Adelaide Lodge Care Home LL Partnership

Netherhayes Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 24 November and 9 December 2014 and was unannounced.

Netherhayes Care Home is registered to provide accommodation for 28 people who require personal care, 21 people lived at the home when we visited. Most people who lived at the home were living with varying degrees of dementia. The provider is a partnership, a lead partner visits the home regularly and is involved in quality monitoring.

At the time of our visit, there was no registered manager. A new manager had been appointed and was due to start the following week. Since the inspection, this manager has registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission 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.

At our last inspection on 23 April 2014 we found a breach of the regulation on care and welfare related to choking risks and improvements had been made in this area.

Summary of findings

However, at this inspection, we identified new risks about people's care and welfare, particularly related to managing people with behaviours that challenged the service.

Where people did not have the capacity to consent or make decisions, the provider had not acted in accordance the Mental Capacity Act (2005) and Deprivation of Liberty safeguards. There were no mental capacity assessments for people who lacked capacity. This meant staff did not have information to assist people to make decisions for themselves. Staff were seeking consent from relatives for people who lacked capacity. There was no records of 'best interest' decision making to show how people, relatives and other professionals were consulted and involved in decision making about people's care and treatment.

People, relatives and visiting professionals gave us mixed feedback about the service provided. Most people were happy with the care and treatment they received and felt well supported by staff at the home. Some relatives expressed concerns about some aspects of people's care and about their ability to influence day to day decisions and improvements for people living at the home.

People's needs were assessed but improvements were needed to ensure all care plans provided staff with the detailed information they needed to deliver consistent and appropriate care. Risks to people and staff from people with behaviours that challenged the service were not always identified or well managed. Improvements in staff training were needed to ensure staff were supported to acquire and maintain skills and knowledge to meet people's needs effectively and safely.

Quality assurance and audit processes were in place to help monitor the quality of the service provided. However, improvements were needed as some of the shortfalls we identified had not been recognised or dealt with. Improvements were required to ensure systems and processes were in place to protect people's rights and to make care more personalised to people's individual needs.

The provider had recently introduced a cook/chill meal provision at the home. Although people had a choice of menu , most people commented that they preferred the home cooked meals previously available at the home.

Staff working at the home knew people's needs and preferences well and people and relatives said staff were caring and kind. There were friendly and respectful interactions between staff and people. People were supported by having enough staff on duty to meet their needs.

People were appropriately referred to a variety of health care professionals for specialist advice and treatment for their specific needs.

Staff were aware of signs of abuse and knew how to report concerns and were confident these would be investigated. A robust recruitment process was in place to make sure people were cared for by suitable staff.

People received most of their prescribed medicines on time and in a safe way. However, some improvements were needed in management of topical creams and ointments.

The provider had a range of improvements planned for the forthcoming year which included new care plan documentation, decoration , improvements to the environment of the home, and additional staff training.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. People and staff were at increased risk as staff were not managing people with behaviours that challenged the service in a safe way.

Staff were aware of signs of abuse and knew how to report concerns and were confident these would be investigated.

Each person had written risk assessments and a risk management plan which identified how to reduce individual risks as much as possible. Some, but not all, risks at the home were well managed.

Some improvements were needed in management of prescribed topical creams and ointments.

People were supported by having enough staff on duty to meet their needs.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. People and staff were at risk of as staff did not have all the knowledge and skills they needed to support people's care and treatment needs.

People did not consistently experience care, treatment and support that met their needs and protected their rights. This was because staff did not understand and were not acting in accordance with the principles of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

Improvements in the environment of care were needed to make it more suited to the needs of people living with dementia.

People and relatives spoken highly of staff and the care they received.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. People and relatives reported that staff treated people with kindness and respect. However, some aspects of people's care was not always managed in a way that promoted their dignity.

Staff were polite helpful and spoke pleasantly to people. They knew people well, visitors were encouraged and welcomed.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. People were not consistently supported to be involved in making decisions about their care. Their views and experiences were not sufficiently being taken into account in the way the service was provided.

People's care and treatment was more task centred on daily routines, rather than focussed on people's individual needs and preferences.

Summary of findings

A range of weekly activities were available. Some people needed more interaction with staff and opportunities to access the local community.

People were aware of the complaints procedure and complaints received were addressed.

Is the service well-led?

Some aspects of the service were not well led. People were at increased risk because of the lack of consistent leadership and decision making at the home.

The quality monitoring arrangements were not fully effective. This was because they had not identified the concerns and breaches of regulations we identified at the inspection.

Notifications were not always reported to CQC in accordance with the regulations.

The provider outlined a range of improvements planned to the environment, documentation and in staff training.

Requires Improvement

Netherhayes Care 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 checked 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 24 November and the 9 December 2014 and was unannounced.

The inspection team was an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using this type of dementia care service. We reviewed information we had about the service such as the provider information return and information we had received directly about care at the home.

We met 20 of the people who lived at the home and received feedback from eight people using the service, six relatives and a friend. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). 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 10 staff, which included care and support staff, the provider, and two senior managers. We looked in detail at the care provided to five people, including looking at their care records. We looked at five staff records and at staff training, supervision and appraisal records. We also looked at a range of quality monitoring information. We spoke to nine visiting health and social care professionals, which included community and mental health nurses, three GP's, a speech and language therapist, and commissioners.

Requires Improvement

Is the service safe?

Our findings

Risks to people were not always well managed. Staff had safety concerns about three people in particular who lived at the home who displayed behaviours that challenged the service. This included shouting, swearing, hitting, pinching and verbal abuse. Staff said this verbal and physical aggression occurred daily and was mainly against staff, particularly when they tried to provide personal care for those people and when moving and handling them.

Staff had referred those people to their GP who had involved mental health services in assessing and reviewing two people's care and treatment. This had resulted in changes to their medication and advice for staff about managing those risks.

When we talked to staff and looked at those people's behavioural care plans, we found the guidance available for staff was not sufficient to enable them to know how to approach those people or to help them to deliver those people's care safely.

For example, in September 2014 in one person's records, staff reported physical aggression towards them when trying to give personal care. In their care records, the goal identified was to "monitor and record any behavioural problems". The action section said, "Staff to try and perform care tasks when the opportunity allows". There were no detailed instructions about how to approach and manage the person or deal with their aggressive behaviours or what to do if staff were unsuccessful. During November and December 2014, the person's monthly review, daily records and behaviour charts all showed this person's ability to co-operate with care had decreased and the level and frequency of physical aggression towards staff worsened. The monthly reviews had not resulted in any changes to these care instructions for staff.

Staff spoke about their daily struggles to get two people into and out of bed, to provide personal care for them and when moving and handling them. One staff member said they had scratches all up their arm and another was worried a person would hurt themselves when they were trying to use the stand aid to transfer them. Staff described trying to get the person to co-operate, walking away and trying again later. However they were not aware of de-escalation techniques or how to use positive behaviour support to reduce risks, and these were not included in people's care plans.

The provider had a policy on managing violence and aggression which outlined risk assessments and care plans and training was available for staff on how to manage these issues. The provider's restraint policy showed where there was a risk of physical injury, staff should attempt to control the situation in the least restrictive way possible and should use of non-physical strategies to deflect and diffuse the situation. However, care practice was not in accordance with these policies.

Two relatives expressed concerns about inadequate supervision of people in the lounge area of the home in order to keep an eye on people and to intervene in any altercations. During our visit, we witnessed a verbal altercation between two people in dispute about a newspaper, but there was no staff member nearby to intervene. One relative, said, on occasions, they had to leave the lounge to find a member of staff to sort out incidents when people were becoming aggressive towards one another. Two people still recalled and spoke about incidents which had alarmed them in the past and which they were anxious would happen again.

We discussed the management of people's challenging behaviour and their supervision with the area manager. They were aware that staff needed more training in this area and were in process of arranging accredited managing challenging behaviour training for staff. They explained they tried to have a designated member of staff in the lounge at all times, but this was not always possible. We asked about checks on two people with challenging behaviour who were confined to their rooms. Staff did 30 minute checks on one person who was upstairs and also checked the other person regularly. This helped anticipate each person's needs, and reduced risks of them becoming isolated.

Accidents and incidents were reported and staff documented the immediate actions taken. However, in the accident reports we looked at there were no information about further actions needed to reduce the risk of recurrence. Although staff described daily incidents of

Is the service safe?

physical and verbal aggression, these were not being incident reported. This meant the level of risks for staff and other people were not being recognised or managed to reduce those risks to an acceptable level.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Each person had written risk assessments and a risk management plan which identified individual risks. These included falls risks, moving and handling risks and risk of pressure ulcers. Risk management plans were in place about how to reduce risks as much as possible. For example, by using bedrails and protectors to reduce the risk of one person rolling out of bed. These instructions were implemented for the people we looked at.

The provider had appropriate safeguarding policies, procedures and staff training to reduce the risk of abuse. One relative said, "I've been coming in at all times almost every day for two and a half years and I've never overheard or seen anything that's given me any cause for concern".

Staff were knowledgeable about how to recognise signs of potential abuse and said they were confident any concerns raised with senior staff would be dealt with. However, some altercations between people should have been reported to the local authority safeguarding team and notified to the Care Quality Commission but hadn't been. This meant staff were not recognising safeguarding risks of verbal and physical abuse.

Most medicines were well managed, although some improvements were needed in relation to prescribed creams and ointments. One person said they had to remind staff regularly to apply their prescribed cream to their back. Records relating to prescribed creams and ointments were confusing and poorly completed. These prescriptions were documented on medicine administration records but separate cream charts were kept in people's care records, which did not include those prescription details. We found large gaps in people's records of administration. This meant it was unclear whether or not people's creams and ointments had been applied, as prescribed.

Medicines which required refrigeration were appropriately stored, however, there were lots of gaps in daily fridge temperature monitoring checks. This meant we could not be assured about whether refrigerated medicines were stored at the correct temperatures to work effectively. When we raised this with senior staff, they agreed to remind staff to carry out these checks daily. A visiting professional said on occasions, when changes were made to medicines administration records, the date of medicines being stopped was not recorded, or removed from the prescription record. This could increase the risk of errors, although we did not see any examples of this.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Senior care staff administered medicines following training and competency assessment. They demonstrated safe practice and were knowledgeable about people's medicines. We looked at the controlled drugs which were stored and accounted for in accordance with the legislation. Records were available of all medicines received and disposed of, which meant all medicines were accounted for. Where people were reluctant to take their medication, medicines needed were sometimes disguised in food or drink, known as "covert medication". The person's GP had discussed and authorised any covert medication, which was documented.

People's care needs were supported because there were enough staff on duty to meet people's assessed needs. People said they received care when they needed and staff responded to call bells within a few minutes. One relative said there had been problems with staffing in the previous few months. They said, "A lot of staff have left and there aren't enough...they're run ragged…if I come in the afternoon I could sit an hour and not see a member of staff". We asked staff about current staffing levels. They said they were short staffed a few months ago, but confirmed more staff had been appointed since then. There were four staff on duty morning and afternoon, which staff said was sufficient to care for people's daily needs.

The provider used a dependency tool to calculate staffing levels to meet the needs of people who lived at the home. This included taking into account people's individual risks assessments, their mobility and care needs. The area manager confirmed they thought staffing levels were appropriate for the needs of the people who lived at the home. Duty rotas showed recommended staffing levels were being maintained. Further recruitment was ongoing for some additional staff hours to help cover peak times such as in early mornings and evenings, when people needed more help. A new member of staff was due to start the following week.

Requires Improvement

Is the service safe?

Communal area areas of the home and people's rooms were clean with no unpleasant odours. People confirmed their rooms were cleaned regularly. There were appropriate cleaning materials and equipment available, and staff followed written cleaning procedures. Staff had access to suitable hand washing facilities and personal protective equipment (PPE's) such as gloves and aprons and about half of the staff had undertaken infection control training.

There were arrangements in place to manage the premises and equipment . Fire checks and drills are carried out in accordance with fire regulations and regular testing of electrical equipment was carried out. There was evidence of regular servicing and testing of moving and handling equipment. The provider planned improvements in 2015 to the nurse call bell system, and the lighting in corridor areas.

Requires Improvement

Is the service effective?

Our findings

Staff sought people's agreement before carrying out any day to day care or treatment. However, staff did not demonstrate they understood the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty safeguards (DoLs) and were not acting in accordance with them. Staff had not received any MCA and DoLs training. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

No mental capacity assessments had been undertaken for people who lacked capacity. This meant there was no information or care plans to guide staff about how they could assist people to make some decisions for themselves. Instead, staff approached relatives to obtained consent for some people's care and treatment. For example, about a decision to use bedrails for one person and the use of a sensor on another person's door to monitor their movements. We were shown a mental capacity assessment tool, however, senior managers confirmed this had not been used for anybody living at the home. This meant staff did not have any information about what aspects of daily living people could make decisions about, because those assessments had not been carried out.

Where people lacked capacity, there were no records to demonstrate how relatives, staff and other health and social care professionals were consulted and involved in making decisions in each person's 'best interest'.

We had concerns about whether the Deprivation of Liberty Safeguards were only being used when it was considered to be in the person's best interest. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. This was because two people were restricted to their rooms without the proper authorisations in place and a third person was a high risk of absconding. Following feedback on first day of the inspection, senior staff contacted the local authority deprivation of liberty team and made applications for people and were awaiting an assessment visit. They confirmed they were reviewing all other people who lived at the home to see whether any other DoLs applications were needed.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff at the home used a range of evidence based tools for assessing people's health needs and identifying any risks. For example, a tissue viability assessment for to identify people at risk of pressure ulcers. Health professionals said people were referred appropriately to them and they were informed when people's needs changed .People were regularly referred to their GP, community nursing service and to the older people's mental health service. A GP commented they were very satisfied with the 'end of life' care their patient had received at Netherhayes. Another GP said people appeared well cared for when they visited. However, they also commented that sometimes when they visited, there was no senior member of who knew why a GP visit has been requested. Also, that staff did not always have the person ready or the relevant information available. We followed this up with the provider who explained people and relatives sometimes contacted the GP directly to request a visit, which staff may not always be aware of.

People needed pressure relieving equipment such as cushions were sitting on them, in accordance with their care plan. However, two people spent all day in their wheelchairs in the lounge, sitting on pressure relieving cushions, rather than being transferred into more comfortable armchairs. This meant they were at higher risk of developing skin damage due to their lack of mobility. A health professional who visited the home regularly also expressed concern about seeing people sitting in the lounge in wheelchairs. When we asked staff about this, staff said one person got very agitated during moving and handling so they tried to reduce the need to disturb that person as much as possible. Staff said the second person liked to go outside regularly so chose to sit in the lounge in their wheelchair. Staff confirmed they had enough moving and handling equipment available to meet people's needs. An external professional commented they would like to see more up to date equipment available in the home to reduce moving and handling risks for staff, such as beds that could be raised and lowered. They also reported staff were not very quick at changing things in response to external professional advice. For example, they had to prompt staff more than once to obtain pressure relieving equipment for a person.

Requires Improvement

Is the service effective?

People did not always receive care, based on evidence based practice, because staff did not always have the knowledge and skills to meet their needs. A health professional said they thought staff wanted to do the best they could for people but had a basic level of skill and they were concerned about whether staff had the skills to care for people with more complex needs. A mental health professional said staff interactions with people with dementia needed to be improved, and that staff needed to spend more time with those people. One relative said they weren't sure the home was fully meeting the needs of the person living with dementia.

The provider's information return showed 13 of 22 staff employed at the home had qualifications in care. The training matrix showed regular staff training was provided on subjects such as safeguarding, moving and handling, infection control, fire safety, and health and safety. Over the past 24 months, training figures showed poor compliance with staff attendance at training. For example, 11 of the 22 staff had attended training in dementia care, eight had attended the moving and handling training. Staff training records showed nine of 22 staff had received DVD training in managing challenging behaviour. However, none of the staff we spoke with felt they had the skills to manage these people safely. Two professionals also said that staff lacked skills in managing people's challenging behaviours . Some staff said they had difficulty getting to the training, as it was provided at another home and they didn't have any transport. However, the provider said transport could be arranged for staff. We found large numbers of staff were not attending the training they needed to meet people's needs. The provider had no system in place to ensure non-attendance at training was followed up.

Staff said they did not receive regular supervision to discuss any care and practice issues. When we looked at five staff files, these showed arrangements for regular staff supervision and appraisal had lapsed. This meant opportunities to identify staff training, development and support needs were being missed.

This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed training with the area manager who was in the process of reorganising the training arrangements, which was out of date. They had plans for all staff to attend overdue training and had reviewed and planned to improve the training provision. Additional training had been arranged, for example, on understanding the needs of people with dementia, and the area manager was trying to find suitable MCA and DoLs training for staff.

All new staff underwent an induction programme in accordance with the national "Skills for care" guidance. This included reading the policies and procedures, and working with more experienced staff to get to know people's needs and how to care for them.

People's nutritional needs were identified and monitored. Where people had difficulty with swallowing or there were concerns about choking risks, they were seen by a speech and language therapist and staff understood and followed their recommendations. People were supported to eat and drink regularly and were offered alternative snack or food supplements, when they declined meals. Fresh fruit was available between meals and people were offered regular drinks throughout the day. One relative said the person was finding it increasingly difficult to eat and they were pleased the person was being taken to dining room ahead of others so staff could encourage and prompt them to eat. We looked at people's weight charts, and saw people's weight was checked regularly and there were no concerns about weight loss.

The provider had recently introduced a cooked/chill range of meals for the lunch and evening meal. Staff said the new service catered well for people on special diets and those needing a high calorie diet. People chose their food preferences from a menu each day. People's feedback was very mixed about these changes and most people said they much preferred the previous arrangements of freshly prepared cooked food. Most people were critical of the main meals, but were more positive about the dessert options. One person said, "The food was excellent, but following the changeover, it's not as good as it was, its edible but sometimes it's not very nice". Another person said, "Sometimes I enjoy it, other times not". A third person said, "It's not too bad". Staff said people were not very happy about these changes.

A relative contacted us directly to raise their concerns about the introduction of cooked/chill meals. They said, if their relative had capacity, they did not think this would be in line with this person's individual preference about meals.

Requires Improvement

Is the service effective?

We asked senior staff how people and relatives had been involved in the decision to introduce cook/chill food to the home. They explained there was a taster day where people were invited to try out different meal options .

People had access to a very attractive walled garden that people could access freely as they wished. This was particularly good for a person who was restless and liked to keep moving throughout the day. We were concerned that one person who lived upstairs could no longer come downstairs, as they could only access the ground floor via a stairlift. This was because they couldn't use this safely because of their challenging behaviours due to their dementia.

The decoration and adaption of the home was not particularly well suited to the needs of people living with dementia. People's room doors all looked very similar, they were varnished with room numbers displayed. There was a lack of signage or other objects of reference around the home to help people identify their own room independently. One person was particularly concerned about whether they would be able to find their room. They kept asking their relative "What's my room number?" Their relative said they would like them to have something on the outside of the door to help them recognise their own room. Another relative also thought the environment was not particularly helpful for people with dementia. They said, "There are no differences in the colour of people's doors and no signs to help people. We discussed this with senior staff at the home, who told us about plans to refurbish and decorate the home. However, the plans did not take into account evidence based practice about environmental improvements to make the home more dementia friendly.

Requires Improvement

Is the service caring?

Our findings

Staff were polite and helpful and spoke kindly to people. Care staff knew people well, about their likes and dislikes and about their families. Care records included details about people's communication needs. For example, how one person was somewhat deaf but had better hearing in their left ear and used hearing aids, and staff were advised to speak clearly to them.

Relatives and friends were made welcome and visited regularly throughout the two days we spent there. Staff helped people keep in contact with relatives, for example, one staff said to a person " I e mailed your brother some photos of your birthday yesterday….he sends his love".

The atmosphere in the lounge was pleasant, calm and friendly, people greeted each other and one or two chatted. People and relatives spoken highly of staff and the care they received. One person said "They look after me very well", another said, "Staff are good, it's lovely and warm here". A relative said, "Staff are great, caring". Another relative said, the staff are "quite alright, mum is always clean, warm and well looked after". A third relative said, "Overall mum cared for kindly, she is looked after well". Health professionals said staff at the home were very caring.

People looked clean and well-presented when we visited. One relative said the person sometimes looked like they were dressed a bit hurriedly. Another relative said occasionally they had some issues with the standard of personal care provided. They explained the person needed supervising with washing and dressing and prompting with their personal hygiene. On occasions, they found the person wasn't properly dressed, and might be missing underwear or a sock. On one occasion, the person did not have their hair washed for a fortnight. Two visiting professionals also commented that occasionally people were not washed when they visited and that one person had rather long fingernails. However, we did not see this during our inspection.

People confirmed staff supported them sensitively and promoted their dignity when assisting them with personal care. They knocked on people's doors before they went into people's rooms. Some people preferred to stay in their room and their wish to do so was respected. A couple of people had "do not disturb" signs on display up so they could spend the morning undisturbed. Staff addressed people appropriately and spoke to each person in a polite and respectful way.

One person who had fallen had bed rails around her bed and needed to call for help to get out of bed. They said, "After I had the fall they've put a rail up on my bed and I would like to be able to get in and out myself". When we asked about how this decision was reached they said they thought it was discussed with them and they had agreed to it reluctantly, for their safety, which we saw in their care records. They said they were not aware of any plans to try and improve their independence.

We asked staff at the home for a list of people who lived there so we could go and meet them and ask for their feedback. Staff gave us a list they used for staff handover, which included information about people needs. However, it also included some comments about some people which weren't very respectful, for example how one person could be "noisy", and another "demanding and complaining". We discussed this with the area manager who agreed this was not very respectful or professional and said they would replace this list.

Two people who lacked capacity, were at risk of going out the garden gate had their pictures displayed on the inside of the gate with a note to alert visitors not to let them out unescorted for their safety. We did not this was very respectful for those people. We asked one person's relative whether this decision was discussed with them and they confirmed it had been. Staff had also spoken to the local authority deprivation of liberty team and person's GP about this.

Requires Improvement

Is the service responsive?

Our findings

Prior to coming to live at the home, each person had a pre admission assessment to confirm the home was able to meet their needs. The provider information return highlighted other professionals such as the person's GP, other health professionals, people and relatives were also involved in this process.

People gave varying feedback about how they were consulted and involved in decisions and planning their own care. One person said, "You become institutionalised… it's authority so I just accept it'. However, a second person said they were very much in charge of making decisions about their own care. They described how they had asked to move to a bigger room when their mobility deteriorated to accommodate the extra equipment they needed. When we asked a person whether they could get up when they wanted to they said, "I get up when I supposed to, I don't like to rock the boat" but they said they were not unhappy about the time they got up each day. Relatives confirmed staff did discuss people's care with them but said they were not involved in developing and reviewing their care plans. One relative said they hadn't had regular contact from staff about their relative since the previous manager left, although staff did let them know when the person became unwell.

The care provided was focused on completing tasks and staff worked to daily routines rather than centred on people's individual needs, to ensure people had regular care. For example, staff had a daily work task list they used to organise and deploy staff to undertake tasks that needed to be completed. This included undertaking a "continence round" mid-morning and before supper to help people use the toilet and provide personal care. Staff also used a predetermined list of people who were bathed or showered on set days of the week. This demonstrated people's care was not always based on the individual needs and preferences but on set routines at the home.

The provider had a complaints process in place. In the provider information return, the provider reported they had received 19 compliments and 1 written complaint. This complaint was dealt with in accordance with the complaint procedure. We asked people visiting relatives about their experience of raising concerns and complaints with the provider. Most people said they were happy to raise concerns with senior staff and were confident they would be dealt with. One person and their relatives said they had some concerns about the care and some of the staff at the home. However, they did not want to discuss these concerns with us, they said they were reluctant to do so in case it impacted on the care of the person at the home.

Relatives told us about their day to day experiences of raising more minor niggles and grumbles. A relative had raised concerns about the person's standard of personal care, and we found this was documented in the persons care records and action was taken in response to address their concerns. Another relative said they had to follow up with a senior manager why the clock hadn't been put back on the wall in the lounge following redecoration. This was because the person was upset by not knowing what time it was and they arranged to have the clock put back.

Another relative told us about an issue where they felt their suggestions were not being acted on. They explained the person needed prompting and coaxing with all their care needs. The relative spoke to staff on several occasions when the person was due to be visited by the chiropodist. They requested the person wear socks under their trousers on these occasions to make the chiropody care easier and prevent their relative become distressed by having to be undressed. They left 'post it' notes to remind staff about this. However, their request was not followed and the person was upset. They said they were told it was not possible to stipulate what the person would wear. When we discussed this during feedback, the area manager agreed this was a sensible suggestion for this person and said they would make sure this happened in future.

There were regular residents/relatives meetings. Minutes of two residents and residents relatives meetings in September and November showed with ideas and suggestions were invited about activities and entertainments. Plans agreed included shopping trips, attending a church service and plans for Halloween and Christmas. At the September meeting plans to refurbish the lounge were discussed. At the November meeting, food was discussed and it was reported that everyone seemed happy with it. However, these minutes did not show which people and relatives attended and was not in accordance with the feedback we received.

Relatives who attended the meetings said they raised some issues and suggestions but were unsure what had happened as a result. For example, one relative suggested having a notice board in the lounge to remind people with

Is the service responsive?

memory problems about the day. Another relative asked about ways to help people to locate their rooms independently. A relative said they had attended the meeting but did not receive any minutes. When they asked about this they said they were told staff was not allowed to circulate them. We followed this up with the provider who said the minutes are on display on a notice board in the home, and on a blog and that additional copies can be provided, on request.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

An activities co-ordinator worked two days a week at the home. The forthcoming Christmas activities programme which included carol singers, quizzes, musical and craft events, skittles, and an outing to the pub. On the first day we visited, several people were making Christmas decorations for the lounge with the activity co-ordinator. People helped one other to select strips of paper to make paper chains. This was physically and intellectually challenging for some people and staff encouraged them and praised their efforts.

One lady speaking about the musical entertainment aid, "It's wonderful. The one who does this with her fingers. (imitating harp) oh it's beautiful… and the girls who do this (imitating drumming)… and the singing, it's making me cry." A visitor praised the activities available for people. One person enjoyed making Christmas card with a family member, and another person enjoyed the carol singing. A person who spent most of her time in their room said: "I'd like to go out more…along the seafront in my wheelchair…(name of staff) takes me out when she can but it's only been once or twice…I used to go to film club in the town but that's stopped…staff haven't got any time". They said they enjoyed when staff came and had a chat and would like to chat more often to people they like and get on with. Another person said, "Staff pop in and out with drinks for them but they don't stay long, they said, "There is very little company, sometimes I'm a little bit lonely".

On the second day we visited, there was no activity co-ordinator on duty and there was very little stimulation or activity for people. The television was on very loudly but people weren't watching it. Some people had a daily newspaper, and in the afternoon a member of staff sat with one person to help them read it.

The activity co coordinator demonstrated a good understanding of people specific needs. They used reminiscence to help people remember past experiences and had an activities "rummage box" specifically to stimulate people living with dementia. However, these were only available when the activity co-ordinator was on duty as they said these had to be tidied away at the end of each day. This meant they were not available at all times when people wanted to use them. A professional who visited the home regularly expressed concern about seeing people sitting in the lounge for long periods with no activities or stimulation.

Care records were variable. Care plans about people's needs lacked detail for staff about how to meet people's specific care needs. For example, one person's continence care plan showed the person needed assistance with using the toilet and used incontinence pads. The care plan instructed staff to assist the person with this and change their pad as needed. This did not take into account how staff might anticipate and improve the person's continence needs by offering them opportunity use the toilet more regularly. These brief care plans meant there was a risk people's care needs were not being met. A health care professional said challenging behaviour records were poorly completed and didn't give enough detail about the behaviour and triggers, which made it more difficult to assess and advise staff.

However, other aspects of the care records included detailed information about people's likes and dislikes, what aspects of care the person needed help with and what they could manage themselves. They also included people's preferences, for example, that one person liked to go to bed early and another liked music and going for a walk along the seafront. They also included details of people's moving and handling needs, how many staff were needed and aids needed to safely transport the person. Staff completed detailed daily records and records of repositioning people and people's food and fluid were well completed.

The provider outlined plans to implement a new "Full person centred care plan" at the home once the new manager started. We were shown an example of this and saw, when implemented, this would provide much more

Requires Improvement

Is the service responsive?

detailed information about people's needs and was particularly focused on the needs of people living with dementia and how staff could help them to remain as independent as possible.

Requires Improvement

Is the service well-led?

Our findings

At the time we visited, there was no registered manager in post, they were due to start the following week. They have since started and have registered with the Care Quality Commission. The previous area manager had left a few months previously and there had been some interim leadership arrangements in place. One relative said, since the manager left, "I haven't felt there has been anyone I could speak to, there is a lack of consistency". However, a new area manager had started and was in their second week in post and was spending a lot of time at Netherhayes getting to know people and staff, which everyone was very pleased about.

The leadership style was a very "top down" approach with a number of decision makers. These included the lead partner, a director of care, an area manager and the home's manager. Staff described having to get permission from different senior staff to make small changes. Some relatives described reluctance by senior staff to take forward simple suggestions for improvement. No survey of people, relatives or health professional had been carried out since our last visit. Two professionals described some staff as "defensive" when they gave feedback about areas for improvement.

During our feedback on the findings of the inspection, we found some senior staff demonstrated a poor knowledge of the Mental Capacity Act 2005 and Deprivations of Liberty safeguards and their responsibilities for people in relation to this. We also discussed information available about simple evidence based improvements which would make the environment of care more dementia friendly. Staff agreed to review this information before proceeding with their planned redecoration.

The provider had a range quality monitoring systems in place to identify, assess and manage risks relating to people's health, welfare and safety. The changes in leadership and interim arrangements meant some systems such as staff training, supervision and appraisal had lapsed. However, other quality monitoring systems in use were inconsistent and had not highlighted some of the risks and breaches of the regulations we found during the inspection.

A managers meeting were held every other month attended by the managing partner, area manager, director of care and home's manager. The minutes over a six month period between July and November 2014 showed a variety of issues were discussed such as health and safety issues, repairs needed and the replacement of equipment. Incidents such as people's falls were monitored and a selection of care plans were reviewed. The quality monitoring systems were reviewed and signed off by the provider. For example, the fire log book, staff training records and fridge temperature monitoring. However, these monitoring systems were not fully effective as they did not highlight some of the gaps issues we identified during the inspection such as the lack of mental capacity assessments, some poor quality care plans that lacked detail and gaps in the medicines fridge temperature monitoring.

The provider is required by law to notify the Care Quality Commission of significant events such as deaths, and any allegations or instances of abuse. Notifications were not always appropriately reported to CQC during 2014.This suggested the systems in place were not fully effective at identifying when notifiable incidents had occurred, or for ensuring the necessary notifications were made.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Senior staff acknowledged things had had slipped at the home over the past few months, that some systems had lapsed and outlined planned improvements. These included plans to introduce more individualised care record documentation, once the new manager started. Also to improve staff training, monitoring attendance at training and to reinstate staff supervision and appraisal systems. Since the inspection, the new registered manager told us they planned to meet with community nurses to introduce themselves and work together to meet people's care and health needs.

There were effective systems in place for managing health and safety at the home. We saw systems for regular servicing and maintenance of equipment, electrical testing and servicing of heating systems. There were legionella controls in place to reduce the risks in the hot water system. (Legionella is a bacteria that can grow in hot water systems which can cause a serious pneumonia like illness).

Staff had a staff handover meeting each day where key information about each person's care was shared. This meant staff were kept up to date about people's changing

Requires Improvement

Is the service well-led?

needs and risks. Staff had met with the new area manager and were positive about plans for further staff training. There were no records of any staff meetings held prior to that, although some staff confirmed there had been some staff meetings. This meant it was difficult to see how staff were consulted and involved in the running of the home and in making improvements.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People were at risk because the provider's did not have an effective system to assess and monitor the quality of service that people receive. This meant people were not protected against the risks of unsafe care and treatment. This is a breach of regulation 10 (1) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People did not always experience care, treatment and support that met their needs and protected their rights. People were at increased risk because people with behaviours that challenged the service were not adequately managed. This is a breach of regulation 9 (1) (b) (i) and (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People were at risk of not receiving their prescribed creams and ointments because the arrangements in place to administer them were not effective. This is a breach of regulation 13.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements. We had concerns some people may be deprived of their liberty without authorisation. This is a breach of regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: People were not always cared for by staff who were trained and supported to deliver care and treatment safely and to an appropriate standard. This is a breach of regulation 23.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: People were not consistently supported to be involved in making decision about their care. Their views and experiences were not sufficiently being taken into account in the way the service was provided. This is a breach of regulation of 17 (1) (a) (b) and (b), 2 (c) and (d).