Mrs Anne Elizabeth Barrows

Nak Centre

Inspection report

The Nak Centre
Sundial House, Coosebean
Truro
Cornwall
TR4 9EA

Tel: 01872260996

Date of inspection visit:
20 November 2023
23 November 2023

Date of publication:
01 February 2024

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of underpinning principles of "Right Support, Right Care, Right Culture.

The Nak Centre is a residential care home providing personal care for up to 6 people with learning and /or physical disabilities and autistic people. At the time of our inspection there were 6 people using the service. The Nak Centre is a detached building located in its own gardens near the city of Truro.

The registered provider, has the joint role of registered manager, and will be referred to in this report as registered provider.

People's experience of using this service and what we found
Right Support
The registered provider did not have effective safeguarding systems in place. The registered provider , did not demonstrate a clear understanding of their responsibilities to report safeguarding concerns. Staff had limited understanding of what to do to help ensure people were protected from the risk of harm or abuse.

People were not always supported by enough staff on duty which placed restrictions on their everyday lives.

Staff supported people to have some choice and control in their everyday lives. Their ability to do this had been impacted by staffing shortages in the service which meant people were not always able to access the community or take part in activities that they enjoyed.

Risk assessments varied in their quality; some identified a person's risk but did not state what should happen to reduce the risk, and therefore didn't mitigate risk.

Infection control procedures and measures were in place to protect people from infection control risks associated with COVID-19.

People lived in a safe and well-maintained environment.

Staff supported people with their medicines and worked with health professionals to achieve good health outcomes.

People were supported to have some choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care
The service did not have enough appropriately skilled staff to meet people's needs.

People using the service told us they felt they were cared for, comments included "They are looking after me" and "It is nice here."

We observed many kind and caring interactions between staff and people.

Right culture
The service was a long-standing family run business, and the size of the staff team was small. Five people had lived with the registered provider since they were young children, therefore they had built a familiar routine with people that they appeared to be comfortable with and it felt more akin to a family unit. This allowed the potential of a closed culture to form. The registered provider had not kept up to date with good working practices and was not part of any manager forums or other similar groups. This meant the service was isolated and there was a risk of a closed culture developing.

The service had fixed routines that were not flexible, for example drink and meal times routines. This was due to how the service had been organised, and perpetuated by the lack of staff available within the service. This meant people lacked opportunity to choose what they wanted to do and when.

Staffing levels had impacted on the registered providers availability to ensure that managerial tasks were completed. Feedback from staff, and the review of records and care documentation evidenced there was poor oversight of the service which was affecting aspects of the operations of the service. Audits to oversee the service were not up to date and therefore were ineffective in identifying areas for improvement.

The service had not sought the views and opinions of people using the service, staff and professionals. Staff team meetings and staff supervisions had not been held which meant that opportunities for staff and managers to discuss any issues or proposed changes within the service had been missed.

The registered provider had not been open and transparent with people and relatives and commissioners in respect of the recent concerns at the service. The lack of opportunity for stakeholders to provide feedback or raise concerns increased the risk of a closed culture developing.

The registered provider was inconsistent in how they worked with professionals. For example, they were welcoming of support but had not attended a meeting that had been arranged.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Last rating and update
At the last inspection the service was rated as good (published 20 July 2022).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety, staffing and

leadership. A person using the service was placed at significant harm. The information CQC received about the incident indicated concerns about the leadership of the service, the safety of people using the service and that staffing was not sufficient to meet people's needs. This inspection examined those risks. As a result, we carried out a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

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

Enforcement and recommendations
We found breaches relating to safeguarding, staffing and the governance of the service. Please see the action we have told the registered provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well led	**Inadequate**

Nak Centre

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
The Nak Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

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

At the time of our inspection a registered manager was in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We had not requested the provider send us a provider information return as this inspection was completed in response to information of concern that the commission had received. We sought feedback from the local authority and

professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We met all the people living at The Nak Centre. Some people were unable to speak to us due to their health conditions. We therefore spent time in the communal lounges observing care practices, so that we could gain an understanding of people's experience in how they received support.

We spoke with staff, read people's care plans, and other records kept about them, carried out a formal observation of care, and reviewed other records about how the service was managed. We looked around the premises.

We spoke with the registered provider, administrator and 2 support workers and the cook. We looked at 4 records relating to the care of individuals, medicine records, staff training records, staff duty rosters and records relating to the running of the service.

We attended safeguarding meetings with health and social care professionals and gained their views on the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk from abuse

- The registered provider did not demonstrate a clear understanding of their responsibilities to report safeguarding concerns. They had not notified the local authority, police or Commission without delay following a significant safeguarding event that was identified by staff.
- Safeguarding systems and processes were not effective. Staff had identified concerns but had not reported their concerns to the registered provider. Staff were not confident in who and when they should report safeguarding concerns. The most recent safeguarding concern was not reported to the provider for 2 days. Staff said, "I know I should have told someone earlier." This meant staff did not fully understand their responsibilities to keep people safe.
- The registered provider reported the safeguarding concern to the Commission 6 days after being informed of the incident. The provider had not reported this to the Local Authority Safeguarding team or the police. The Commission made a safeguarding referral to the local authority, who then reported this to the police. This meant that the incident was not referred to safeguarding for 8 days.
- Staff were not enabled to develop the necessary skills, knowledge and guidance in safeguarding. Staff had completed safeguarding e learning, but records showed this this was overdue for refreshing.
- Safeguarding information was available to all staff by the entrance of the service. However, staff were unaware that this information was available and therefore had not referred to it when needed.

The registered provider had not taken all practicable steps to protect people from risk of abuse. This was a breach of Regulation 13, Safeguarding service users from abuse and improper treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- When the registered provider was made aware of the safeguarding concern, they took immediate action to ensure service users were safe by reviewing their staffing rota.
- Following the inspection, the registered provider contacted an external training company to organise safeguarding training for all staff.

Staffing and recruitment

- On the first inspection visit we found there were insufficient staff on duty to meet the needs of people. From the hours of 11.15am to 4pm, 1 member of care staff was on duty to provide support to 5 service users. Risk assessments for 3 people stated that they needed 1;1 support at mealtimes. However only 1 member of care staff was available to provide support to 5 people, this meant 1;1 support was not provided at mealtimes.
- The registered provider told us the staffing level at The Nak Centre required to meet the needs of the 6 people currently living there should be, "3 [staff] in the morning as and 2 [staff] in the afternoon. With a cook

and a cleaner as well." On the day of inspection 1 carer was supporting 5 people in the service.
● From reviewing the service's staffing rotas in November 2023, it was clear the service was routinely operating below the staffing levels identified as necessary. The rotas showed that 2 care staff were normally on duty during the day. However, there were times when the rotas had planned for only 1 member of care staff to be present in the service.
● No domestic staff were in post, and these tasks were now completed by care staff. In addition, there was no cook available Friday to Sunday, so care staff had to prepare all meals on these days. This was in addition to providing personal care and support to all 6 people living in the service.
● Where only 1 or 2 members of staff were on duty people's freedoms and quality of life were restricted as there was insufficient support available to enable them to access the community. Staff told us there was not enough staff on duty which had limited people's opportunities to go out.

The registered provider had failed to ensure sufficient, qualified staff were available to provide consistent care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The Commission re-visited the service 2 days later and were assured that a staffing agency had been contacted and due to this staffing levels were expected to improve. However, we identified there remained some gaps in rotas between 14;00 to 16;00 where only 1 staff member was on duty to support 6 people. The deputy manager then arranged that further staff were available to cover this time period.

Assessing risk, safety monitoring and management
● Risk assessments varied in their quality; some identified a person's risk but did not state what should happen to reduce the risk. For example, a person was at risk of choking but there was no risk assessment in place. Therefore, there was either limited or no guidance or direction for staff in how to support a person to mitigate the risk.

The registered provider had not assessed or acted on the risks to the health and safety of people receiving care. This contributed to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the first day of inspection fire doors were wedged open. This created a risk if a fire was to occur in the service. This was raised with the registered provider and on our second visit we noted all fire doors were no longer wedged open.

Learning lessons when things go wrong
● There was no evidence the service reflected and learnt from issues and incidents when things went wrong. There were no systems to record and report incidents or concerns. When things went wrong no reviews or investigations were carried out. This increased the risk of reoccurrence.

Systems and processes were not in place to ensure the service was continually evaluated and improved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines records showed that people may not have always received their medicines as prescribed. People's medicines administration records (MAR) had one or more gaps for regularly prescribed medicines. The registered provider reviewed this immediately and was able to explain why staff signatures were missing

from MAR sheets and rectified this.
● From a tablet count of medicines and comparing these to medicines records we found they tallied with the actual stock that was present in the location.
● People who had a specific medical condition had the relevant information and guidance for staff in how to administer medicines and when to request additional support in certain situations, for example an epilepsy plan had been developed for one person.
● There were suitable arrangements for ordering, receiving, storing and disposal of medicines.
● When medicines were prescribed to be given 'when required', person-centred protocols had been written to guide staff when it would be appropriate to give these medicines. We discussed with the deputy manager that a record of administering these medicines, so that they could monitor their use was best practice. This was actioned immediately.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Capacity assessments were completed to assess if people were able to make specific decisions independently.
● For people who lacked mental capacity, appropriate applications had been made to obtain DoLS authorisations when restrictions or the monitoring of people's movements were in place.
●Staff worked within the principles of the MCA and sought people's consent before providing them with personal care and assistance. We heard staff asking people if they wanted assistance with their personal care and waited for the person to reply before supporting the person.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered provider had no oversight of the service. The registered provider confirmed that due to staffing shortages they had no capacity to complete managerial duties such as oversight of the care files, completing audits or arranging staff training or supervision. The registered provider acknowledged that the level of cover they needed to provide had impacted on their leadership and oversight of the service.
- The registered provider was supported by a deputy manager. They both routinely covered care shifts to deliver care during the day and covered 3 sleep in duties at night per week each. There were no domestic staff and, for three days a week, no cook. Therefore, these tasks were completed by the managers and care staff in addition to providing personal care and support to all 6 people living in the service. As the registered provider and the deputy manager were covering significant care shifts, this meant there was a lack of leadership oversight as governance of this service had been reduced and had impacted on the provider and deputy managers ability to fulfil their roles and effectively manage The Nak.
- There were no records of the registered provider undertaking any audits to monitor the quality and safety of the service. Consequently, there had been a failure to identify or act on the concerns found during the inspection. For example, there was no process in place to monitor the Medicine Administration Records (MAR). Gaps in MAR charts were identified where it was not possible to establish if people had received their medicine as required. This issue was not identified by processes. The registered provider confirmed they had not completed audits in relation to care plans or risk assessments.
- Staff did not fully understand the deputy manager role and individual staff member responsibilities and limits of their authority were not clearly defined. This had impacted on the running of the service, for example audits had not been completed, staff told us they had not had supervision and systems to effectively monitor the service had not been established.
- The registered provider had failed to report significant incidents or injuries to service users to CQC as required by law.
- Staff working at the service had received limited training and no supervision. There was no assurance that staff had the appropriate skills and training for their role.

The provider's governance systems were ineffective in monitoring and improving the service people received. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

Continuous learning and improving care.

● There was limited evidence of the provider's ability to drive improvement in the service. No feedback or analysis of accidents, incidents, and safeguarding had been undertaken to promote learning and improve care.
● Governance systems were not being used effectively in the service to identify areas that needed improving.

The provider had failed to establish satisfactory governance arrangements. This contributed to the breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There was no evidence available to demonstrate people's and relatives' views on performance of the service had been sought.
● There were no formal opportunities for staff to provide feedback, for example, staff meetings and staff supervision had not been taking place. This meant there was no structured platform for staff to identify areas of improvement collectively.
● The registered provider was inconsistent in how they worked with professionals. For example, they were welcoming of support but had not attended a meeting that had been arranged.

The provider had failed to seek and act on feedback in order to improve the service. This was contributed to the breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong,
● The registered provider had not told people or their relatives of the recent concerns at the service.
● The registered provider had not informed the relevant agencies of significant incidents in a timely manner.

The provider had failed to be honest and transparent when something went wrong. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The service was a long-standing family run business, and the size of the staff team was small. There was limited engagement with other manager forums or similar. This increased the potential of the service becoming isolated and a closed culture developing. The service had fixed routines that were not flexible, for example drink and meal times routines. This was due to how the service had been organised, plus the lack of staff available within the service. This meant people lacked opportunity to choose what they wanted to do and when.
● The registered provider had not kept up to date with good working practices and was not part of any manager forums or other similar groups. This meant the service was potentially isolated and there was a risk of a closed culture developing
● Management and most staff had built positive and caring relationships with people. However, the lack of oversight had impacted on people's safety.
● People told us they felt cared for. Comments included "They are looking after me" and "It is nice here."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed or acted on the risks to the health and safety of people receiving care. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to be open and transparent when something went wrong. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken all practicable steps to protect people from risk of abuse. This was a breach of Regulation 13, Safeguarding service users from abuse and improper treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were ineffective in monitoring and improving the service people received. The provider had failed to seek and act on feedback in order to improve the service. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient, qualified staff were available to provide consistent care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took: