Mr Pierre Grenade

Nada Residential and Nursing Home

Inspection report

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27 June 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 26 and 27 June 2017 and was unannounced. Our last comprehensive inspection of the service took place in December 2016 where the home was found to be inadequate overall, with the safe, effective and well led domains being inadequate, requires improvement in responsive and good in caring. The provider was placed into special measures by the Care Quality Commission. We took enforcement action and issued three warning notices to the provider.

Following a serious safeguarding incident a focused inspection, looking at the safe and well led key questions, was carried out in March 2017. The service was rated as inadequate in both of these key questions.

After both inspections the provider sent us action plans detailing how they were going to make improvements to meet the Health and Social Care Act regulations. This inspection was carried out to check what improvements had been implemented since these inspections.

We found that whilst improvements had been made in some areas, for example staff training, the security of the building and monitoring people when they accessed the local community to help ensure they were safe, no improvements had been made in other areas. We found continued breaches in five Regulations with regard to fire safety checks, medicines management, the environment, the lack of service specific staff training for the needs of the people living at the service, staff supervisions, lack of activities for people living at the home and a lack of quality assurance systems used to improve the service provided by the home. We also found four new breaches with regard to the planning and provision of care and support to one person nearing the end of their life, staff not having the time or knowledge to provide 1:1 support around people's anxieties and drug or alcohol use and for the registered manager retrospectively completing records for checks on the fire safety equipment. We are currently considering our options in relation to enforcement and will update the section at the back of the full version of this report once any enforcement has concluded.

We have also made a recommendation that Personal Emergency Evacuation Plans (PEEPS) should be kept in an easily accessible file that the staff can pick up in the event of an emergency so that the information in the PEEPS would be available for the emergency services.

Nada is a privately owned care home that is situated in the Cheetham Hill area of North Manchester close to a variety of local shops and other community services. The home is registered to provide nursing care and accommodation for up to 28 people who may have a combination of mental health and personal care needs. At the time of our inspection there were 20 people living at the home.

The provider was also the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social

Care Act 2008 and associated Regulations about how the service is run. The day to day management of the home was delegated to the deputy manager and clinical lead. However the clinical lead was the designated nurse on duty when working and so did not have time as supernumerary to the rota to complete their other tasks.

At the time of our inspection in December 2016 the deputy manager had been off work, returning shortly after our inspection. At this inspection we were told the deputy manager worked five days each week. The registered manager was available to be contacted if required but did not regularly attend the home.

The service had tried to reduce the amount of smoking that took place within the building. Staff had completed on line and taught courses in fire awareness. The fire safety checks log book had been completed each week by the registered manager up until May 2017. A note then stated a member of staff would complete the checks. None had been completed since this date and neither the registered manager nor deputy manager had checked to ensure this delegated task had been done. The registered manager had also retrospectively made entries in the fire log book for the period 7 September to 12 December which were seen to not have been completed at our inspection in December 2016.

Staff told us they had completed a range of training courses since our inspection in December 2016. More training was planned. However the service supported people with a history of drug and alcohol abuse and mental health issues. Some staff had received training in these areas in 2013, but they had not completed refresher training and so the training was not current. Additionally staff who had joined the service since 2013 had not received any training in these areas so did not have an insight into the needs of the people who used the service. Records showed care staff did not have supervisions, although some nurses and domestic staff had.

No action had been taken to improve the activities provided at the service. People told us an entertainer occasionally visited the home. The care staff member whose role was to organise activities had left the service and no one had taken over this role.

The environment required re-decorating and upgrading. We saw one bedroom with a broken radiator cover and walls with different shades of paint on them. Walls were marked and scuffed. A few pieces of furniture had been purchased since our last inspection. One room had a strong odour, due to the person's incontinence, which affected the surrounding corridor and bedrooms. No referrals had been made for specialist continence services. Staff cleaned the room as best they could but the odour persisted.

Care plans and risk assessments were in place and had been written for people accessing the community independently. However an end of life care plan for one person had not been written for three weeks after their discharge from hospital on palliative care. The care plan was written after a safeguarding had been raised by a social worker. The person had been found to be dirty and they did not have a pressure relieving mattress in place. During our inspection the person was seen to be comfortable, clean and with a suitable mattress.

Care plans did not contain sufficient detailed guidance about what support the care staff needed to provide and what people were able to do for themselves. One to one sessions identified in people's care plans to reduce people's anxiety or to discuss their alcohol consumption did not take place.

Medicine Administration Records (MARs) were seen to be fully completed. Protocols for any 'as required' medicines had improved. They included how the person would communicate, either verbally or non-verbally that they needed the 'as required' medicine to be administered. However we noted one person's

Fybogel medicine had run out and had not been re-ordered for six days, meaning this person did not receive their prescribed medicines for this period. A code had been entered on the MAR stating the Fybogel had been offered but not administered, which was not possible as it was out of stock.

Since our focused inspection keypads had been fitted to the external doors. Staff knew when people were leaving the building. A record was made of where they were going and when they were due to return to the home. Staff and people we spoke with liked this system as it made them feel safer.

Staff had a clear understanding of who had capacity to access the community on their own and who required staff to support them. Contingency plans were in place in case a person did not return at the agreed time. Care plans were in place where staff held cigarettes or property on behalf of people living at the service.

The registered manager and deputy manager did not have a robust quality assurance system in place. Only three care plans had been audited since our inspection in December 2016, no spot checks on the environment had been completed, records such as the fire log book and deep clean records had not been checked.

Residents meetings were held and surveys conducted but it was not clear what action had been taken as a result of these. One person said they did not feel able to make a complaint about the service as they would be told to leave.

Incidents and accidents were recorded and reviewed by the deputy manager. People received support with their nutritional needs.

Staff files showed a system of recruitment was in place; however this had not been followed in one instance as only one reference had been obtained.

The overall rating for this service remains 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

inadequate for any of the five key questions it will no longer be in special measures.

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.

Weekly fire checks had not been completed since May2017. Fire records had been written retrospectively for the period September to December 2016. Staff had now completed fire awareness training.

One person's prescribed medicine had not been available for six days before it was re-ordered. Records stated the medicine had been offered when it had not been available.

There was a strong odour on one of the first floor rooms which affected the corridor and nearby bedrooms. The person refused support and urinated in their room after consuming alcohol; however no referrals had been made to specialist services.

Sufficient staff were on duty to meet the day to day needs of the people currently living at the home.

Is the service effective?

Inadequate

The service was not effective.

Staff supervisions were not held for the members of care staff. Staff said they could speak with the nurse on duty if they wanted to.

No improvements had been made to the building since the last inspection. The environment was tired and in need of refurbishment. Recommendations from an environmental health audit to replace cupboards in the kitchen had not been actioned.

Improvements in assessing people's capacity and applying for Deprivations of Liberty Safeguards had been made. Systems were in place to monitor who had left the building and when they were due to return. The external doors had been made secure.

Staff training had been arranged and completed for key areas, including fire training. Staff did not have any specific training such as alcohol awareness to meet the needs of the people living

at the service.

Is the service caring?

Requires Improvement

The service was not always caring.

An end of life care plan had not been written detailing the care and support one person required at the end of their lives. Appropriate support was not provided until recommendations were made by a social worker.

We saw and heard good interactions between staff and people living at the service during our inspection.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not have sufficient guidance for staff to be able to provide consistent care and support. One to one discussions with staff did not take place as stated in the care plans.

Activities were not arranged for people to take part in and be occupied in.

Residents meetings and surveys had been held; however we saw no evidence of what action had been taken as a result of these.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were still not in place to help monitor and improve the service.

A registered manager was in place as required by the service's registration with CQC. The day to day management of the service was delegated to the deputy manager.

Staff felt happier working at the home since the external doors had been secured.

Nada Residential and Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 27 June 2017 and was unannounced. The inspection was carried out by one inspector.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We contacted the local authority commissioning and safeguarding teams as well as the local Healthwatch board for feedback on the service.

During the inspection we observed interactions between staff and people who used the service. We spoke with four people living at the home, the registered manager, the deputy manager, two registered nurses and four care staff. We observed the way people were supported in communal areas and looked at records relating to the service. This included four care records, two staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, quality assurance systems, incidents and policies and procedures.

Inadequate

Is the service safe?

Our findings

At the last comprehensive inspection in December 2016 we were told that people felt physically safe but there were concerns about personal property being taken from people's rooms by other people who used the service. At this inspection we saw that this issue had again been raised in a residents meeting held in May 2017 as more items had been taken from people's rooms. People were able to lock their bedroom doors but often did not do so. At the last comprehensive inspection one person was unable to access their bank card as they had given it for safe keeping to a member of care staff. This member of staff was not on duty and other staff said they could not access it. At this inspection we were told that all property was kept in the office on the first floor and the registered manager and deputy manager had access to this office. This meant that if they were not on duty, for example at a weekend, staff would not be able to access people's property when they asked for it.

At our last inspection in December 2016 we found a breach of the Health and Social Care Act 2008 Regulations (Regulations) because staff had not received training in fire awareness, regular checks on the fire systems were not completed and fire drills were not undertaken.

At this inspection we found that staff training on fire awareness had been completed by all staff. We also saw that the service had reminded people at the residents meetings in March and May 2017 that there was a designated smoking room or people had to smoke outside. We saw smoking risk assessments were in people's care files and they were encouraged to use the smoking room. Staff encouraged people to keep their cigarettes and lighters in the office if they were likely to smoke in the building. Staff told us that people were smoking less within the building than previously, although people still did smoke in their rooms, especially at night or if they had been drinking alcohol.

At the inspection in December 2016 records showed that weekly fire alarm tests and fire door checks had been completed up until the 7 September 2016, with none being completed after this date. Records seen at this inspection showed that the registered manager had completed the fire log book as if weekly fire system checks had been completed for the period 7 September 2016 to May 2017. This meant following our inspection they had retrospectively completed the fire log book.

The retrospective completing of the weekly fire check records for September to December 2016 by the provider / registered manager was a falsification of the records. We found the provider / registered manager had not fulfilled their statutory responsibilities and was a breach of Regulations 4 and 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
An external fire risk assessment for the service had been completed in November 2016. This had identified fire awareness training was required for staff and weekly tests of the fire alarm, emergency lighting and fire door operation should be completed.
A note in the file stated the registered manager had shown a member of care staff how to complete the fire alarm and emergency lighting checks and check the fire doors closed correctly. Completed checks should be recorded in the fire log book. The registered manager was not aware that the log book had not been completed since May 2017, but claimed the checks had been done with the staff member recording this on a

piece of paper rather than in the log book. We were not shown these pieces of paper. We were told no fire drills had been conducted.

The risk of having a fire was heightened due to people continuing to smoke in their rooms. The lack of weekly checks of the fire alarm, emergency lighting and fire doors and the lack of any fire drills was a continued breach of Regulation 12 (1) with reference to 2(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had a personal emergency evacuation plan (PEEP) in their care files. PEEPs identify the support a person needs to evacuate the building in the event of an emergency and should be available to staff and the emergency services, for example the fire service, in case people are still in the building when they arrive at the home. We recommend that the service compiles a separate emergency fire file containing a plan of the building and each person's PEEP so that it is easily accessible for staff in the event of an emergency.

At the inspection in December 2016 we found a continued breach of Regulations due to inconsistent as required medicine guidelines and the nurses signing medicine administration records for thickeners and creams when they had not added the thickener to drinks or applied the creams themselves.

At this inspection we found some improvements had been made. As required medicine guidelines were in place which stated how a person would inform staff, either verbally or non-verbally, that they required an as required medicine to be administered.

Thickeners' are added to drinks, and sometimes to food, for people who have difficulty swallowing. They may help to prevent a person from choking. We saw guidelines were available for care staff for what consistency of fluids each person needed. A thickeners chart was signed by the care staff who added the thickener to people's fluids. Cream charts had been introduced for the care staff to sign when they had applied the prescribed creams. We saw these had been fully completed. Staff told us they had received training for thickeners and applying creams.

We saw the medicine administration records (MARs) were fully completed. A stock record of all boxed medicines was kept. However, one person was prescribed Fybogel but there were none in stock. Fybogel is a laxative used to treat constipation. The last Fybogel sachet was administered on the 20 June 2017. Nurses had written a code on the MAR stating that the medicine had been offered. This was not the case as there were none in stock to offer. We were told by the nurse on duty that the Fybogel had been re-ordered on the 26 June 2017. It therefore would not be available at the home until the 28 or 29 June 2017 as the GP had to sign the prescription and the pharmacy had to deliver the medicine to the home. This meant the person would not have received their prescribed Fybogel medicine for over one week.

The delay in re-ordering prescribed medicines by the nurses and stating on the MAR that the medicine had been offered when it wasn't available was a breach of Regulation 12 (1) with reference to (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the registered nurses had completed refresher training in the administration of medicines. The clinical lead had recorded their observations of the nurses' competencies when administering medicines.

The MAR sheets were checked each month by a nurse to reconcile the quantity of tablets received, quantity administered and the quantity carried forward to the next month or disposed of. The quantities of medicines we checked were all correct.

At the last comprehensive inspection we found there was a breach of Regulations as there were insufficient staff on duty to meet people's needs. At this inspection we noted that the number of people living at the service had decreased and a person who had needed one to one staff support was no longer living at the service. The rotas showed there were one registered nurse and three care staff on duty during the day, and one registered nurse and two care staff at night. All the staff we spoke with told us this was now sufficient to meet the needs of the people currently living at Nada. Staff also told us that shifts were covered by agency staff if the Nada staff team were unable to work additional shifts. We found the staffing levels were sufficient to provide the level of service that it currently offered; however this should be reviewed in line with the findings of this inspection.
We saw risk assessments for falls, nutrition using the Malnutrition Universal Screening Tool (MUST), skin integrity, challenging behaviour, smoking and manual handling. These were evaluated each month. Guidelines were in place for staff on how to de-escalate instances of behaviour that may be seen as challenging.

We looked at the staff files for two staff members appointed since our inspection in December 2016. We found they contained an application form detailing previous employment histories, a record of the interview and showed appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. The registered nurse's registration with the Nursing and Midwifery Council (NMC) had been checked to ensure they were registered to practice as a nurse in the UK. However one file only contained one reference from a previous employer. We noted that a request for the second employer reference had been made but this had not been received. Nada's recruitment policy states that two references would be obtained. The deputy manager told us the staff member could not provide any other employer references and the service had not asked for a character reference.

This meant that a system for recruiting staff suitable to work with vulnerable people was in place but had not been followed in one instance.

At the inspection in December 2016 we recommended the service wrote a business continuity plan to guide staff of actions to be taken in the event of an emergency affecting the running of the home, for example a utility failure. We saw this had been written and was available for staff to consult in the event of an emergency.

On walking around the home we noted a very strong odour coming from one of the bedrooms. We were told the person regularly consumed excessive alcohol at the beginning of the week when they had money available. When drunk the person urinated in their room and was also incontinent, leading to the odour. They were non-compliant with staff when staff encouraged them to change their clothes and bedding. Staff said they cleaned the room as best they could. The domestic staff we spoke with said that they had extra strong detergents and cleaning products for this person's room and completed a deep clean when the person was sober and allowed them into their room. This meant the room did not smell as strongly at the end of the week as the person was able to access the toilet as they had not been consuming alcohol.

Whilst the inspector acknowledges the issues the staff team have in supporting this person, the odour affected the corridor and the bedrooms of people close by. We looked at the cleaning schedules for the home. We saw the daily schedule for communal areas and bedrooms was completed; however the monthly deep clean of each bedroom was not signed as completed. The schedule indicated only five bedrooms had been deep cleaned in 2017. Weekly tasks had also not been signed as complete, for example dusting window sills and shelves in communal areas. The schedule also had a section to record spot checks completed by the registered manager or deputy manager. We saw that no spot checks had been recorded

since February 2017.

The strong odour affecting the corridor and other bedrooms and the lack of deep cleaning of people's rooms was a breach of Regulation 15(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not see any referrals to alcohol services or continence nurses in this person's care file. We were told they had refused these services in the past and did not want to stop drinking. Staff completed observations every 15 minutes when the person had been drinking to ensure they were safe and noted any support they had been able to provide. We also noted that professional support from district nurses and McMillan nurses had not been sought for one person who was near the end of their life.

The lack of referrals to specialist services was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff members we spoke with were able to explain the correct action they would take if they witnessed or suspected any abuse taking place. They told us that they would inform the nurse on duty or the registered manager. Staff members told us they had received training in safeguarding vulnerable adults and training records confirmed this.

We noted accidents and incidents were recorded. The deputy manager compiled a bi-monthly log of all accidents and incidents. They told us this was so they could identify and patterns or trends.

Records showed the equipment within the home had been serviced and maintained in accordance with the manufacturer's instructions. The service held records of tests completed for the manual handling equipment, fire alarm, lift and electrical items at the home. This should help to ensure that people were kept safe.

Inadequate

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Our focussed inspection in February 2017 was prompted by a serious safeguarding incident. In this incident a person who used the service left the home unaccompanied, when their DoLS authorisation and assessment of need was that they should always have a member of staff with them when they accessed the community. The person was involved in an accident whilst in the community on their own. We found risk assessments were not in place for three people assessed as requiring a DoLS authorisation, but still being able to access the local community.

At this inspection we found these risk assessments were now in place. Risk assessments were also in place for all people who accessed the local community on their own. These included details of where people went to and systems for informing their family when they had set off to visit them and that they had arrived safely. The risk assessments noted that the person had shown that they knew the safest routes and were able to cross roads safely. Guidance for staff was also available on what to do if people did not return to the home at the agreed time.

At this inspection clear information was available on a notice board in the nurse's office about who had a DoLS in place, who was waiting for an assessment and who had capacity to make their own decisions. It was also clear who was able to leave the home on their own, who needed to go out only with staff and who could go to local shops on their own. The doors now had keypads on them so people could not leave the home without asking staff to open the door for them. A file had been set up to record who went out on their own, where they were going, what they were wearing and what time they were due to be back. One person told us they liked this system, saying, "It helps to keep me safe as the police can be called if I get lost." However we noted that the staff did not always sign the file to state when the person had returned to the home. It was not clear who checked the file to ensure people had returned when they said they would. This meant the staff were aware of who had left the building, but records were not always completed to show that they had returned. Staff completed observations of people's whereabouts every 30 minutes for those who had a DoLS authorisation and hourly for those with capacity. This meant a record of who was in the building was regularly completed.

All the staff we spoke with said there had been an improvement since the safeguarding incident in February

2017. Staff said, "It's more secure now we have the locks on the doors," and, "It's really improved now as people can't leave without us knowing."

At the focussed inspection we also found that one person living at the home required one to one staff support. A DoLS had not been applied for on behalf of this person. At this inspection we saw the person no longer lived at the home. The new system for identifying who had capacity and who required a capacity assessment should mean that any new people moving to the home would have the required capacity assessments and DoLS applications made.

At the last comprehensive inspection in December 2016 people's consent was not recorded when staff held their cigarettes in the staff office on the ground floor. People asked staff when they wanted to have a cigarette. The staff were able to provide people with their cigarettes when asked. At this inspection we saw in people's care files that a care plan had been written where staff kept money or property on behalf of people. This included details of the person's agreement for staff to hold these items.

At the last comprehensive inspection there was a breach in Regulations due to the lack of up to date staff training. Records we saw at this inspection, confirmed by staff, showed that a series of training courses had been organised. Fifteen out of 17 staff had completed five on-line training courses in safeguarding, health and safety, fire awareness, mental capacity act and DoLS. Taught courses had also been completed including moving and handling, the use of thickeners, MCA, fire training and medicines. A training plan had been written for the whole of 2017. We saw nurses had undertaken a course in the use of syringe drivers for the administration of medicines at the end of people's lives.

This meant that staff had received training in key areas however staff did not have the service specific training to meet the needs of the people living at the service. This was a breach of Regulation 18(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care staff we spoke with said they did not receive regular supervisions' with a nurse or manager. Supervision meetings are important as they enable feedback to be given to the staff on their work and give the staff an opportunity to discuss any ideas, training or concerns they may have. At our last inspection we also found that regular supervision meetings had not been held. Records showed that supervision meetings were planned to take place every two months. However we saw only seven supervision meetings were held in April and May out of the twenty that had been planned. We noted all the supervisions that had been held were carried out by the registered manager or the deputy manager. The nurses had not completed their supervisions with members of the care staff. One nurse told us that they had not been able to hold a supervision meeting with the care staff they supervised as they had not been working on the same shifts. Staff said they were able to talk with the nurses if they needed to and felt supported by them.

This meant the care staff did not receive formal supervisions to support them in their roles. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the handover between the night staff and the incoming day shift staff. A brief overview of each person's health and wellbeing was given. This meant the staff had up to date information about the people living at the home and any changes in their support needs.

At the last inspection we found a breach in the Regulations as the home was in need of refurbishment. At this inspection we found no improvements had been made. A few new dining room chairs had been bought and we were told some people had new furniture for their bedroom. The kitchen cupboards highlighted in the environmental health report in November 2016 had not been replaced. No changes had been made to

the decoration of the bedrooms or communal areas of the home. The bedrooms we saw were contained mismatched furniture. In one bedroom the radiator cover had a broken front and the bedroom walls had different colour shades of paint on the same wall. Wall surfaces were marked and scuffed and had not been re-decorated.

The visiting professionals we spoke with all commented that the environment of the home required improvements to be made.

This was a continued breach of Regulation 15(1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We again received mixed reports about the food at the service. Some people told us the food was sometimes cold. We saw reasonable portions were provided. There was one main meal prepared for dinner and tea; however we saw that people could choose something different if they did not want the main meal. For example on one day of our inspection some people chose to have a steak pudding instead of the chicken. We saw snacks were available each morning and afternoon and one person told us they had milkshakes in the summer.

We saw that referrals to dieticians and the Speech and Language Team (SALT) were made when appropriate. Where people were considered to be at risk of not eating or drinking enough a food and fluid chart was completed. This noted what people had actually eaten and drunk. This information is useful to monitor any decline in people's food and fluid intake and is used by dieticians and the SALT when reviewing people's care and support in relation to their nutrition.

Each person was registered with a local GP. A GP we spoke with said the staff referred people to them appropriately and followed any advice they were given. We saw referrals were also made to other health care professionals as required. The nurses recorded monthly observations of people's weight, blood pressure and pulse.

Requires Improvement

Is the service caring?

Our findings

We observed and heard positive interactions between people who used the service and the staff during our inspection. People we spoke with said the staff were 'alright' and were helpful; however one person told us that a member of care staff had shouted at them. The staff we spoke with knew people's needs and the support they required.

We noted the care plans we looked at, except one, only had brief details about people's life history. As noted at our last inspection in December 2016, most people did not have any family involved in their lives and were not able to provide many details about their own life history.

We saw one person had an Independent Mental Capacity Advocate (IMCA) supporting them to ensure their rights were protected and who was able to speak on their behalf.

At the time of our inspection one person living at the service was being supported with end of life care. We saw they had been discharged from hospital with palliative end of life care to be provided by the home. We saw the GP had visited regularly and issued a Statement of Intent. A statement of intent is issued where a person's death is expected and confirms that the GP will issue a death certificate if the person passes away outside of surgery hours. The GP had also prescribed anticipatory drugs. Anticipatory drugs are medicines prescribed to ease the pain and distress a person may have at the end of their lives.

However an end of life care plan detailing the care and support staff should provide was not written until the 23 June 2017. The person's nutrition care plan had been updated on the 2 June 2017 stating the person now required a pureed diet due to having swallowing difficulties. This meant there was no specific plan of care for the person's end of life in place for three weeks after their discharge from hospital. The end of life care plan stated that the person was able to communicate with staff if they were in pain and required pain relief medicines to be administered. The end of life care plan also guided staff to look for signs of pain or distress such as agitation or breathlessness.

We were aware that a social worker had raised a safeguarding concern about the care this person was receiving on the 23 June 2017. They said that recorded information about the person's care was not forthcoming from staff, the person's hands were not clean and they did not haven a pressure relieving mattress. A GP told us the person had looked unkempt and had dry lips on their visit on the 23 June 2017. Part of the end of life care was to ensure the person was supported to have fluids and oral care so that their mouth was clean and not dry.

We saw food and fluid records were kept for the person. Food supplements were now available if they did not want to eat. Other medical professionals we spoke with during our inspection said the person was now looking comfortable, was clean and had the correct pressure relieving mattress in place.

We also noted that the district nurses and McMillan nurses had been contacted following the social workers visit. The home did not have a 'syringe driver' that was required to administer one of the anticipatory drugs.

The district nurse team were going to provide the home with one.

This meant the home had not written an end of life care plan to detail the care and support the person required as soon as the person was identified as being at the end of their life. The person had not received the care and support required with regard to their personal hygiene and pressure relief. This was a breach of Regulation 12 (1) with reference to (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We looked at four care files and saw they contained details about people's support needs. Each file had a pre-admission assessment giving brief details of people's needs.

The care plans covered areas such as hygiene, smoking, social activities, alcohol and drug use, and challenging behaviour. The plans gave some guidance for staff to follow; however this was not always detailed. For example, one care plan stated that staff needed to support the person to dress, shower and to provide encouragement to use the toilet. There was no guidance as to what the person was able to complete for themselves and what support the staff were required to provide. This meant that the support provided by the care staff may not be consistent across the staff team.

The care plans were evaluated each month by one of the registered nurses; however these had not added details of the support to be provided by staff.

The lack of clarity as to the support staff were to provide and one to one sessions not taking place as stated in the care plans was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the care plans referred to staff talking with people on a one to one basis to discuss their use of alcohol or to reduce their anxiety and possible aggression. We did not see any records that these discussions took place. We read the daily notes for the previous month for one person whose care plans stated one to one discussions should be used and saw no reference to any such discussions with staff taking place. We had raised this issue with the clinical lead and registered manager at our last inspection in December 2016 and were told the one to one discussions were completed by the nurses when required. This was not stated in the care plan which said they were to be used to reduce the person's anxiety and use of alcohol. This meant people were not receiving the support they required as stated in their care plans.

We found the care staff did not have the training and skills to complete the 1:1 sessions and the nurses did not have sufficient time to undertake them. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found a breach in Regulations due to the lack of activities being arranged for people living at the home. At this inspection we found no improvements had been made. The registered manager told us they had planned to provide additional hours for one staff member so they could arrange and co-ordinate activities within the home. This staff member had subsequently left the service and no one else had been provided with the time to undertake this role. We were told that every two or three months an entertainer visited the home, mainly around people's birthdays. People told us there were no other activities arranged by the home. During our inspection we saw the TV was on in the lounge; however there were no other games or activity items available for people to use.

We saw an activities survey had been completed in March 2017. Thirteen people had responded and stated

they wanted more activities to be arranged, for example board games, music, 1:1 discussions with staff and painting. We saw no evidence that any of these requests had been acted upon.

This was a continued breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed an observation form throughout their shift. This recorded where everyone was both within the home or if they had gone out. For people who had been assessed as requiring a Deprivation of Liberty Safeguards authorisation these observations were every 30 minutes. For people who had been assessed as having capacity they were every two hours. We were also shown a monitoring chart used if a person had been drinking alcohol. This recorded observations on their breathing and if they were in the recovery position every 15 minutes. The chart also detailed the support staff had provided or attempted to provide, for example if the person had been supported to change or their bedding had been changed. This helped to ensure the person was safe even if they were under the influence of alcohol.

We saw minutes from residents meetings that had been held in March and May 2017. These included information about smoking within the home, discussions about the food provided and trips out. We noted that no trips out had been arranged at the time of our inspection.

A relatives meeting had also been arranged for March 2017 but no relatives had attended. This meant the service tried to engage with the people who lived at the home, however it was not clear what action had been taken as a result of the surveys or meetings.

We saw the service had a complaints policy, with a copy displayed in the foyer. We saw no formal complaints had been recorded in the last six years. However one person we spoke with told us, "[registered manager] will kick me out if I say bad things about the place." A similar comment had been made to the inspector by a relative of a person who previously lived at the service. This meant that whilst the service had a complaints procedure people did not feel they could use it.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). The registered manager was also the owner of the home. We were told the registered manager was not always present at the home and they delegated the day to day management of the home to the deputy manager and clinical lead. However the clinical lead was the designated nurse on duty when working and so did not have time as supernumerary to the rota to complete their other tasks.

At the last inspection there was a breach in Regulations because audits were not in place to monitor and improve the quality of the service, the registered manager did not have oversight of the service and issues previously identified by the CQC had not been remedied. We found that information was not readily available as the registered manager was not able to easily find what we requested and the deputy manager was not in work. At this inspection the deputy manager was able to provide the information we asked for.

At this inspection we found some improvements had been made with regards to the home being secure and a system being in place to monitor who was able to leave the home on their own. Care plans had been written for people accessing the local community which detailed where they usually went and if they knew the safest route to use. This would help in keeping people safe when accessing the community. We also saw that training had been arranged for staff, including fire training.

However improvements had not been made in other areas. Weekly checks of the fire system had not been completed since May 2017 and records had also been completed retrospectively by the registered manager. Audits had not been completed for the environment or health and safety. We saw a care plan audit in one of the care files we looked at, however the other three files had not been audited. We were told by the registered manager that eight care plans had been reviewed. Following our last inspection we were told five care plans had been audited which means only a further three care plan audits had been completed since December 2016. These audits had not identified the issues noted in this report.

From the rota we saw that the clinical lead was the designated nurse on duty when they were on shift. This meant they did not have the time as supernumerary to the rota to complete care plan audits, update care plans or complete supervisions with the staff team.

The registered manager and deputy manager also did not check that delegated tasks, such as the weekly fire alarm tests and staff supervisions had been done. Staff told us that the registered manager was not present at the home very often, but was contactable if needed.
The home has been rated as inadequate and placed in special measures since the inspection in December 2016. Following this inspection three warning notices were issued for breaches of regulations 12, 17 and 18. We found the provider had not met the requirements of these warning notices.
The provider does not operate effective systems and processes to enable them to assess, monitor and improve the quality and safety of the service provided in carrying on the regulated activity and is unable to ensure compliance with the regulations.
This was a continued breach of Regulation 17 (1) with reference to (2)(a) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Staff told us they liked working at the home and felt happier now that keypad locks had been installed on the exterior doors so they knew when people were leaving the home. We saw staff meetings were held. Staff said these were open forums where they could raise any issues they wanted to discuss. The minutes showed that the people who had a Deprivation of Liberty Safeguards in place and the systems used to monitor when people left the home were discussed. Information about which people required a modified diet or thickeners added to fluids were also discussed.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We had received notifications from the home and saw incidents had been recorded and reviewed by the deputy manager.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Lack of clarity as to the support staff were to provide and one to one sessions not taking place as stated in the care plans. The home had not written an end of life care plan to detail the care and support the person required as soon as the person was identified as being at the end of their life. The person had not received the care and support required with regard to their personal hygiene and pressure relief.

The enforcement action we took:

The Commission took action and de-registered this service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The risk of having a fire was still heightened due to people continuing to smoke in their rooms. The lack of weekly checks of the fire alarm, emergency lighting and fire doors and the lack of any fire drills. The delay in re-ordering prescribed medicines by the nurses and stating on the MAR that the medicine had been offered when it wasn't available.

The enforcement action we took:

The Commission took action and de-registered this service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	There was a strong odour affecting the corridor and other bedrooms and the lack of deep cleaning

of people's rooms.

No improvements had been made to the decoration of the bedrooms or communal areas of the home. The bedrooms we saw were contained mismatched furniture. In one bedroom the radiator cover had a broken front and the bedroom walls had different colour shades of paint on the same wall. Wall surfaces were marked and scuffed and had not been re-decorated.

The enforcement action we took:

The Commission took action and de-registered this service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Audits of the environment, care plans and health and safety were not completed. Delegated tasks were not checked to ensure they had been completed.

The enforcement action we took:

The Commission took action and de-registered this service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The retrospective completing of the weekly fire check records for September to December 2016 by the registered manager was a falsification of the records. The provider had not fulfilled their statutory responsibilities.

The enforcement action we took:

The Commission took action and de-registered this service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive formal supervisions to support them in their roles.

The enforcement action we took:

The Commission took action and de-registered this service