Mr Pierre Grenade

Nada Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12, 13 and 15 December 2016. After that inspection we received concerns in relation to a serious safeguarding incident, which prompted this focussed inspection. In this incident a person who used the service left the home unaccompanied. The person had a Deprivation of Liberty Safeguards (DoLS) authorisation in place which should have restricted them from accessing the local community without staff support. The person was involved in an accident whilst in the community on their own.

This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of absconsion, particularly for those people who lacked the mental capacity to access the community independently. This inspection examined these risks.

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.

The provider was also the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Registered Manager gave the inspector a list of 13 people living at the service where DoLS applications had been made. Two of these had been authorised by the local authority, with the remaining 11 applications waiting for the local authority to complete their mental capacity assessments. We saw one person who required one to one staff support did not have a DoLS application in their care file.

Of the 13 people with DoLS applications in place, six people were assessed as being able to access the local community independently if they informed the staff where they were going and when they would return to the home. However people had been able to open the front door and fire exit themselves. Staff were not always able to respond to the single buzzer that sounded when the doors were opened as they were supporting other people. Keypads were being fitted at the time of the inspection to prevent this from happening in the future; however this had taken two weeks to arrange after the serious incident. The registered Manager told us this was the earliest that the keypads could be fitted.

Care plans and risk assessments were not always in place for people accessing the community on their own. There were no contingency plans in place if people did not return at the agreed time.

Systems were not in place for staff to record who had left the home and what time they were due to return.

This meant staff may not always be aware of who had gone out and that they had to check that they had returned as agreed. Thirty minute observations had been introduced to monitor the whereabouts of each person who lived at the service. This would alert staff within 30 minutes of people had left the building without informing staff.

There was no evidence that people had been shown the safest routes to go to the local shops, for example using pelican crossings to cross main roads.

The staff we spoke with were aware of who was able to access the community and that they had to agree when they would return. However there was no overview of who was able to go out on their own and who required staff members to support them when they went out. This meant new staff or agency staff members may not know they had to agree what time people were due to return with them and so may not inform other staff or the nurse in charge that they had gone out or not returned.
Since the serious incident staff told us they supported people to cross the main road.

During this focussed inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Care plans and risk assessments were not always in place for people accessing the local community on their own.

Systems were not in place to clearly inform staff who was able to go out on their own and who had restrictions placed on them through the Deprivation of Liberty Safeguards.

30 minute observations were now being completed. Keypads were being fitted to the front door and two fire exits at the time of our inspection. However there were no agreed contingency plans for staff to follow if a person did not return at the agreed time.

We have not changed our rating from the inspection in December 2016 for effective from inadequate.

Is the service well-led?

Inadequate

The service was not well led.

Systems were not in place to record who had gone out from the home and what time they were due to return.

Contingency plans for each person were not in place to identify the action staff were to take if a person did not return to the home at the agreed time.

Keypads were being fitted to the front door and two fire exits at the time of our inspection. However these had taken two weeks to arrange since the serious incident.

We have not changed our rating from the inspection in December 2016 for well led from inadequate.

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 and to provide a rating for the service under the Care Act 2014.

We carried out an unannounced comprehensive inspection of this service on 12, 13 and 15 December 2016. After that inspection we received concerns in relation to a serious safeguarding incident. In this incident a person who used the service left the home unaccompanied, when their assessment of need was that they should always have a member of staff with them when they accessed the community to support them to be safe. The person had a Deprivation of Liberty Safeguards (DoLS) authorisation in place to restrict them to accessing the local community with staff support. The person was involved in an accident whilst in the community on their own.

As a result we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nada Residential and Nursing Home on our website at www.cqc.org.uk.

This inspection took place on 8 March 2017 and was unannounced. The inspection team consisted of one adult social care inspector.

The concerns raised form part of the two domains; is the service effective and is the service well led. Our findings for this incident are reported under these domains.

We spoke with the registered manager and two care staff. We looked at DoLS applications made for all people living at the service and relevant care records for any deprivations of liberty applied for or

authorised.

Inadequate

Is the service safe?

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.

The Registered Manager gave the inspector a list of 13 people living at the service where DoLS applications had been made. The applications stated that six people accessed the local shops, post office and banks on their own. However they had to inform the staff they were going out and what time they would return to the home. This was so the staff could ensure that they had returned safely.

Two applications had been authorised. The Mental Capacity Assessor had noted that the two people did not have complete freedom to leave the home as they had to ask the staff to unlock the door to allow them to access the local area and had to agree to the time they would return to the home.

We noted that new key pads were being fitted to the front door and two fire exits at the time of our inspection. Prior to this the doors could be opened by people living at the home and a buzzer would sound to alert staff. However we were told that staff had not always been able to check on who had left the building as they were supporting other people at the time. This meant people who had been assessed as being required to inform staff where they were going and when they would return could leave without these checks being made. This meant people had been able to leave the building without the staff being aware who had left and where they were going, prior to the keypads being fitted.

We looked at the care plans for the six people noted above. We saw three people had care plans in place for social activities where they needed to inform staff where they were going and what time they were due to return to the home. However there was no formal system in place to record this, inform members of the staff team and remind staff when they were due to return. This meant staff may not be aware when the person was due to return and would not check they had returned at the agreed time.

Two people did not have any care plan or risk assessment in place about accessing the local community on their own and the need to inform staff. One person had a care plan stating they go out with staff support but the DoLS application said they accessed the local community independently, but informed staff when they would return to the home. This meant there were no clear guidelines in place for staff to follow for these three people.

We also saw that there were no contingency plans in place if the person did not return at the agreed time. This meant staff did not have a formal procedure to follow in these circumstances and so may not look for people or inform the relevant authorities in a timely manner. This could place people at risk.

We spoke with two staff members at the service. They knew which people needed to inform staff when they were going out. They said the staff were much more aware of when people were going out following the incident that led to this inspection and were quick to respond to the door buzzer sounding. Staff said they informed the nurse on duty if a person had not returned at the agreed time. They also said they supported people to cross the main road outside the home following the incident to ensure people were safe. However there was no written overview in place to inform staff who was able to go out independently, who had to inform staff and agree a time to return and who could only go out with staff support. This meant staff, especially new staff members or agency staff could be unaware of the restrictions in place for an individual when they went out.

We noted there were no records that staff had supported people to learn safe routes to the local shops; for example by using pelican crossings to cross main roads. This meant people may not use the safest route to access the local shops.

The lack of clear guidance for staff in care plans and risk assessments, contingency plans if a person did not return to the home at the agreed time not being in place and people not being shown the safest way to access the local area meant that people's health and welfare was placed at risk of harm. This was a breach of Regulation 12(1) with reference to (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a new observation sheet had been introduced since the incident. This recorded each person living at the home's whereabouts every 30 minutes. This meant staff would be aware if a person had left the home within 30 minutes of them leaving and would be able to inform the nurse on duty to take the appropriate action.

We noted one person living at the service had one to one staff support during the day due to their assessed needs. This meant they were under constant staff supervision. This meets the definition of requiring a DoLS to be in place. We did not see a DoLS application or authorisation in this person's care file.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At our inspection in December 2016 we found a breach of the Regulations because there was not a robust system to monitor and improve the quality of the service in place.

Following the serious safeguarding incident the provider had arranged for keypads to be fitted to the front door and two fire exits. However this had taken two weeks to arrange. The registered Manager told us this was the earliest that the keypads could be fitted. During this time people could still leave the home without informing staff.

The provider did not have care plans and risk assessments in place for all the people who could access the local community on their own. A system was not in place for staff to record who had gone out and when they were due to return. People were not supported to learn the safest way to travel in the local area. A written contingency plan was not in place for staff to follow in case someone did not return when they had agreed to.

This meant the provider did not have systems and procedures in place to reduce the risks of people accessing the local community independently.

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

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The lack of clear guidance for staff in care plans and risk assessments, contingency plans if a person did not return to the home at the agreed time not being in place and people not being shown the safest way to access the local area meant that people's health and welfare was placed at risk of harm. This was a breach of Regulation 12(1) with reference to (2) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment One person living at the service had one to one staff support during the day due to their assessed needs. This meant they were under constant staff supervision. This meets the definition of requiring a DoLS to be in place. We did not see a DoLS application or authorisation in this person's care file. This was a breach of Regulation 13 (5)

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 The provider did not have systems and procedures in place to reduce the risks of people accessing the local community

independently.

This was a breach of Regulation 17 (1) with reference to (2) (a) and (b)