person said, "There always seem to be plenty of staff on duty in the home", while another person remarked, "Staff always come if I call them." Relatives were equally complimentary about staffing levels. One said, "The balance of staff and residents is about right here I think." Throughout our two-day inspection we observed one-to-one staff support was provided to people who required it. We also saw numerous examples of staff responding quickly to call bells being activated or people's verbal requests for assistance.

The provider used a dependency tool to calculate the amount of care each person living at the home needed to receive which helped the unit managers plan the staff rotas. Unit managers routinely reviewed staff rotas in response to people's changing needs and circumstances. The registered manager told us staff could be redeployed to work on other units at short notice where additional staff were most needed.

People continued to be protected by the prevention and control of infection. People told us the home always looked clean and tidy. The service was free from any unpleasant odours. We observed staff using appropriate personal protective equipment. For example, we saw staff always wore disposable gloves and aprons when providing personal care to people and there was always soap and paper towels in the toilets. Records indicated all staff had received up to date infection control training and there were clear policies and procedures in place. Staff were knowledgeable about what practices to follow to prevent and control the spread of infection. For example, staff were aware which bags to use for infection control and how to

dispose of sharps safely in the specially designated bins located in clinical rooms on each of the units. One member of staff told us, "Mattresses and bedrails are checked and cleaned every day."

Appropriate systems were in place to minimise any risks to people's health during food preparation. We saw the kitchen was kept clean, and catering staff used colour coded chopping boards when preparing different food groups and checked fridge and freezer temperatures daily. The home had been awarded the top food hygiene rating of 5 stars in April 2017 by the food standards agency. Records indicated all staff had completed basic food hygiene training.

Medicines continued to be managed safely. People told us they had confidence in the staff who supported them to take their prescribed medicines on time. One person said, "The staff take their time when they give me my medication", while a relative remarked, "Yes, my [family member] gets all his medicines on time." We saw medicines were securely stored in locked medicines trolleys or cupboards in clinical rooms located throughout the home which only authorised staff could access. People's care plans contained detailed information about their prescribed medicines and how they needed and preferred them to be administered. We saw medicines administration records (MARs) were appropriately maintained by staff authorised to handle medicines in the home. There were no gaps or omissions on MAR charts. Checks of medicines stocks and balances, indicated people received their medicines as prescribed. Protocols for managing 'as required' medicines were in place and clear instructions were printed on MAR charts so staff knew when and how to administer these types of medicines.

The provider employed an in-house pharmacy technician to help staff manage medicines safely. Nurses and senior care staff authorised to handle medicines on behalf of people living in the home had completed training on the safe management of medicines and their competency to do so safely continues to be routinely assessed by their unit managers. One member of staff told us, "We take handling medicines very seriously here. It is a big responsibility and I am very careful. We also have all the support we need from the nurses on the units and our own pharmacist." Medicines audits were routinely undertaken by nurses, the provider's in-house pharmacy technician and an independent community pharmacist. The most recent report produced by the independent community pharmacist following a medicines audit they conducted at the home in April 2018 stated they had no concerns about the way medicines were managed at Nightingale House. The pharmacy technician told us, "The service takes great care to monitor how all medicines prescribed to people living in the home are managed."

## Is the service effective?

### Our findings

People continued to be supported to eat a healthy, well-balanced diet. People said they enjoyed the meals they were offered at the home and typically described the quality of these meals as "good". Comments we received included, "I enjoy the food here and there's always plenty to drink", "The food is delightful, tasty and hot...I love it" and "The food is outstanding...Just the right amount for me...I think the chefs do a wonderful job." We observed lunch being served on most units on the first day of our inspection. The meals looked and smelt appetising and the atmosphere during this mealtime felt relaxed and unhurried. Staff were attentive to people's needs and offered and respected their meal choices. We also saw staff routinely offered people drinks during and outside of mealtimes.

People's care plans included detailed nutritional assessments which informed staff about people's food and drink preferences and any risks associated with them eating and drinking. Each unit continued to have their own nutrition and hydration lead. In addition, since our last inspection new Dietetic Assistant Practitioners (DAP) had been appointed to work on the units and were responsible for developing nutritional risk management plans and liaising with other healthcare professionals about nutritional issues. At mealtimes we observed staff ensure people who were at risk of choking had their food appropriately cut up or pureed in accordance with their nutritional risk assessments. Routine weight checks were completed for people at risk of malnutrition or dehydration, which ensured any significant weight loss could be identified quickly and appropriately managed.

Staff demonstrated a good understanding of people's dietary needs and preferences. Several staff told us nutrition and hydration was regularly discussed at team meetings so they kept up-to-date on how they should be supporting people to eat and drink enough to stay healthy and well. We observed catering staff prepare a range of soft, pureed and fortified (high calorie) meals for people with specific nutritional needs. Catering staff received specialist training in how to prepare pureed, soft and fortified food that looked appetising to eat. For example, we saw they used food moulds to improve the presentation of pureed meals and sometimes added beetroot to dishes to make them more colourful and visually stimulating for people living with dementia.

People continued to be supported to maintain their health and well-being. People were positive about the healthcare support they received at the home. One person told us, "The staff are very good at looking after me and would make sure they call the nurses or my GP if I wasn't feeling well", while another person said, "I had a fall not long ago and the nurses called for an ambulance straight away when they saw I was in pain." Visiting health care professionals were equally complimentary about the way the service promoted their clients' health and well-being. A district nurse told us, "They [staff] follow all the advice we give them about how to manage our client's health and always call us for advice if they're not sure what to do", while another nurse remarked, "Staff are very good at making prompt referrals to our nursing team as soon as they notice a person's health condition deteriorate."

People's care plans set out how staff should be meeting their specific health care needs and contained a detailed person-centred document entitled 'Signs of ill-being and well-being'. People who were in receipt of

regular pain control medicines had monthly pain management risk assessments carried out on them. Staff carried out regular health checks and maintained daily records of the support people received, including their observations about people's general health. People also had hospital passports. This is a document that has been developed for people living with dementia that contained important information medical staff may need to know about the individual and their health if they needed to go to hospital.

Nightingale House had five on-site GPs and an advanced nurse practitioner who were in regular contact with the units and available to answer emergency calls. This GP surgery is registered with the CQC, which we rated 'Good' in February 2017. The service also had a large well-equipped gym, managed by eight in-house occupational therapists (OTs) and physiotherapists. People's care plans included detailed OT and physiotherapist assessments, and management plans to prevent falls and mitigate risks associated with people's mobility and their physical environment. Incidents of falls were recorded and analysed, and specific measures such as the introduction of sensory mats in people's bedrooms and/or one-to-one staff support were put in place to reduce the likelihood of similar incidents reoccurring. It was mandatory for all staff to receive manual handling and falls prevention training. A physiotherapist also told us falls prevention classes were available for people living in the home and their relatives.

People told us Nightingale House was a comfortable place to live. One person said, "I love it here. I'm very pleased with my room. It's got everything I need", while another person remarked, "It's a very homely place. Always clean and plenty of space to wander around." We saw most of the units were well-decorated and maintained. Since our last inspection three of the units had been refurbished and the nursing stations removed to make the main communal areas more spacious and wheelchair accessible for people. We also saw the provider had made some of the units more dementia friendly which had been achieved by painting people's bedroom doors different colours, using easy to read pictorial signage and memory boxes filled with photographs and objects that were important to people. This made it easier for people living with dementia to identify different rooms in the home and orientate themselves.

However, the positive comments made above notwithstanding, we found one unit was not as well-maintained or decorated as some of the other units. For example, during a tour of the Sherman unit we identified a damaged window restrictor in a toilet, some bathrooms being inappropriately used to store latex gloves and chipped paintwork throughout most of the communal areas. We discussed these issues with the registered manager who immediately arranged for the broken window restrictor to be repaired and latex gloves removed from bathrooms. The registered manager also told us the plan to refurbish this unit over the next five years had been revised following our inspection and the Board of Trustees had agreed a new timetable by the end of our inspection for the refurbishment work to be completed by the end of 2018. Progress by the provider to achieve this newly stated aim of making the unit more dementia friendly will be assessed at the homes next inspection.

Staff continued to have the right knowledge, skills and experience to effectively carry out their roles and responsibilities. People and their relatives were complimentary about the staff who worked at all levels in the home. One person said, "I think staff are really good at what they do", while another person's relative remarked, "The training the staff get here must be pretty good because they all seem to know what they're doing."

All staff routinely completed training in topics and subjects that are relevant to their roles and responsibilities. There was a rolling programme of training in place which ensured staff's knowledge and skills remained up-to-date and reflected current best practice. All new staff were required to complete a thorough induction and shadow experienced members of staff before being approved to support people unsupervised. To complete their induction staff had to achieve all the competencies required by the Care

Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Nursing staff also completed additional training in the use of specialist medical equipment to meet people's more complex health care needs. This included training in the safe use of syringe drivers, percutaneous endoscopic gastrostomy (PEG) feeding tubes and catheters. A syringe driver is a device used to administer a continuous infusion of drugs and PEG feeding is an endoscopic medical procedure in which a tube is passed into a person's stomach. Since our last inspection three new senior lead nurse posts had been created to improve the on-going training, supervision and support registered nurses working in the home received.

Staff spoke positively about the training they received. One staff member said, "I've learnt so much from the training that's been made available to us here", while another told us, "My training is continuously refreshed which ensures my practice knowledge and skills remain relevant".

Staff had sufficient opportunities to review and develop their working practices. There was a well-established programme of regular supervision (one-to-one meetings), competency assessments and annual appraisals where staff were encouraged to reflect on their work practices and identify their training needs. Records indicated staff at all levels attended regular supervision meetings with their line manager. This included annual appraisals of their overall work performance during the past 12 months. Staff told us they were encouraged to talk about any issues or concerns they had about their work. One member of staff said, "In supervision meetings with my manager we talk about how I feel about my work, and they let me know how I'm getting on." Another member of staff remarked, "My last annual appraisal with my manager was really useful. They talked about what I could do to improve my work and how I could put that into practice."

People's ability to make and consent to decisions about their care and support needs was routinely assessed, monitored and reviewed. People had signed their care plans to indicate they agreed to the support they were provided. We saw staff prompted people to make decisions and choices and sought their permission and consent before providing any support. Care plans contained various assessments of people's capacity to understand and make decisions about the care they received, as well as records of best interests' decisions undertaken when the person was assessed as not having capacity. These included the placement within the service, medicines, finances, personal care and nutrition, fall sensor mats and bedrails. Since our last inspection the service had created a new Mental Capacity Act 2005 (MCA) and DoLS post to provide staff with on-going mental capacity training, to quality assure DoLS applications and to liaise with the local authority DoLS team. Staff had received training in MCA (2005) and DoLS and it was clear from their comments they understood their responsibilities under the Act.

We checked whether the service was working within the principles of the MCA (2005) and DoLS. The MCA (2005) provides a legal framework for making 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. 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.

We found applications made to deprive people of their liberty for their own safety had been properly made and authorised by the appropriate body. A local authority service manager told us, "They [the provider] are proactive in sending us their Deprivation of Liberty Safeguards (DoLS) applications and they always seek our

advice and guidance where necessary." Records showed the provider was complying with the conditions applied to the authorisation. For example, we saw these authorisations were up to date and managers kept them under constant review to ensure they remained appropriate and in the person's best interests.



## Is the service caring?

### Our findings

Feedback we received from people and their relatives indicated a high level of satisfaction with the standard of care provided at Nightingale House. Typical feedback included, "I think the home is outstanding", "Best thing I ever did was move into this home" and "My [family member] is extremely happy living here." Visiting health care professionals were equally complimentary about the home. A nurse told us, "They are an excellent provider. We have no concerns about the quality of care they offer people", while another nurse said, "I think it's the best care home and group of staff I've ever had the pleasure to work with...The staff clearly care about the residents."

People and their relatives were extremely positive about all the staff who worked at the home and typically described them all as "compassionate" and "kind". Examples of positive feedback we received included, "They [staff] are so kind, it's really important that they care and are empathetic...It makes such a difference", "I really love the staff. They treat my [family member] and everyone else who lives here so well" and "Staff are always so friendly, helpful and kind. They're amazing."

Throughout our inspection we observed good interactions between people living in the home and staff. We saw staff greeted people warmly and spoke to them in a kind and considerate way. Staff seemed to genuinely enjoy the company of the people living at Nightingale House, which added to the friendly and homely atmosphere we found there. People looked at ease and comfortable in staff's presence. We observed two staff speak reassuringly to a person who had become anxious about using a mobile hoist and in doing so managed to gain their trust and transfer them safely to their wheelchair. During lunch we also saw staff frequently asked people if they were enjoying their meal or needed a drink.

Staff understood and responded to people's diverse cultural and spiritual needs. People told us staff understood the Jewish faith and culture. One person said, "They celebrate all the main Jewish holidays and festivals here, just like my family and I would do at home." A relative also told us, "The bonus for us is that this is a Jewish home, so our faith which is really important to us as a family, is very much supported and celebrated here." Information about people's spiritual needs was included in their care plan.

The provider had their own religious co-ordinator and on-site synagogue. People and their relatives told us the synagogue was always open and they could visit whenever they liked. Staff told us if people were too frail to attend the synagogue the religious coordinator would visit them in their room or unit. Staff received equality and diversity training as part of their induction which had included a module about understanding what it means to be Jewish, and Jewish Faith and culture in general. The registered manager told us several specially trained volunteers regularly presented seminars to people living in the home, their relatives and staff on Jewish history and specifically the Holocaust. The catering staff demonstrated a good understanding of how to prepare kosher food to conform with Jewish dietary law. For example, the chef was aware the main kitchen and pantries on the units all had specially designated areas for preparing and cooking meat and milk separately so these two food groups were never mixed in accordance with the Jewish Faith.

The service continued to ensure people living in the home maintained positive relationships with people that were important to them. Relatives told us they were always made to feel welcome at the home by staff and were not aware of any restrictions on visiting times. A relative said, "I visit my [family member] whenever I want and staff always seem happy to see us." We observed several instances of staff warmly greet people's visitors when they first arrived on a unit.

The service had designated accommodation on-site where people's relatives or close friends could request to stay overnight. The registered manager gave us a good example of how the partner of a person living in the home regularly used this accommodation to stay over because of the distance they had to travel to reach Nightingale House. This enabled this couple to spend more quality time together at the home. Staff also used assistive technologies to help people remain in contact with people that mattered to them. For example, we saw several electronic tablets were available for people to make video calls to relatives and friends who were unable to visit the home because they lived abroad or were too ill to travel. People could attend one-to-one computer sessions with staff to learn how to use the internet, social media and Skype. The service also had its own café on the ground floor, which we saw was a popular place for people living in the home and their guests to socialise over a hot or cold drink, a snack or cake.

Staff encouraged people to be as independent as they wanted and could be, although most people living in the home were dependent on the care and support they received from staff with day-to-day activities and tasks. People told us staff promoted their independence. One person said, "I often go out on my own to the local shops to buy things for my husband and I've just renewed my bus pass so I can travel on the buses for free." Another person remarked, "I like the idea that I can keep my tablets in a lockable cabinet in my room, so I can keep them safe and manage them myself."

We saw the various ways staff promoted people's independence. For example, during lunch people who were unable to use traditional cups and plates had their needs assessed and where appropriate, had been given a plate-guard or special crockery which enabled them to drink and eat with minimal assistance from staff. Staff could also explain to us what aspects of their care people needed support with, such as moving and transferring or assistance at mealtimes, and what people were able to do independently. Throughout the home we saw handrails, ramps and passenger lifts enabled people to move freely around their bedroom, communal areas of the home and garden.

An occupational therapist (OT) told us people's bedrooms were OT assessed and suitably adapted when required to include grab rails for example, to help people with mobility needs maximize their independence. We also saw a working ATM machine and Royal Mail post box were available on the ground floor, which meant people had the option of withdrawing cash and posting their own letters whenever they wished. People's care plans contained detailed information about their level of independence in the key tasks of daily living and the support required from staff where people could not manage these by themselves. For example, care plans made it clear who enjoyed and could complete certain household tasks, such as helping staff fold laundry or set dining tables for meals. The physiotherapy team also actively encouraged people to participate in a range of physical exercises including chair and bean bag based exercises, dancing and using weights in the homes gym.

The service helped people to express their views. Staff demonstrated a good awareness of people's preferred method of communication and used a variety of tools to communicate with people according to their needs. This enabled staff to understand people's preferences, wishes and choices. For example, we saw staff frequently used picture 'flash' cards and photographs to help people who found it difficult to communicate verbally make informed choices about the food they ate and activities they might like to engage in. We also observed a member of staff calmly talk to a non-English speaking person in their first language, which helped eased this person's distress. To help people living with dementia understand what

was being said to them, guidance in their care plan instructed staff to use plain and simple language when speaking to them and to allow people plenty of time to respond. Several staff described how they knew from people's facial expressions that they might be thirsty and needed drink.

People's privacy and dignity continued to be respected and maintained. People told us staff always treated them with dignity and respect. We overheard a person telling a member of staff how much they liked them because, "You [staff] always call me by my name! My name is [person's name], not [abbreviated versions of their preferred name] or any of the other things people try to call me." Throughout our inspection we saw staff knocked on people's door to obtain their permission before entering their bedroom. We also observed staff who assisted people to eat at mealtimes do so in a dignified manner. Staff achieved this by sitting on small stool next to people so they could be in the person's line of sight.

Care plans contained information about how each person would like staff to support them with personal care to preserve their privacy and dignity. This included people's preference about whether they liked to be supported by male or female staff. Each unit had a designated 'Dignity Champion' whose primary role was to ensure staff remained aware of how to respect and treat people with dignity and respect. Staff received privacy and dignity training as part of their induction and the service ran annual dignity awareness workshops. Since our last inspection all staff had been given prompt cards that set out the principles and values around dignity and respect which they could keep on their person and use as an aide-memoir.

Staff were aware of the importance of ensuring information about people was kept confidential. People said they felt comfortable talking to staff in confidence. A person told us, "Staff are very good at not discussing my husband's care in front of me and they [staff] make sure my husband isn't about when they're talking to me about my care." The registered manager gave us a good example of how the service respected a person's wish to attend healthcare appointments without his wife, by ensuring an additional member of staff was always available to support him on these appointments. The provider had a confidentiality policy and records indicated it was mandatory for all staff to receive confidentiality training as part of their induction.

People could access independent advocacy services when they needed support to make decisions. We saw information about advocacy services was given to people and their relatives. The registered manager told us they ensured people's relatives or professional representatives were always involved in making decisions in people's best interests, where people lacked capacity to do so.

## Is the service responsive?

### Our findings

When people were nearing the end of their life, they continued to receive compassionate and supportive care at Nightingale House. The service had achieved the Gold Standards Framework (GSF) with 'Beacon' status. The Gold Standards Framework is a professional accreditation awarded to care homes in recognition of their high-quality end of life care practices. Beacon status is awarded to services who maintain best end of life care practice across the GSF standards.

People's preferences and choices for their end of life care were clearly recorded, kept under constant review and acted upon. People told us they had been asked about their end of life care wishes, which had included whether they wanted to be resuscitated, where they wished to spend the last few days of their life, what music they wished to have playing, any specific aromas they preferred, who they wished to be present and where they wished to be buried. We saw numerous examples of people's end of life care wishes recorded in their care plan. One person's end of life care plan included their expressed wish to have their children present when they passed away, while another person had clearly stated they wanted staff to talk with them and be a reassuring presence when they were nearing the end of their life.

We saw the GSF's 'Dying Matters week' had taken place at Nightingale House in May 2018 to raise awareness about end of life care. Staff told us as part of the 'Dying Matters week' they had decided to start finding out if people had a 'bucket list' of things they would like to do before they died. A member of staff gave us a good example of how they were in the process of helping a person plan a trip to France to watch the Tour de France cycle race, which had been a life-long ambition of theirs.

We saw people had advanced end of life care plans which had been developed with them and their relatives, and included Do Not Attempt Resuscitation (DNAR) forms where people had agreed to this. In addition, the provider gathered feedback from people's relatives about how well supported they had felt at the end of their relative's life and how well the person's end of life care plan had supported their wishes.

Staff received end of life care training, which included a specific module on understanding death and dying from the perspective of the Jewish Faith and race. Staff also completed bereavement training, which enabled them to support people living in the home, relatives and other staff to go through the grieving process. It was clear from staff's comments they knew what was important to people and their families, such as whether they wished to remain at the home and details about their funeral arrangements. Staff demonstrated a good understanding of how to support people who were nearing the end of their life and their families, which was compassionate and dignified. The registered manager told us, "I try to get the staff to think how would they care for someone if we knew it was their last meal, their last conversation or even the last time they received any personal care."

People were reassured that their pain and other symptoms would be assessed and managed effectively as they approached the end of their life, including having access to support from specialist palliative care professionals. The provider worked closely with the on-site GPs and palliative care professionals from a local hospice. This ensured staff had access to specialist advice and guidance regarding best end of life care

practice, and people's changing needs as they neared the end of their life were kept under constant review.

The service supported people's families, other people living in the home and staff when someone died. Accommodation was available on-site for relatives and close friends to stay-over when someone was receiving palliative care. Staff demonstrated good awareness of the special candlelight ceremonies (known as 'Yahrzeits') that were often held in the home to commemorate the lives of people who had died at Nightingale House.

The service had built up strong links with the wider community. Since their last inspection, Nightingale House was the first care home in the UK to open an on-site nursery to bring children, their parents and older people together daily to participate in shared social activities, such as baking, storytelling and singing. We received extremely positive comments from people, their relatives and community professionals about this innovative inter-generational project. Typical feedback included, "I absolutely adore the young children who come to see us every day here. I can't wait for them to arrive... They make me feel young again", "My [family member's] face just lights as soon as the kids from the nursery come over. There's a nice buzz about the place when the children from the nursery are here" and "The link with the nursery should be highly commended. I think it's particularly good because the activities are structured and it runs daily rather than at random times." It was evident by the amount of laughter, smiles and hand-holding going-on between the children from the nursery and the people living in the home that they knew each other well and really enjoyed one another's company.

People and their relatives told us entertainers, drama groups and musicians visited the home several times a week to perform. A relative gave us a good example of a recent community event the activity coordinators had arranged for people to have their artwork displayed at the Tate Modern gallery, while a member of staff told us about how they helped train a person who lived at the home to participate in a local five-kilometre run. The service had its own mini-bus which was used to take people to shops, cafes and restaurants within the local area, and on day trips to museums and the coast. In addition, the registered manager told us about a mother and toddler group they invited to spend time interacting with people living at the home every week. The service also employed a community outreach worker whose responsibilities included keeping people living in the home informed about what's happening in the local Jewish community.

People were supported to live an active and fulfilling life at the home and in the wider community. People and their relatives told us there were plenty of opportunities for people to participate in meaningful activities. Typical comments we received included, "The activity co-ordinators are very good. There's so many activities here to suit all the different hobbies and interests we enjoy doing", "My [family member] attends so many of the activities here. I found out on one of my visits that he really enjoyed the singing group and the musical entertainers, which I didn't even know he attended" and "Activities are a real highlight here. People really look forward to them." In addition, an external social care professional was equally complimentary about the activities on offer at the home and told us, "I was impressed by the range of meaningful engagements on offer to the residents."

Activities provision within Nightingale House was person-centred and innovative. The service had its a large well-equipped activity centre with pottery kiln, cooking facilities and internet-café; a concert hall, well-stocked library, a pool table, six pianos, a café, hairdressing salon, well-kept gardens and a pet's corner with rabbits, guinea pigs and an aviary full of birds. Throughout our two-day inspection we observed people engaged in a variety of interesting activities including cooking, painting and pottery in the activity centre, petting animals in the garden and dancing to live music in the concert hall. People also told us they could have a daily newspaper delivered to their room if they wished.

The service had five full-time activities coordinators who implemented a daily activities programme across all the units along with the assistance of numerous volunteers. We saw monthly activities timetable displayed on noticeboards in each of the units which had been designed to reflect feedback they had received from people living in the home about what social activities they enjoyed doing and what they might like to try. An external social care professional told us, "The activities team clearly know the residents well and try to focus on meeting their individual needs." People could choose to engage in a wide variety of activities in the home including baking, making pottery and textiles, listening to live music, singing, dancing, gentle exercises classes, watching films, pet and drama therapy, gardening, pampering sessions, and playing bridge, bingo and word games.

The service had introduced the Namaste programme and designated staff on each of the units had been specially trained to deliver it. We saw each unit had a purpose-built Namaste sensory room which had been kitted out with soft lighting, comfortable chairs, oil burners and light music to create a calming and relaxing environment. The Namaste programme is an evidence-based programme designed to improve the quality of life for people living with dementia.

The service took appropriate action to protect people who preferred or needed to stay in their bedrooms from social isolation. For people who were not able to get out of bed there were bed therapy and bed based activities on offer on a one-to-one basis. We saw staff routinely asked people if they wished to take part in a group activity even though they did not normally engage.

People, or those with authority to act on their behalf, contributed to planning their care and support. People said they had been involved in developing their care plan. People received personalised support which was responsive to their specific needs and wishes. We saw pre-admission assessments were completed in all instances and contained relevant information about a person's medical history and personal care needs. This information was used as the basis to develop a person's care plan, which set out in detail how staff should be meeting a person's needs and preferences. People's care plans were written in a person-centred way and contained detailed information about everyone's specific needs, abilities, likes and dislikes, and people and places that were important to them. For example, people's care plans each included a person's life history with headings entitled, 'My early life', 'My Working Life' and 'Life now'. Information about people's sexuality and sexual needs and wishes were also included in their care plan.

Care plans for people living with dementia included a cognitive profile, which contained detailed information about people's diagnosis of dementia, and were clear what personalised care and support staff should provide them to meet their individual needs and wishes. The service had developed a 'key needs profile' for each person using Kitwood's 'Flower of Emotional Needs' model of person-centred care for people with dementia. The key needs profile included how the person had their needs for love, comfort, attachment, occupation, inclusion and identity met by the service and others involved in the person's life. The service also used dementia care mapping to evaluate how effective the person-centred care they were providing people with dementia. Staff had completed dementia awareness training which ensured they had the right knowledge and skills to provide personalised care and support to people living with dementia.

Staff provided care and support that was tailored to meeting people's individual needs and choices. For example, in accordance with the wishes recorded in one person's care plan, we observed staff support them to have a late breakfast. All the staff had received person-centred care training as part of their induction. In addition, each unit had a designated member of staff who was a trained 'Person-Centred Care Champion'. The Champion's role was to offer staff advice and support on how they could improve working practices and make them more person centred.

People's care plans were kept under constant review by their key-worker and key-nurse, and updated in a timely manner when there had been any changes to a person's needs or circumstances. In addition, everyone's care plan was reviewed by a multidisciplinary team within the first six weeks of admission and at least annually thereafter. Where changes were identified, people's care plans were updated promptly and information about this was shared quickly with staff through daily shift handovers and various team meetings. This ensured staff kept up to date with any changes in people's needs or circumstances.

People were supported to make informed decisions and choices about various aspects of their daily lives. People told us staff supported them to make choices about the care and support they received. Typical comments included, "I chose the colour my room was decorated and I could bring a lot of my own furniture from home when I first moved in", "I like to eat my meals with my friend from Sherman as we both prefer the smaller dining room there" and "I can choose when I get up, what I wear and whether I want to take my meals in my room or any of the dining rooms on the units."

Relatives and staff gave us several good examples of imaginative ways the provider had responded to the wishes of people living in the home with dementia. For instance, we saw an old black Morris Minor car had been put in the garden specifically for a person who was fond of this type of car, for them to work on. Similarly, an office had been created in the home for another person who said they missed going to work in their old office. The registered manager also told us a former architect who lived in the home was encouraged to sit in on planning meetings regarding the home's building projects.

In addition, the catering managers gave us good examples of how they promoted people's choice in the home. They told us they actively encouraged people to select the meals they wanted to see on the menu for the forthcoming season at quarterly 'food forum meetings' and had also created an additional menu that included foods that could be prepared quickly for people who did not like any of the meal options available on that's days main menu.

The service used new technology to support people. Since our last inspection staff had helped people compile a personalised playlist of music that was important to them and been given their own iPod and headphones to listen to it. Several staff gave us good examples of how songs people liked to listen to when they were younger which were now on their personalised playlist could be used to help them relax if they became anxious. An activities coordinator told us they often used people's personal playlist of their favourite music to help people living with dementia reminisce. Another member of staff told us about a song a person liked to listen too on their iPod because it was playing when they first met their wife.

The provider had suitable arrangements in place to respond to people's concerns and complaints. People and their relatives said they knew how to make a complaint if they were dissatisfied with the service provided at the home and told us they were confident that any concerns they had would be dealt with appropriately. One person said, "I complained about the food once and the chef brought me something else I liked straight away."

We saw the complaints procedure was readily available and on display in the home and used pictures and simple language to help people state what had made them unhappy and why. We saw when a concern had been raised managers had conducted a thorough internal investigation, provided appropriate feedback to the person and checked that they were satisfied with the actions taken to resolve the issue raised. The registered manager ensured any issues or concerns people raised were discussed at staff team meetings to share learning and ways working practices could be improved to stop mistakes reoccurring unnecessarily.

## Is the service well-led?

### Our findings

The service was extremely well-managed. The leaders had the right mix of skills, knowledge and experience. There was a clear hierarchy of management with well-defined responsibilities and lines of accountability. The CEO was supported by a competent senior management team which comprised of six directors/heads of care that included care, human resources, facilities, finances, operations and marketing. The director of care was also the registered manager who was supported by the home's five unit managers. The unit managers were supported in turn by the team leaders, nurses and care workers. Since our last inspection all the home's managers and senior nurses had received leadership training. The registered manager told us they were currently studying for their doctorate in adult social care. The registered manager was aware of the requirements of their CQC registration and submitted statutory notifications about key events that occurred at the service.

The service had an open and inclusive culture. People and their visiting relatives spoke positively about the service's management and their leadership style. People typically described the culture in the home as being open, transparent and mutually supportive. People also said managers and senior staff were ever present in the home and accessible. A relative commented, "The managers can often be seen walking around the home and talking to people. I think because they're so visible that's why they have built up a really good rapport with the residents and staff." An external healthcare professional was equally complimentary about the service's management, and the registered manager in particular, who they described as, "Doing an extraordinarily excellent job. He [registered manager] is extremely hard-working, dedicated, respected and loved by the staff which is the key to embedding relationship-centred care." Throughout our two-day inspection we observed managers interacting with people, their relatives and staff in a friendly and professional manner.

The provider continued to work closely with numerous other professional agencies and bodies to review joint working arrangements and to share best practice. They worked with local multi-disciplinary teams, which included St George's Hospital ophthalmology and audiology teams and various community nurses and dietitians. A community professional told us, "This provider often invites us to give them feedback about their care practices." The service had direct access to some healthcare professionals who provided services on site, such as the in-house GPs and OTs, but also had good communication links with social services and local authority DoLS leads.

In addition, the provider worked in close partnership with a specialist team of psychiatrists from a local mental health hospital known as the Behavioural and Communication Support Service (BACSS) who ran bi-monthly workshops at Nightingale House to train and help staff prevent and develop interventions to appropriately manage behaviours that challenged the service. The registered manager told us with the support of BACSS staff had significantly reduced the number of incidents of challenging behaviour and the use of anti-psychotic medicines to manage such incidents.

The registered manager gave us another good example of multidisciplinary joint working the provider had participated in with external GPs, hospital dietitians and local catering businesses. In 2017 a week-long



serious of workshops had been held at Nightingale to consider how to improve the specialist diets of people at risk of malnutrition. It was clear from the meals served, menus we looked at and feedback we received from people living in the home the meal options that were now available for people on special diets to choose from had significantly improved as a direct result of the partnership working.

The provider also worked closely with various academic institutions and stayed abreast of best practice and current research in the field of adult social care. For example, they supported numerous PhD student placements from City, Kings College, Kingston, and Surrey universities who were participating in various research projects at the home. These research projects included dementia, bowel and bladder and end of life care, spirituality, and staff interaction with people. The registered manager told us they planned to use the findings from these research projects to help the service develop more effective ways to support people living in the home and improve their lives. The provider was also part of the Royal Society of Medicine's advisory group which had developed a medicines charter that had been successfully piloted at Nightingale House and was in the process of being rolled out nationally to other care homes. Managers also told us they regularly visited other adult social care providers in the local area to share best practice, discuss challenges, and to learn from one another.

The provider continuously sought ways the service could be improved and encouraged people and their relatives to actively participate in discussions about how this could be achieved. People told us they had opportunities to share their views about the home, and most felt managers and staff listened and acted upon what they had to say. One person said, "We often have meetings in the unit where people can voice their opinion", while another person told us, "People aren't afraid to stand up and be counted around here, especially if they don't like something. I think the staff do take on board what we say most of the time." People gave us numerous positive examples of how feedback they had given to managers and staff had been acted upon. One person told us after they had complained about the way the catering staff made traditional Jewish pancakes (blintzes), managers arranged for this person to lead a cooking class to demonstrate to staff and anyone else who was interested how they made blintzes.

We saw a wide range of mechanisms in place to obtain feedback from people and their relatives including a suggestions box, regular residents' and relatives' meetings and satisfaction surveys, which the volunteers were responsible for distributing. People living in the home and their relatives who had participated in the provider's most recent survey said they were extremely satisfied with the standard of care and support provided at the home.

Staff were actively involved in developing the service and encouraged to contribute their ideas about how it could be improved. For example, staff regularly attended team meetings and were encouraged to reflect as a group what they had done well and what they could do better. Staff were also complimentary about the leadership style of the managers and said they were all 'approachable' and 'supportive'. Typical feedback we received from staff about the managers included, "I feel able to make suggestions or complaints if necessary and know I will be listened too and valued", "He [registered manager] has a very hands-on approach and knows all the residents by name" and "I think most staff here are happy in their work and motivated because we're confident the managers are doing a good job running the home. There's a real sense we're all in it together, which makes for an excellent team spirit."

The provider rewarded staff for demonstrating excellence in the work place. Where staff had a positive impact on the quality of people's lives or gone the 'extra mile', the provider recognised their efforts through an 'Employee of the Month' scheme. Several staff gave us some good examples of the benefits of working for this provider, which included having a staff canteen where subsidised meals were served and free membership of an on-site gym. A member of staff gave us a good example of how the provider encouraged

staff to participate in regular team building exercises, which had recently included a bake-off style competition.

The provider's values and vision for the service were focussed on the provision of high quality care. The registered manager told us they used regular staff forums, supervisions and appraisal meetings, prompt cards and a newsletter to remind staff about the organisation's core values and principles. This was confirmed by discussion we had with staff, several of whom showed us the aide-memoir prompt card they had recently been given that set out the organisation's values and how they could put them into practice. This helped the managers gauge staff's understanding of the home's values, share information on 'best practice' and monitor how well staff were following guidance.

There was clear oversight and scrutiny of the service. The provider's senior management team continued to meet fortnightly to review people's care plans whose needs or circumstances had significantly changed. The senior management team and senior staff were also members of various governance committees that were responsible for conducting regular audits and monitoring spot-checks on all aspects of the home. For example, there was a health and safety committee that routinely checked the home's physical environment and specialist medical and mobility equipment; a nutrition and hydration committee that met monthly to review the care people at risk of malnutrition received; and, an OT lead committee which was established to analyse and prevent incidents of falls. Several managers and senior staff gave us good examples of routine monitoring spot checks they carried out on staff working practices, which including observing staff assist people to eat and drink at mealtimes, using mobility equipment and administering medicines. Staff confirmed managers continued to spend a lot of their time visiting units and would routinely carry out unannounced spot checks on them to assess their working practices and overall competency.

The service had an embedded culture of ensuring improvements were made when issues were identified. The range of governance systems described above were also used to review any accidents, incidents or near misses involving people and developed improvement plans when recurring themes and issues had been found. The registered manager gave us several good examples of appropriate action the provider had taken to improve the service. They told us it was now custom and practice for all hospital admissions following acute illness or a serious injury to be analysed to determine whether these incidents could have been managed better, and if not, what lessons could be learnt. The registered manager also said they were an active member of a governance committee that had identified a spike in the number of pressure sores people had developed at the home. After the data was analysed it was discovered a probable cause was the reduced level of external tissue viability nurse (TVN) cover the home now received, so it was agreed Nightingale House would employ their own specialist TVNs to bridge the gap. It was clear from records we looked at and comments we received from staff at all levels that the number of pressure sores people living in the home now experienced had been significantly reduced in the past 12 months since the new TVN posts were introduced.

In addition, the care governance board, whose members included external health and social care experts and the providers senior management team, met on a quarterly basis. This board was responsible for reviewing the homes risk register, improvement plans that were in place and Key Performance Indicators (KPIs). These KPIs were based on the requirements stipulated within the Health and Social Care Act 2008 and associated Regulations. The service also had a five-year strategic plan that set out future goals for the home and practical guidance about how these ambitions would be achieved and financed. This demonstrated the provider was forward thinking and continually trying to improve the standard of care they provided people.