Nightingale Residential Care Home Ltd

Cherrydale

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Cherrydale is a care home without nursing for up to 22 older people, including people living with dementia. There were 20 people living at the home at the time of our inspection.

People's experience of using this service and what we found
People were not always receiving safe care at Cherrydale because the provider had failed to mitigate known risks. For example, one person who had been identified as at risk of leaving the home was able to do so without being observed by staff.

Some people used pressure-relieving mattresses to protect them from the risk of pressure damage. Pressure-relieving mattresses must be set according to the weight of the person using them to function effectively. However, staff did not maintain accurate records of people's weights, which meant they could not be sure whether their mattresses were set at the correct pressure.

Some people needed to be repositioned in bed by staff to protect them from the risk of pressure damage as they were unable to reposition themselves. However, the daily care logs maintained by staff did not always record whether people had been repositioned.

Personal Emergency Evacuation Plans (PEEPs) had been recorded for all the people who lived at the home permanently. However no PEEPs had been developed for people who were receiving respite care, which meant staff would have no information about the support these people needed in the event of a fire.

People were not adequately protected from the risk of infection because staff did not use personal protective equipment (PPE) effectively. We observed some staff wearing their face masks around their chins, including while they were supporting people. There was no hand towel dispenser in a first-floor toilet. A roll of paper towels next to the toilet was visibly dirty. The smell of urine that was noted at our last inspection was still present in the home's entrance hall.

People's medicines were not managed safely. One person had been prescribed pain relief to be administered once a week. We found this had been not administered since 1 September 2020. We made a safeguarding referral to the local authority about this concern.

There were no care plans in place for a person who had moved into the home four days before our inspection. This meant there was no guidance in place for staff about the care the person needed.

The provider's quality monitoring processes were not effective in identifying and addressing shortfalls. For example, recent medication audits had highlighted errors in people's medicines administration records but this continued to be a concern at the time of our inspection.

The service had not had a registered manager since April 2019. The current manager had taken up post in April 2020 but had not registered with CQC.

Incidents such as safeguarding referrals had not always been reported to CQC when necessary, which meant we were unable to check the provider had taken appropriate action in response to these events.

Staffing levels had increased since our last inspection. An additional member of care staff had been deployed on each daytime shift. Residents' meetings had been implemented and people had been asked for their views about the menu and activities. Team meetings took place monthly and staff told us the manager and provider were approachable and supportive.

Why we inspected
We carried out an unannounced inspection of this service on 5 September 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, good governance, staffing and fit and proper persons employed.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

We looked at infection prevention and control measures 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 that the service can respond to coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has deteriorated from Requires Improvement to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cherrydale on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches of legal requirements at this inspection.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of Inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-led findings below.

Cherrydale

Detailed findings

Background to this inspection

The inspection
This was a focused inspection to check whether the provider had met the requirements of the last inspection in relation to regulation 12 (Safe care and treatment), regulation 17 (Good governance), regulation 18 (Staffing) and regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we looked at the infection control and prevention 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
The inspection was carried out by three inspectors.

Service and service type
Cherrydale is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This meant the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24-hours' notice of the inspection. This was because we needed to check our visit was carried out in a way which complied with the provider's policies and procedures about infection control and the use of PPE during the coronavirus pandemic.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included feedback about the home from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information

about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection. We asked the manager to provide documentation we could review before visiting the home, including the provider's visiting policy and coronavirus contingency plan.

During the inspection
We spoke with the manager, two staff and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. 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 reviewed five people's care records, including their risk assessments and support plans. We checked the recording of care for four people who required repositioning in bed. We looked at four staff recruitment files, accident and incident records, quality monitoring systems and the arrangements for managing medicines.

After the inspection
We asked the provider to send us further information, including care records, audits and staff training records. We spoke with a healthcare professional who had an involvement with the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection systems and processes to manage risks to people were not effective. Care plans did not contain clear information for staff about the care people needed. Personal Emergency Evacuation Plans (PEEPs) had not been completed for all the people living at the home. Systems to prevent and control infection were not always effective. There were unpleasant odours in some parts of the home.

This was a breach of regulation 12 (Safe Care and Treatment) 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.

● The provider had failed to manage and mitigate risks. For example, one person who had been identified as at risk of leaving the home was able to do so on 27 September 2020 without being observed by staff. The person was found in the home's car park by the police, who alerted staff, and taken to hospital for assessment.
● The person's pre-admission assessment, carried out on 17 September 2020, recorded that the person was known to be at risk of leaving unescorted and at risk of falls.
● Despite this risk being identified before the person moved into the home, measures were not put in place to ensure the person was protected from the risk of leaving the home unnoticed.
● Several people had been recommended pressure-relieving mattresses to protect them from the risk of pressure damage. To function effectively, pressure-relieving mattresses must be set according to the weight of the person using them. It is therefore essential to maintain accurate weight records for people using pressure-relieving mattresses.
● One person's mattress was set approximately 20kg above their actual weight, meaning the mattress was not being used safely or effectively.
● Another person's pressure-relieving mattress was set for a person weighing 55kg. However, the person's weight had not been recorded since March 2020 so it was not possible to know whether the mattress was set at the appropriate pressure.
● Staff recorded mattress checks but did not check mattress pressures when performing these checks, instead recording 'OK' following a visual check. This was ineffective in ensuring that people's mattresses were at the correct setting for their weight.
● A healthcare professional had made a safeguarding referral to the local authority on 25 August 2020 due to

their concerns about the care people were receiving at Cherrydale. The healthcare professional reported that, 'Monitoring of patient weight is poor, also concerned regarding pressure relieving equipment is not patient appropriate and reused from other patients.' However, these concerns were still apparent at our inspection one month later.

● Another healthcare professional had previously raised concerns that people who were unable to weight-bear could not be accurately weighed at the home. The manager had advised that a hoist weighing scale would be purchased to enable accurate weights to be recorded and monitored. The provider had not purchased the hoist weighing scale at the time of our inspection.

● There were no care plans in place for a person who had been admitted to the home four days prior to our inspection. This meant there was no guidance in place for staff about the care and support the person needed.

● Personal Emergency Evacuation Plans (PEEPs) had been recorded for all the people who lived at the home permanently. However, the manager told us that no PEEPs had been put in place for the four people who were receiving respite care at the time of our inspection. This meant staff would have no information about the support these people needed in the event of a fire.

The failure to manage and mitigate risks was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. During our inspection we observed some staff wearing their face masks around their chins, exposing their mouth and nose. At lunchtime, a member of staff supported a person from a distance of less than two metres whilst their mask was around their chin.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was no hand towel dispenser in a toilet on the first floor. There was a roll of paper towels on a shelf next to the toilet but these were visibly dirty.

● The smell of urine that was noted at our last inspection was still present in the home's entrance hall. The nominated individual told us that the carpet in this area was cleaned regularly but had not been replaced since the last inspection.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or that social distancing rules were being adhered to in line with Department of Health and Social Care guidance. We observed a member of staff supporting two people to eat in the lounge simultaneously. The member of staff moved back and forth between the two people, supporting them to eat a mouthful of their meal each time. The member of staff used both people's cutlery without changing gloves.

● We were not assured that the provider was preventing visitors from catching and spreading infections. The visiting policy stated that visitors have their temperature taken when they arrived at the home. However, the manager told us that this did not always happen.

The failure to maintain adequate standards of infection prevention and control was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service. The manager told us that people admitted to the service had to have a negative Covid test before moving in and to isolate for 14 days after moving in.

● We were assured that the provider was accessing testing for people using the service and staff. The manager told us that staff and people who lived at the home were being tested weekly.

● We were assured that the provider's infection prevention and control policy was up to date.

Using medicines safely

● People's medicines were not managed safely. One person had been prescribed a transdermal patch for pain relief to be administered once a week. The controlled drugs book had no record that this had been administered since 1 September 2020.

● We pointed this out to a member of staff, who checked the person's medicines administration record and confirmed the patch had not been administered since that date. In addition, there was no body map in place to record the site of administration. The member of staff immediately contacted the person's GP for advice. We made a safeguarding referral to the local authority about this concern.

● Some people had no photograph in their medication folder to help staff be sure they were administering medicines to the correct person.

Failure to ensure the proper and safe management of medicines was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

● Learning had not been implemented following adverse events such as safeguarding enquiries. For example, a safeguarding investigation in July 2020 found that a person had not been adequately protected from the risk of pressure damage whilst living at Cherrydale.

● Following the investigation, the provider reported they intended to put measures in place to prevent this happening in the future, including the introduction of a daily audit to ensure accurate documentation of any pressure areas was maintained. However, we identified continuing concerns in relation to pressure area care and prevention at this inspection.

This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood the different kinds of abuse people could experience and knew how to report any concerns they had. They told us they would feel confident to speak up if they had concerns about people's safety or well-being. They said they knew how to escalate concerns outside the home if necessary.

Staffing and recruitment

At our last inspection, there were not always enough staff available to meet people's needs. This was a breach of regulation 18 (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.

● Staffing levels had increased since our last inspection. An additional member of care staff had been deployed on each daytime shift, taking the number to four. One person was receiving one-to-one support during the night to meet their needs. This care package was funded by the local authority and provided by two regular agency staff on a rota basis.

● Staffing rotas showed that the staffing levels calculated as appropriate were maintained.

At our last inspection, we found staff were not always recruited safely. A member of staff had been employed

without a Disclosure and Barring Service (DBS) check. DBS checks enable providers to check applicants' suitability for employment. This was a breach of regulation 19 (Fit and proper persons employed) 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 19.

● The recruitment files we checked demonstrated that staff were recruited safely. Staff files contained evidence of appropriate recruitment procedures, including an application form, proof of identity and a DBS check.

Inadequate

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found that audits, including of care records and medicines, were not effective. The was no evidence of effective management oversight of quality and safety.

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.

Important documentation relating to people's care was not up-to-date and quality monitoring systems were not always effective.

- Accurate recording of people's care was not maintained. This meant it was not possible to confirm that people were receiving the care they needed.
- Some people needed to be repositioned in bed by staff to protect them from the risk of pressure damage as they were unable to reposition themselves. To ensure repositioning is effective, people must be repositioned according to the frequency set out in their care plans. In addition, staff should record how they have repositioned the person to ensure that they are supported to redistribute their weight evenly throughout the day and night.
- The daily care logs maintained by staff did not always record whether people had been repositioned. For example, one person's support plan stated they should be repositioned in bed every four hours. The person's care records stated they had been repositioned during the night of 28 August 2020 but failed to mention repositioning in records of night care on the four following nights. This meant there was no evidence that the person had received the care their support plan said they needed.
- The provider had failed to make improvements when things went wrong. Following a safeguarding investigation in July 2020, the provider told the local authority they would put measures to protect people from the risk of pressure damage. However, we found people were still at risk of developing pressure damage at this inspection.
- Quality monitoring systems were not effective in identifying and addressing shortfalls. For example, the last four medication audits (May, June, July and August 2020) had highlighted errors in people's medicines

administration records. Medication audits stated that staff had been reminded to record medication properly. However, we identified concerns in relation to the management of medicines at this inspection. Therefore improvements had not been made or sustained in response to known concerns about recording of medicines.

● Since our last inspection, the provider had begun to record quality monitoring checks of the service. We saw that these took place each month. However, areas identified for improvement at these checks had not been addressed.

● For example, the provider's check carried out in August 2020 noted that the most recent CQC rating was not displayed in the home and recommended that it should be. The check also recommended that PEEPs be kept up-to-date for all the people living at the home. Neither of these actions had been completed at the time of our inspection.

Failure to implement effective quality monitoring systems or to maintain accurate records of care was a continued breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Since the last inspection, incidents had not always been reported to CQC when necessary. For example, one safeguarding incident in which a person had suffered pressure damage and another safeguarding incident in which a person left the home unnoticed. This meant we were unable to check the provider had taken appropriate action in response to incidents.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection, the service did not have a registered manager in place, the previous registered manager having de-registered in April 2019. At this inspection, there was still no registered manager in place. The manager had taken up their post in April 2020 but had not submitted an application for registration with CQC.

This was a breach of Section 33 of the Health and Social Care Act 2008.

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; Working in partnership with others

● Residents' meetings had been implemented, the last of which took place in June 2020. People were asked for their views about the menu and activities they would like to try.

● The manager told us satisfaction surveys had been distributed to people's friends and families and that one survey had been returned thus far. The feedback provided by the one survey returned was positive about the home.

● Team meetings were held monthly and staff told us their ideas and contributions to these were encouraged. One member of staff said, "If I have an idea, I will always tell them." The staff member said there was also a WhatsApp group for staff, which facilitated more regular communication.

● Staff told us the manager and provider were approachable and supportive of staff. One member of staff said, "They are good people and approachable."

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 Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12(1)(2)(b) The registered provider had failed to do all that is reasonably practicable to mitigate risks. Regulation 12(1)(2)(g) The registered provider had failed to ensure the proper and safe management of medicines. Regulation 12(1)(2)(h) The registered provider had failed to implement appropriate measures to prevent and control the spread of infections.

The enforcement action we took:

We served a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17(1)(2)(a) The registered provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. 17(1)(2)(c) The registered provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.

The enforcement action we took:

We served a Warning Notice.