National Neurological Services Ltd

Albert Road

Inspection report

24 Albert Road
Manchester
Lancashire
M19 2FP

Tel: 01612248736

Date of inspection visit:
15 October 2019
17 October 2019

Date of publication:
08 January 2020

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Albert Road is a care home providing accommodation and personal care for up to 7 adults with an acquired brain injury. At the time of this inspection there were 4 adults living at Albert Road.

The home is a large, converted semi-detached house with four floors. Bedrooms and dining areas are situated to the first and second floor. There is some communal living space to the ground floor, although this is limited. The basement has been converted to accommodate a games room and a small, independent living unit for one person. This was out of use as repairs were needed. There is a car park to the rear of the home, although not used for this purpose, and a large, wooden gazebo.

People's experience of using this service and what we found

There were significant and widespread shortfalls in the governance of the service. The provider and managers had failed to identify issues we found with medicines, person centred care and record keeping.

Systems were ineffective in driving improvements and high quality care. The provider had failed to act on concerns and errors with the management of medicines identified by their own staff. This left people at risk of harm.

People were at risk of avoidable harm because risks were not recorded accurately, monitored or managed.

Health and safety of the premises was not well managed. No control measures had been actioned to reduce the risk of legionella in water systems. People were at risk of potential harm.

Staff had not received adequate training or support to equip them for their roles and responsibilities. Staff had not always completed aspects of training relevant to people's needs.

Good outcomes were not always achieved for people living at the service. The environment did not always meet people's needs, as there was limited communal areas. The outside space was a disused car park and a gazebo with steps, therefore not accessible to all.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's had some independence but not all staff were confident in engaging and involving people in tasks such as household chores or cleaning their own personal rooms.

People had access to the wider community with support from staff however, more meaningful activities had

not been discussed or fully explored. There had been improvements in the variety and frequency of activities since the arrival of the new manager.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
A focused inspection of the service at Albert Road was carried out in June 2018. This was in response to concerns raised with the Care Quality Commission shortly after the service opened. We looked at the key areas of safe, caring and well led and all were rated requires improvement.

The provider of this service changed on 17/10/2018. This was an internal move following a restructure within the parent company.

Why we inspected
This was a planned inspection based on the new provider's registration date.

Enforcement
We identified three breaches during the inspection. These related to safe care and treatment, need for consent and good governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. 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 six 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 than12 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.
Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.
Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.
Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.
Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well led.
Details are in our well led findings below.

Inadequate

Albert Road

Detailed findings

Background to this inspection

The 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 Care Act 2014.

Inspection team
The inspection team consisted of one inspector.

Service and service type
This service is a care home. It provides accommodation and personal care to people living at Albert Road. The service did not have a manager registered with the Care Quality Commission at the time of this inspection. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager in post and they had submitted an application to be registered with the Care Quality Commission.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we were aware of the manager's scheduled absence, so we needed to be sure that the provider would be at the home to support the inspection.

Inspection activity started on 15 October 2019 and ended on 17 October 2019.

What we did before the inspection
Before the inspection, we reviewed statutory notification's and information about the service. Statutory notifications are what the home needs to send by law. We contacted the local authority to gather feedback about the service, but they did not commission any placements at Albert Road.

The provider completed a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and

improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with the provider, the manager, three members of staff, four people who used the service and a relative. We reviewed four care files and three medication administration records. We viewed four staff recruitment records and information relating to the induction, training and supervision of staff. We looked at audits to monitor and improve the service and any quality assurance documentation.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted two other relatives, a mental health professional and a commissioner from another local authority to gather further feedback about the service.

Inadequate

Is the service safe?

Our findings

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

At the focused inspection this key question was rated requires improvement. At this comprehensive inspection this key question has deteriorated to inadequate.
This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
● There were significant failings with the administration and the recording of medicines, as these were not safe or accurate. We could not be assured people had received their medicines as prescribed. This placed people at risk of potential harm.
● People had missed doses of their medicines as medicines were not always ordered in a timely manner.
● Training in the administration of medicines was mandatory, but two staff members had not received this training at the time of this inspection. Staff did not have their competency to administer medicines checked or observed whilst supporting people with medicines.
● The provider had policies in place regarding the safe management of medicines, but these were not always adhered to.
Whilst there was no evidence people had come to harm this was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● A legionella risk assessment had been carried out by an external contractor on 29 August 2019. There was no formal documentation in the home regarding water system checks and provider responsibilities had not been met.
● Not all risks specific to people had been assessed. Staff were not provided with accurate information and guidance to help them support people in the safest way. For example, risks were posed to people with diabetes. One person's choice of diet included a daily intake of fast food and sugary snacks. A discussion with the person about the potential risks had not taken place and ways in which staff could help to reduce the risks were not documented.

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

● Environmental risks such as pets, smoking and going out into the community were assessed and physical risks included mobility and moving and handling.

Staffing and recruitment
● Safe recruitment practices had been followed. Staff received appropriate pre-employment checks prior to commencing employment
● The provider used agency staff to cover staff absences such as sickness and holidays, but agency staff did not appear on rotas. Rotas should accurately reflect all staff who are on duty in the home, and we brought

this to the provider's attention, so appropriate action could be taken
● People told us there were enough staff deployed to ensure their wellbeing and to meet their social needs. We saw that people who wanted to go out did leave the home daily with support from staff.
Systems and processes to safeguard people from the risk of abuse
● Staff received training to recognise and report any abusive practices. Staff told us they were confident any concerns they reported to management would be acted upon.
● People told us they felt safe living at Albert Road.

Preventing and controlling infection
● Staff received training in infection prevention control, although provision of staff training in infection control was inconsistent.
● Staff had access to personal protective equipment, such as gloves and aprons.
● The home was clean and there were no malodours at the time of this inspection.

Learning lessons when things go wrong
● Accidents and incidents were recorded and analysed to help prevent future occurrences.
● The provider was proactive and responded to concerns we raised around the safe management of medicines.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the focused inspection this key question was rated requires improvement. At this comprehensive inspection this key question has deteriorated to inadequate.
This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

- People had some choice and control regarding their diet, but this was not always well managed. One person chose options that were not healthy, and not suitable for their health condition. For example, on our first day of inspection the person told us they had eaten a piece of chocolate cake for breakfast and eaten fast food for lunch. Staff did not encourage healthier alternatives with the person and their care plan did not contain guidance on this, or evidence of discussions with the person.
- The menu on display in the home did not always reflect what was served to people. On our second day of inspection the menu indicated rump steak with peppercorn sauce for the evening meal, but people were served burgers. We saw no records indicating this was their choice or if people had been informed of the change to the menu.
- Information in relation to people's diet was recorded on daily shift planners, although this was not consistent. It was not always clear what people had eaten during the day due to poor record keeping. Likes and dislikes of food and drinks were contained within the care plan. We saw no records of staff having discussions with people about the consequences of following an unhealthy diet.
- People were able to prepare their own breakfast, make drinks and snacks if this was their choice in the small satellite kitchen on the first floor.

We recommend the service reviews how it involves people in discussions about lifestyle choices, including a balanced diet and the potential consequences of following an unhealthy diet.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People had access to health and social care professionals, such as the GP, podiatrist and social workers. Only one person had access to a dentist therefore others had not received oral health treatment.
- People were not always supported to health care appointments. Where people refused to attend these, follow up appointments were not made by staff. One person had missed an appointment for a diabetic eye screening, vital for early detection of eye problems caused by diabetes. A new appointment had not been made due to a lack of management oversight. This could have a detrimental impact on the person's health to their health.
- Care plans indicated the involvement of diabetic nurse professionals, but we saw no evidence of their input or advice for those people that warranted this. People did not have their weight routinely monitored so the service could not identify if further action was needed, such as referral to a dietician.

People did not always have timely input from healthcare professionals due to a lack of management oversight. This represents a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● It was not always clear how decisions in relation to people's care and lives at the service were decided. The MCA was not understood to ensure people's capacity was assessed and decisions made in their best interests. For one person, a decision had been made about managing their finances with no record of how the person's capacity had been assessed or how the best interest decision was reached. Where people did have capacity and made unwise decisions there was no evidence of any conversations around these unwise choices, for example with regards to diet.
● Staff did not have a robust knowledge of the MCA. Certain decisions were being made on behalf of people with or without capacity, however the principles of the MCA had not been followed. People were not involved to the maximum extent possible and we saw no records of best interest decisions being formally documented.
● Consent to care and treatment was not fully sought in line with relevant legislation and guidance. Where relatives had an LPA in place regarding health and welfare they had not been fully involved in planning care and support for the person.

People did not have their rights protected. The failure to ensure the principles of the MCA were followed was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Effective systems to ensure staff were fully trained were not in place at the time of this inspection. We identified two members of staff who had completed little or no mandatory training. We made the provider aware of this and the members of staff were removed from the service until this was addressed.
● Staff had not always received appropriate training in relation to people's specific health needs and associated risks, such as diabetes. Refresher training in relation to acquired brain injury awareness had not been scheduled but was addressed by the provider following this inspection.
● An effective system was not in place to observe staff practice, to make sure the correct procedures were carried out, for example when administering medicines.
● Staff told us they had not felt supported after the registered manager had left in July. There had been some improvements in staff sentiment since the new manager had joined the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Preadmission assessments were carried out before a person was admitted to Albert Road to ensure specific needs could be met.

● The provider told us that the needs of people living at Albert Road would also be taken into consideration when carrying out assessments for any future admissions to the service.

● People's assessed needs and choices were not always kept under regular review to ensure care and support reflected their needs and was person-centred.

Adapting service, design, decoration to meet people's needs

● Communal areas in the home were limited and small, especially on the ground floor. Additional seating arrived for the communal lounge area during this inspection, allowing four people to sit down together. People tended to stay in their rooms when at Albert Road, either by choice or possibly because communal space was limited.

● The home wasn't fully accessible to all at the time of this inspection. The front entrance to the home was via a set of steps. We saw the installation of a small external lift was due shortly after our inspection. There was additional access to the home via a side door, all on the same level. There was no garden and no suitable outside space where people could relax. A tarmac car park at the rear of the home was no longer used. People used a large, wooden gazebo in the corner as a smoking shelter. Steps up to this meant it was not accessible to people in wheelchairs and they were unable to use it for this purpose.

● Bedrooms were of various sizes and all had en-suite facilities. Some bedrooms had been decorated to reflect people's interests and personalities. For example, one had a colour scheme matching that of the person's favourite football team. Photographs, posters and football memorabilia lined the walls.

We recommend that the provider reviews the accommodation and ensures that the home is fit for purpose and outside areas are fully accessible to all.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection of this key question. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People were able to express their views about their care, but we saw examples where these views had not been acted upon.
- In May 2019 a college placement was suggested for one person, as this was of interest to them. At this inspection in October no action had been taken to explore the options available to the person.

Respecting and promoting people's privacy, dignity and independence
- People were supported to maintain or gain independence, but this was not always actively promoted by staff.
- There was no guidance in place for staff to help them encourage people to engage in household chores, such as tidying their personal spaces or taking responsibility for their pets.
- People were treated with dignity and respect. Attempts were made by staff to ensure people presented smart in their appearance, whilst respecting their lifestyle choices.

Ensuring people are well treated and supported; respecting equality and diversity
- Due to the concerns identified during the inspection, we could not be assured the provider ensured people received a high-quality compassionate service.
- People told us they considered the staff to be kind and caring. One person lived with their dog. Staff supported the person to look after the dog, accompanying the person to walk the dog.
- Staff were seen proactively engaging with people. People left the home and went out into the community with one to one support from staff. People had built up good relationships with staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection of this key question. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care records and practices did not promote person-centred care. One care plan indicated a person needed staff support with meal planning and shopping, but we saw no evidence of this.
- People's care reviews had not taken place. Any changing needs or additional risks had not been identified.
- There was some good information in care plans about people's behaviours when in the community and specific triggers that staff should avoid.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Where the service had identified meaningful activities or stimulation for people, based on their interests and preferences these had not been fully explored or instigated. Religion was a specific interest to one person. The service had plans to accompany the person to different places of worship, including a synagogue, but this had not been done in a timely manner.
- People were able to spend time in their rooms or go out with support from staff. This time was spent eating out or shopping in the community.
- Relatives we spoke with confirmed things had improved since the new manager had come into post. We saw photographs on display in the home of outings people had enjoyed together, such as bowling. People had also been to a football match and for a carvery lunch.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Due to the nature of their health conditions people had varying degrees of communication. The service had not explored how to better present information to people in a way they could understand. For example, in a pictorial format or easy read version.
- Information about specific health needs, or the potential consequences of a poor diet and smoking were not communicated to some people in ways they might understand.

Improving care quality in response to complaints or concerns

- People told us they would complain if they needed to, either to a member of staff or to the manager.
- The provider and manager were responsive to concerns highlighted during the inspection.
- Medicine audits were carried out immediately following this inspection to ensure people remained safe.

End of life care and support.

● People had been consulted about their wishes for care at the end of their lives, although not all had provided a response.

● Where people had expressed specific wishes this information was contained within care plans.

● At the time of inspection, the service was not supporting anyone at the end of their life. The service told us they would involve other health professionals to help with end of life care and support.

Inadequate

Is the service well-led?

Our findings

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

At the focused inspection this key question was rated requires improvement. At this comprehensive inspection this key question has deteriorated to inadequate.
This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
- Risks specific to people were not always fully considered. Staff were not provided with adequate information or guidance to manage all risks.
- Following monthly submissions of quality data to the provider there was no evidence of further checks or actions to drive up the quality of care.
- Following the departure of the previous registered manager in early July 2019, there had been some oversight and management of the service, although this had not been consistent. Staff told us they had not felt fully supported in the service.
- A manager employed at the service had submitted an application to the Care Quality Commission to become a registered manager. At the time of this inspection the manger was absent after having surgery, but was present for some of the inspection and was planning a phased return to work soon afterwards. There was a temporary manager in post, providing oversight and supporting staff for three days a week.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
- People were at risk of harm as systems in place did not support the safe management of medicines. No audits of medicines had been carried out by managers, the provider or a pharmacy.
- The quality of record keeping was poor and inconsistent. Errors we found in relation to medicines had not been identified by management. Following identification of discrepancies in the controlled drug counts by a member of staff, no action or investigation by the provider had taken place to account for these.
- Care was not always person-centred. Whilst staff were aware of people's personal preferences, management had not always acted on these to improve outcomes for people living at Albert Road.
- There were plans in place to introduce a range of audits to monitor and improve the service. These were not yet implemented in the service and there had been no clear oversight or monitoring from the provider in the absence of a registered manager.

The delivery of high-quality care was not assured by the leadership of the service and current systems to manage the quality of the service were inadequate. This was a 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
● Management had not consulted or engaged with relatives, staff or other professionals to gauge their views on the quality of the service and how this might be improved.
● The provider had consulted with people who used the service to gain their views. People were complimentary about the service.
● Staff we spoke with were complimentary of the new manager. They were given the opportunity to share their views. Staff told us they would be listened to and supported by the manager if they raised any concerns.

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 provider was aware of their obligation to notify CQC of all of the significant events occurring within the home and understood their responsibility to act on duty of candour.
● Relatives were not always kept informed about incidents or accidents that had occurred in the home. In this respect the home did not always fulfil the duty of candour.

Continuous learning and improving care
● The provider planned to purchase a cloud-based governance system. This would provide improved oversight the service and help with the monitoring and implementation of standardisation across the company.
● The provider's aim was to improve the quality of care for individuals living at Albert Road by focusing on helping people achieve their goals.

Working in partnership with others
●The service worked with the local authority, mental health professionals and other commissioners of care to monitor and review placements at the service.

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 11 HSCA RA Regulations 2014 Need for consent The home failed to ensure the principles of the Mental Capacity Act were followed. It was not always clear how decisions in relation to people's care and lives at the service were decided.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm. Safe practices were not followed with regards to the management of medicines. Provider responsibilities to help reduce the risk of legionella in water systems in the home had not been undertaken.

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 delivery of high quality care was not assured by the leadership of the service and current systems to manage the quality of the service were inadequate.

The enforcement action we took:

Warning notice served