Mr Pierre Grenade

Nada Residential and Nursing Home

Inspection report

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Date of inspection visit:
12 December 2016
13 December 2016
15 December 2016

Date of publication:
20 March 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook this inspection of Nada Residential and Nursing Home (Nada) on 12,13 and 15 December 2016. The inspection was unannounced which meant the provider did not know we were coming on the first day of the inspection.

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 24 people living at the home.

The service had a registered manager in place. 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. However the deputy manager was not available during our inspection. We were told they had been off work for several weeks and it was not known when they would be returning to work. Following the inspection we have been informed the deputy manager had returned to work shortly after our inspection.

At the last inspection in November 2015 we identified six breaches of the Health and Social Care Act 2008 and one breach of the CQC (Registration) Regulations 2009. The service provided CQC with an action plan detailing how they would make improvements to meet the regulations.

During this inspection we found improvements had not been made and there were continued breaches in the regulations with regard to managing the risk of fire, medicines management, following the principles of the Mental Capacity Act (MCA), staff training, the environment, the provision of activities and good governance. There was also a new breach with regard to the staffing levels within the home. We have also made a recommendation about the home having a written business continuity plan for staff to follow in the case of an emergency.

People said they felt physically safe living at Nada, however three people reported they were worried that their money and cash card would be stolen by another person living at the home. Staff encouraged people to give them their money and cash card to keep them safe. However we saw one person asking for their cash card and not being given it as the staff on duty could not access where it had been stored by a colleague who was not working that day.

People smoked within the home. They were encouraged to smoke in a dedicated smoking room or outside, however people continued to smoke in their bedrooms or bathrooms. Smoking risk assessments were in place where appropriate. Staff training on fire awareness was not up to date, the fire alarm and fire doors had not been checked since September 2016.

People received their medicines as prescribed. However guidelines for when people needed 'as required' medicines were not in place for everyone and those that were did not always specify how the person would inform staff, either verbally or non-verbally, that they needed an as required medicine to be administered. Care staff applied some creams and added thickeners to people's fluids to reduce the risk of choking. The nurses signed the medicines administration record even though they had not personally administered these items.

A person had moved to live at Nada in August 2016 who required one to one staff support during the day. The staffing had not been increased at this time. This meant there were insufficient staff on duty during the day to meet everyone's needs. The registered manager arranged for an additional staff member to be on duty on the days of our inspection. This shows they were aware of the need for one more member of the care staff to be on duty.

Some improvements had been made in following the principles of the MCA. Deprivation of Liberty Safeguards (DoLs) had been applied for where appropriate. However consent or best interest decisions were not in place where the home held people's cigarettes and money for them. A capacity and best interest form had been completed for one person but we did not see this in place for other people living at the home.

We found not all staff training was up to date. This included fire training, moving and handling, challenging behaviour and continence care.

The environment at the home needed re-decorating and upgrading. The maintenance person had left the service three months prior to our inspection. Maintenance tasks were being completed by a member of the care staff, who was provided time on the rota to complete them.

There were no activities provided at the home. One member of staff had been identified to arrange activities; however they did not have any time set aside for them to do this.

With the deputy manager not being in work at the time of our inspection the registered manager could not find all the information we requested, for example the incident forms that were reviewed by the deputy manager. Other information was not easily found. The deputy manager had been the only person able to access the home's computer system. The clinical lead was given the passwords during our inspection to access the system. Therefore any information held on the computer had not been updated since the deputy manager had been off work and the registered manager did not have a full oversight of the home.

We found management audits were not in place to monitor and improve the service. We saw a care plan audit had been completed once for one person. The registered manager and clinical lead were unaware of any other audits that had been completed. After the inspection we were told five care plan audits had been completed in total. At the time of our inspection there were 24 people living at Nada. A nurse audited the medicine administration records (MAR) each month to check all entries had been signed and the quantities of tablets received and administered corresponded. However the (MAR) audit did not cover the 'as required' medicines guidelines as we found some 'as required' medicines still did not have clear guidelines in place.

Care plans and risk assessments were in place. These gave detailed guidance for staff in how to support people. Care plans were reviewed each month and updated when people's needs changed.

Staff were safely recruited and relevant checks were made. We saw examples of staff treating people with dignity and respect and responding to people's needs in a kind and caring way.

People had access to relevant health care professionals, although four people said they needed to see a dentist. People's nutritional needs were met. However 40% of people said the food was cold. We saw snacks being offered during the day. The clinical lead said snacks were offered each day. However a relative informed us after the inspection that snacks were not given regularly.

A complaints policy was in place. However we were aware of a complaint made on behalf of one person that had not been recorded. The complaint itself had been dealt with by the home.

The overall rating for this service is '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 always safe.

There were insufficient staff on duty during the day to meet people's needs. Staffing levels had not been increased after one person required one to one staff support.

People who used the service smoked within the home. Risk assessments were in place but staff fire training was not up to date and weekly fire safety checks had not been completed since September 2016.

Medicines were administered as prescribed; however guidelines for the use of as required medicines were not consistently in place. Nurses signed that creams had been applied and thickener added to drinks when this had been completed by care staff.

Is the service effective?

Inadequate

The service was not always effective.

Improvements had been made in respect of applications being made where people were deprived of their liberty. Best interest decisions were not routinely recorded, especially where the home held cigarettes and money on people's behalf.

Staff training had not been kept up to date. Staff felt supported by the nurse team and managers, however formal supervisions were not always held.

The environment needed improvement and investment to provide a good standard of accommodation.

People had mixed views about the food. Systems were in place to provide people with the support they needed to help ensure their health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People who used the service told us staff were kind and caring in their approach. Throughout the inspection we observed kind and respectful interventions between staff and people who used the service.

Staff we spoke with were able to show that they knew the people who used the service well.

People were supported to make advanced care plans for their wishes at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities were not provided for people living at the home. Staff did not have time to organise activities and there was not a dedicated activities co-ordinator in place.

People's care records contained enough information to guide staff on the care and support people required. These were reviewed each month.

A complaints policy was in place. However a complaint that had been made had been dealt with but not recorded as per the complaints policy.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were 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. However the day to day management of the service was delegated to the deputy manager who was not available during the inspection. Information was not available or easily located and no one had access to the home's computer system.

The registered manager increased the number of staff on duty during our inspection. This showed the manager was aware the staffing levels were insufficient to meet the needs of the people living at the service.

The provider had systems in place for gathering the views of the people who used the service, their relatives and staff.

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 the 12, 13 and 15 December 2016 and was unannounced on the first day. The inspection team consisted of one adult social care inspector and an expert by experience on the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of mental health services. The adult social care inspector returned for the second and third day of the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. This 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 information 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.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 12 people, the registered manager, the clinical lead and six care staff. We observed the way

people were supported in communal areas and looked at records relating to the service. These included three care records, four staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, policies and procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

People we spoke with said they felt physically safe living at Nada Residential and Nursing Home. However three people reported they were worried about their money and cash cards being stolen from their rooms by another person who used the service. Bedroom doors could be locked from the inside; however people did not lock their rooms regularly. When people left their rooms they were not able to lock them. The service encouraged people to give their money and cash cards to staff to keep safely in the office. However on the first day of our inspection one person was asking for their cash card that they had given to a particular member of staff to keep in the office. This staff member was not on duty that day and the other staff said they could not access the card. This meant that the home did not have an effective way of managing and keeping people's money safe and that people did not have access to their personal monies at times that suited them.
At our last inspection in November 2015 we found a breach of the Health and Social Care Act 2008 Regulations (Regulations) because improvements identified in a fire risk assessment had not been implemented.

We observed that the majority of people who used the service smoked. A small smoking room was available for people to use, or they could smoke outside. We saw smoking risk assessments were in people's care files and they were encouraged to use the smoking room. However we noted a large number of cigarette burns in the flooring of bathrooms and bedrooms, indicating people continued to smoke in other areas of the home. Staff told us they conducted checks on people every two hours to monitor if they were smoking and kept people's cigarettes and lighters in the office if they were likely to smoke in the building. People were able to ask for their cigarettes when they wanted one.

We saw minutes of staff meetings from July 2016 where the registered manager had said a smoking shelter would be purchased for the back garden to encourage people not to smoke in the building. This had not been done at the time of our inspection.

We saw people had a personal emergency evacuation plan (PEEP) in place. These plans detailed people's mobility needs and understanding of a possible emergency situation.

At this inspection we found a further 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. Records showed that weekly fire alarm and fire door tests had been completed up until the 7 September 2016. No checks had been made since this date. We saw staff fire training was due to be refreshed in June 2016; however this had not been arranged at the time of our inspection. Records did not show that regular fire drills were completed.

We saw the fire systems, emergency lighting and firefighting equipment were serviced annually.

Given the increased risk of fire due to people who used the service continuing to smoke in their bedrooms or the toilets it is important that staff are fully trained in fire awareness, the fire systems are checked to be

working properly and regular fire drills are undertaken.

This meant that people's health and welfare was placed at risk of harm. This was a breach in Regulation 12(1) with reference to (2)(b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2015 we found a breach of the Regulations because clear and accurate records were not in place for the management of medicines.

The registered nurses had completed annual medicines administration training. The clinical lead told us they observed the nurses as they administered medicines to check their competency. However these observations were not recorded and so could not be evidenced.

All medicines were stored securely in a locked medicines trolley kept in a locked medicines room. Two people kept their creams in their rooms; this had been risk assessed. The remainder of the creams were stored in the medicines room. The registered nurses were the only staff who had access to the medicines room. We found the Medicine Administration Records (MARs) were fully completed and showed people had received their medicines as prescribed.

We saw one person's medicines were administered covertly. This means the medicines were disguised in food or drink. We saw records that showed the decision had been made in the person's best interest and agreement had been sought from the person's GP.

At the last inspection we found where people were prescribed as required medicines, guidelines were not in place so staff would know when people needed these medicines. At this inspection we found as required medicines guidelines were in place for some people and not others. The guidelines that were in place did not always state how the person would communicate, either verbally, through body language or behaviour, that the as required medicines were needed. Guidelines for as required medicines are important so nursing staff know when the person requires them and ensure that people receive their medicines when needed.

The nurses applied the medicated creams for people assessed as requiring nursing support. Care staff, directed by the nursing staff, applied creams for those people assessed as residential support. However we did not see body maps in place to guide staff as to where the creams needed to be applied. This meant the care staff did not have clear written instructions where and how often to apply topical creams and lotions.

We saw that some people who used the service were prescribed 'thickeners'. 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 each person needed. Staff had received training in preparing thickened drinks. We saw the nurse signed a monitoring sheet to state the thickener had been added. The nurses also signed the MAR sheet when the care staff told them they had applied any creams. Good practice guidelines state that the person adding the thickener or applying the cream should sign any monitoring chart to state they had completed the task. In this case a nurse was signing when they had not undertaken the task themselves.

We found the inconsistent as required medicine guidelines and the nurses signing records when they had not completed the task themselves to be a continued breach of Regulation 12 (1) with reference to (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

From our observations, confirmed by the rota and staff we spoke with, there was usually one nurse and three care staff on duty during the day. A clinical lead nurse was in post; however on the rotas we saw they were the duty nurse for at least three days a week. This meant they did not have time as additional to the staffing rota to complete other tasks such as care plan reviews, supervisions and liaising with social workers or other professionals. If two people had an appointment and needed staff to support them an additional staff member would be on duty.

We saw one person required one to one support at all times. We were told that the number of staff had not been reviewed and increased since the one to one support had started in August 2016. One staff member was deployed to be present in the lounge area at all times to be able to de-escalate any potential incidents between people who used the service. The care plans we looked at showed that people needed two staff to support them with their personal care. Alongside care tasks staff were also responsible for completing the laundry for people, this was a change since we last inspected. At the last inspection there had been dedicated laundry staff working at the home five days a week.

We also saw that there were usually two domestic staff working during the day to undertake all the cleaning of the home. We were told, and saw during our inspection, the domestic staff were also asked to be present in the lounge area when all the care staff members were busy supporting people. These staff had received some training in dementia care but would not know the people who used the service as well as the regular care staff and did not have the training and experience to support people appropriately.

This meant there were not sufficient staff on duty during the day to meet the needs of the people living at the service.
On the first day of our inspection we noted an additional member of staff was brought in by the registered manager after we arrived to work on the day shift. The rota showed they had been due to work the night shift, not the day shift. There was also one extra staff member on duty on the second day of our inspection. This meant the registered manager was aware that there was not enough staff with the appropriate skills and knowledge deployed within the home and brought in additional staffing during the inspection. One member of staff said, "There's an issue with the staffing levels, especially when we take our breaks," and another told us, "We need the nurse and four staff during the day now with [Name] needing one to one support."

At night there were three members of staff on duty. We were told this was sufficient to meet people's needs.

This was a breach of Regulation 18 (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 a senior carer or the registered manager. Staff members told us they had received training in safeguarding vulnerable adults. However we could not see evidence of this in the training file. The deputy manager who was responsible for organising the training for the home was not available during our inspection. We saw the service had appropriate safeguarding and whistleblowing policies in place to support the staff in providing safe care. Safeguarding referrals had been made to the CQC as required. This should help ensure that the people who used the service were protected from abuse; however we recommend the safeguarding vulnerable adults training is reviewed and refreshed where required.

We looked at three people's care files. We saw risk assessments were in place, including for falls, manual handling, smoking, challenging behaviour and nutrition using the Malnutrition Universal Screening Tool (MUST). These were reviewed monthly and updated as required. Appropriate action was taken to reduce identified risks. Where people had been assessed as potentially displaying behaviour that challenges a plan was in place to guide staff of the potential triggers and how to distract the person to diffuse the situation. This meant the risks were identified and mitigated by the service so that people were kept safe.

We looked at the recruitment files for four members of staff. We found they all contained application forms 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. Three of the files contained two references from previous employers. However one file only contained one reference from a previous employer. The recruitment checklist for this person indicated two references had been received but one could not be located in the personal file. This meant the people who used the service were protected from the risks of unsuitable staff being recruited.

We looked around all areas of the home. The home was clean with no malodours present; however we did see incontinent products discarded in the bathrooms on three occasions. Some of the people who lived at the home were ambulant and may have removed the incontinence product themselves without staff being present. We saw soiled items were put in a red bag to keep it separate from the other laundry. We saw the domestic and care staff had received training in infection control.

The service did not have an emergency business plan in place. An emergency business plan details the actions to be taken in the event of an emergency that affects the running of the home such as a utility failure. The registered manager said that staff would contact them in the event of an emergency. However there would be occasions when the registered manager would not be contactable, for example if they were on holiday, and staff would need guidance on the actions to take and the people they needed to contact. We recommend the service follows current best practice guidance to develop a written business continuity plan.

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.

At our last inspection in November 2015 we found a breach of the Regulations because records did not clearly demonstrate if a person had the capacity to consent or if decisions had been made in the person's best interest. At this inspection we found applications for DoLS had been made where required. We also saw one person had a capacity assessment and best interest information about day to day decisions and whether they were able to make these decisions or if staff were to make them on their behalf. However we did not see these documents in the other care files we looked at.

The service held people's money, cigarettes and lighters on their behalf. People's consent to this had not been documented or best interest decisions made where they lacked capacity to agree to staff holding these items for them. As noted previously in this report one person had given their cash card to a member of staff for safe keeping, however they were not able to access it when they asked for it.

We found this to be a continuing breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2015 we found a breach of the Regulations because staff training and development was not up to date. At this inspection we found staff training was still not up to date. We viewed the training file for the service. This contained details of training courses held since April 2016, which included dysphasia, dementia e- learning and the control of substances hazardous to health (COSHH). However an up to date training matrix could not be located by the registered manager. The deputy manager was responsible for organising the staff training and they were not available during the inspection.

We viewed a training matrix from December 2015 which showed training in fire awareness, moving and handling and continence care were needed in June and July 2016. The training file did not include any reference to these training courses being organised. Challenging behaviour training had also been due to be completed in 2015; there was no record that this had been arranged. In a staff personal file we saw one staff member had only received training in infection control, the use of thickeners to reduce the risk of choking and dementia awareness since joining the service one year ago. This meant the staff may not have the update skills and knowledge to support the people living at the service.

We found the gaps in staff training to be a continued breach of Regulation 12 (1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff received an induction when they joined the service. This included being introduced to all the people who used the service and shadowing an experienced member of staff. We saw induction checklists in staff files had not always been signed as being completed. We were not told, or see evidence, that staff completed the care certificate when they joined the service. The care certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life and is especially important for staff members who have not worked in a care setting before.
Staff told us they felt well supported by the nurses, clinical lead, deputy manager and registered manager. They said they could talk to one of the management team if they had an issue or concern. Staff said they had regular supervisions with a named supervisor. We saw formal supervisions had been planned to take place every two months. However the records in the staff personal files showed the plan had not been adhered to. The last recorded supervision for two staff was July 2016 and for two others it was May 2016.

Staff said they received a handover at the start of every shift. We observed the handover on the first day of our inspection. A brief update on people's health and wellbeing was given and any appointments for the day discussed. This meant that formal supervisions had not been consistently held; however staff felt well supported in their role.

At our last inspection in November 2015 we found a breach of the Regulations because maintenance work was required to improve the standard of the home. At this inspection we found some new chairs had been purchased for the lounge area and the dining room furniture had been updated. However we found the bedroom furnishings were old and worn and there were numerous cigarette burns in the floorings in some bedrooms and the bathrooms. The smoking room had three wooden chairs and two other worn chairs.

We were told the maintenance person had left the service three months previously and had not been replaced. A member of the care staff completed repairs and they had time specified on the rota for these tasks. We were told professionals such as plumbers or electricians were called when required. The environment looked tired and needed re-decoration and upgrading. We did not see any audits or checks made by the registered manager or deputy manager to monitor the environment and maintenance at the home.

We saw an environmental health audit in November 2016 had awarded the kitchen a 3 rating which means 'generally satisfactory'. The audit highlighted concerns about the state of the cupboards and window in the kitchen as well as a broken freezer lid and the need for a deep clean to be carried out behind the kitchen equipment. The registered manager told us they were planning to upgrade the areas highlighted in the audit in 2017.

The local authority commissioner and the two health professionals we spoke with also raised concerns about the environment at Nada.

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

People we spoke with gave us mixed views about the food served at Nada. 60% of people we spoke with said they enjoyed the food, whilst the remaining 40% said that the food was cold and they did not get a choice. The chef told us the menu had been compiled with support from the dietician team. We saw hallal meat was purchased to meet people's cultural needs.

There was one main meal and pudding offered at each meal time. However people were able to ask for an alternative if they did not want the main meal; for example we saw one person ask for scrambled egg on toast. People were supported by staff to eat their food when required.

Staff told us that milkshakes and snacks were available each day. We saw these being offered during our inspection. We saw snacks being offered during the day. The clinical lead said snacks were offered each day. However a relative informed us after the inspection that snacks were not given regularly.

We saw there were systems in place to meet people's nutritional needs. The care files we looked at all contained an assessment of people's risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). People were weighed monthly and their MUST score calculated. Referrals to the Speech and Language Team (SALT) or dietician were made where there were concerns about people losing weight. Food and fluid charts were completed where required.

Each person was registered with a GP. We saw referrals had been made to other medical professionals when required. Records showed health professionals, such as community psychiatric nurses, had visited people at the home. The health professional we spoke with said staff tried to follow the advice provided; however the people who used the service did not always comply. However, we were also told by four people that they did not have access to a dentist and that they needed some dental treatment. One person said, "My teeth hurt so badly I can't eat properly." This meant the service supported people with most of their health needs but people required referrals to a dental service and this could have a detrimental effect on their health and wellbeing.

Good

Is the service caring?

Our findings

People we spoke with said that the staff were kind and caring. We saw that people were referred to by their preferred names and were supported in a patient manner. We saw good interactions between people and staff throughout the inspection.

The care plans we saw contained minimal details about people's life history and their likes and dislikes. We did see one person had completed a 'my life story;' booklet with staff. We were told the booklet was completed with those people who were able and willing to engage with staff to complete it.

We saw most care plans were not signed by the individual. We were told this was because people did not want to go through all their care plans with staff. People we spoke with said they had been asked by staff about their preferences. We were also told people's relatives had been asked about the support their loved one needed. However, many people living at Nada did not have any family involved and therefore information about people's previous history was not always available. We saw information about an advocacy service was available in the office but this was not accessible to people. We were told by the clinical lead that people were referred for advocacy services; however no one we spoke with knew what an advocate was and did not have one involved in supporting them when agreeing their care and support.

From our observations and discussions with staff they were able to show they understood people's needs and how to support them. People told us they were able to make their own choices; for example going out when they wanted to, choosing their clothes and when they wanted to get up in a morning.

We noted there were four shared rooms at the service, three of which were used at the time of our inspection. We saw screens were used between the beds to maintain people's privacy when required. Staff were able to explain how they maintained people's dignity when supporting them with personal care tasks.

We saw a detailed booklet called 'Preferred Priorities for Care' in one person's care file. This detailed their wishes at the end of their life. We asked the clinical lead about the booklet. They told us the booklet was in place for those people who were able to engage with staff about their wishes at the end of their lives or if they had family involvement. However it had not been possible to complete the booklet with other people who did not wish to discuss their end of life care with staff.

Nada was also accredited as providing the 'Six Steps' programme of end of life care. This is a recognised programme for providing appropriate support and care at the end of people's lives and was led by the nursing staff at the home. This meant people were able to receive the care they wanted at the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

We reviewed three care files and saw they contained details about the care and support people needed. The care plans provided guidance for staff on the support each person required.

We saw a pre-admission assessment was completed by the clinical lead and registered manager. This contained brief details of a person's needs. An assessment was provided by the hospital, local authority or clinical commissioning group (CCG) which gave more details of people's needs. Where there was only a shared room available people were made aware of this at the time of the assessment so they could decide if this was suitable for them or not. We saw monthly reviews of the care plans were completed and any changes in people's needs recorded. Daily logs and observations were written to record the personal care and support people had received each day.

Regular two hourly checks were made for each person, to ensure they were well, encourage them to smoke in the smoking room or outside and not in the building and check when people had returned from going out independently. These were increased if a person had been drinking to excess. These checks were recorded.

People we spoke with said they had discussed their preferences with staff and relatives were also asked to provide information where they were involved in the person's life. People said they were asked to sign their care plans; however one told us they did not go through this with staff. We saw in one care file the person had said they only wanted to sign their care plan if it had changed and not each month when it was reviewed.

This meant that people were asked to contribute to their care plans but did not necessarily feel involved in planning and agreeing their care and support.

We saw in one person's care plan 1:1 sessions with staff were part of the strategy to reduce their anxiety and re-assure them. We asked about these sessions and were told they were completed as and when they were needed by the nurses and were not regularly conducted. No records of the sessions were kept. We were told it would be noted in people's daily logs when they had been completed. We looked at the daily logs for this person for the last month and did not see any notes for 1:1 sessions taking place. This meant that this person was not regularly receiving the support assessed as required and this could have a detrimental effect on their health and wellbeing.

The health professional we spoke with said the nurses and staff were knowledgeable about the needs of the people who used the service and were able to provide them with the information they required when they visited.

At our last inspection in November 2015 we made a recommendation about the choice of activities offered to help promote the well-being of people with living with complex health and support needs. At this inspection we found the volunteer activities co-ordinator was no longer working at the service. At the last inspection they had worked 20 hours each week. A member of the care staff had taken on the additional role

of activities co-ordinator but had not been given any time on the rota to complete this. We saw no activities had been arranged since June 2016 when a new person moved to Nada who required 1:1 staff support. As previously noted in this report the staff on duty had not been increased to accommodate this additional support so the staff member had not had any time to organise any activities.

We saw prior to June 2016 a record of activities had been kept. These were not regular and included music and pampering sessions when staff had time. We saw brief details of what activities people liked to do had been compiled, for example reading the newspaper, going to the park for a walk.

The resources available for activities within the home were minimal and included two incomplete jigsaws, one board game, a domino set and a bingo machine. No one we spoke with mentioned any activities that took place at the home and two people said they were bored living at the home. One person told us, "I just smoke to pass the time."

We asked about any activities that were being arranged for the Christmas period and were told none had been arranged at the time of our inspection.

We found this to be a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted those people who were able to access the local community independently were able to leave and return to the home when they wanted to.

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 12 months. However CQC had been made aware of a complaint made on behalf of one person who lived at the home, who had requested to move to another service. We asked about this person and were told how the person's social worker had been involved and they had visited other services before deciding to stay at Nada. The issue had been dealt with but not recorded under the home's complaint policies and procedures. The registered manager and clinical lead told us most issues people had were resolved verbally without the need for a formal complaint to be made. People we spoke with said they would raise any issues they had with the staff; however they were not aware of the home's formal complaints procedure.

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 to the deputy manager. At the time of our inspection the deputy manager was not available. Staff told us they were not certain when the deputy manager would return and felt the home lacked direction due to their absence. Following the inspection we have been informed the deputy manager had returned to work shortly after our inspection.

At our last inspection in November 2015 we found a breach of the Regulations because there was not a robust system of monitor and improve the quality of the service in place.

During our inspection we found that information was not readily available as the registered manager was not able to locate it quickly and had to spend time finding it. We also noted that the deputy manager had been the only person able to access the computer system at the home. Therefore any records held electronically, for example the training matrix and notifications made to the CQC and local authority safeguarding teams were not accessible. The clinical lead was given the password for the computer and was using it for the first time during our inspection. This meant we were unable to see any evaluation of incidents, accidents or safeguarding referrals as these were all completed by the deputy manager.

We saw accident forms were completed appropriately; however there was no evidence that these were analysed for trends or that they were mitigated against to reduce the risk of re-occurrence and keep people safe. Staff told us they completed an incident form when required, for example following an altercation between two people who used the service. We were unable to view these as the deputy manager held these. We saw no evidence that the incident reports were analysed to identify any common triggers or trends or if there had been any action taken to prevent these from happening again to keep people safe.

As noted previously in the report the registered manager increased the number of care staff on duty during our inspection. This shows he was aware additional staff were required to meet the needs of the people living at the home, but did not ordinarily deploy them on a day to day basis and this was due to the inspection taking place. We were also told snacks were not usually offered to the people who used the service but had been during our inspection.

In one care file we saw a care plan audit had been completed by the deputy manager in April 2016. This had been completed after the care plans had been re-written following a social worker visit when they could not find all the information they required. At the time of our inspection the registered manager and clinical lead were unaware of any other audits that had been completed. After the inspection we were told five care plan audits had been completed in total. At the time of our inspection there were 24 people living at Nada.

We read in the staff meeting minutes for the deputy manager had completed a spot check on one room prior to the meeting and found it to be untidy. However we saw no evidence of regular checks of the

environment being made by the deputy manager.

We did not see any evidence of any other internal audits being completed, for example health and safety, infection control or staff training. It is clear that the registered manager did not have oversight of the home or the governance arrangements in place to ensure that people were kept safe, their needs were being met and that the quality of the service continually improves. Additionally the service had not remedied the issues we identified when we last visited.

This was a continuing breach of Regulation 17 (1) with reference to (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw monthly residents meetings were held. Minutes of the meetings showed people were asked about the food and if they had any issues they wanted to raise. The home also tried to arrange meetings for people's relatives. However few relatives are involved in people's lives and none attend the meetings. An annual survey was conducted in December 2015 for people who used the service, relatives and visitors. The results of the survey were mainly positive; however the décor of the home was mentioned in three surveys. There was no evidence of the results of the survey being correlated or of any action taken in response to the survey comments.

We saw team meetings were held every three months. However as previously noted in this report the subject of the purchase of a smoking shelter had been raised by the deputy manager in the July and October 2016 staff meetings. This had yet to be bought. Staff told us they were able to raise any issues they wanted to during these meetings.

Staff we spoke with were positive about their roles, their colleagues and the support they received from the nurses, clinical lead and deputy manager.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We had received notifications form the home; however we were unable to check the incident records at the service so could not establish that all incidents had been recorded, investigated and reported correctly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The lack of activities organised to promote the health and wellbeing of people who used the service. this was a breach of Regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Capacity assessments and best interest meetings for were not completed. People's consent was not evidenced where the home held money and cigarettes on people's behalf. This was a breach of Regulation 11 (1).

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	The environment was in need of maintenance and re-decoration. This was a breach of Regulation 15(1)(e).

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were not fully trained in fire awareness, the fire systems were not checked to be working properly and regular fire drills were not undertaken. This meant that people's health and welfare was placed at risk of harm. This was a breach in Regulation 12(1) with reference to (2)(b) and (d). We found the inconsistent as required medicine guidelines and the nurses signing records when they had not completed the task themselves to be a continued breach of Regulation 12 (1) with reference to (2)(g). We found the gaps in staff training to be a continued breach of Regulation 12 (1)(2)(c).

The enforcement action we took:

To hold a MRM

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 There was not a robust system of monitor and improve the quality of the service in place. Information was not readily available and the computer system could not be accessed as the deputy manager was not available. The registered manager increased the staff on duty during the inspection, showing the manager was aware the staffing levels were insufficient to meet the needs of the people living at the service. This was a continuing breach of Regulation 17 (1) with reference to (2)(a).

The enforcement action we took:

To hold a MRM

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 This meant there were not sufficient staff on duty during the day to meet the needs of the people living at the service now one person required the one to one staffing support. This was a breach of Regulation 18 (1).

The enforcement action we took:

To hold a MRM