Nethercrest Care Centre (Dudley) Limited

Nethercrest Residential Home

Inspection report

Brewster Street
Netherton
Dudley
West Midlands
DY2 0PH

Tel: 01384234463

Date of inspection visit:
04 October 2017
10 October 2017
11 October 2017

Date of publication:
11 December 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 04, 10 and 11 October 2017. The inspection visit was unannounced on 04 and 10 October 2017 and we then announced our return on the 11 October 2017 to continue our inspection.

Nethercrest Residential Home is registered to provide accommodation and personal care to a maximum of 43 older people who may have a diagnosis of dementia. At the time of the inspection there were 41 people living at the home.

The inspection was a responsive comprehensive inspection and was taken to follow up on serious concerns that had been brought to our attention by the provider and a whistle-blower with regarding to Nethercrest Nursing Home which shares a site with the residential home. These concerns included people sustaining fractures, people being dehydrated and having unexplained bruising. Due to the severity of these concerns, we took the decision to also inspect Nethercrest Residential Home. We have also shared this information with partner agencies.

There was no registered manager on site during our inspection visits, as they were on leave on the first day of our inspection. One the second day of our inspection we found the registered manager had been dismissed from their post. 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. Nethercrest Residential Home was being run by a new manager, who had been in post for two days on the first day of our inspection.

At our last inspection in September 2016 we rated the home as 'Requires Improvement'. We found staff did not always manage risks to keep people safe, that there were not always enough staff available in communal areas, that staff training was not always up to date or specific to meet the needs of the people being supported. We also found that staff did not always know how to support people in line with Deprivation of Liberty Safeguards (DoLS) and there were no systems in place to ensure people's dietary requirements were being met. In addition, there was no registered manager in post at that time and audits completed to monitor the quality of the service had not identified the issues raised at the inspection.

We found similar issues on this inspection. Improvements to the service had not been made and there had been a further deterioration in the quality and safety of care people received. We found that people were not cared for safely and were at risk of harm. We identified two safeguarding concerns at the home during our inspection visit and these were referred to the Local Authority.

People were supported by insufficient numbers of staff with the right skills and competencies to meet their needs. Occupancy levels had increased but staffing levels had remained the same. People's dependency levels had been assessed, but some of the information recorded was incorrect and was not used to assess staffing levels in the home. People had been admitted to the home with complex needs and staff were not

provided with the training, guidance and support on how to support these people safely and effectively.

Staff practice was not observed and management could not be confident that people were being supported safely and in line with their assessed needs. A lack of effective management and deployment of staff meant that people were not always supported in a timely way.

People were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and DoLS. This meant people were at risk of being unlawfully deprived of their liberty. The provider had failed to notify CQC when authorisations to deprive people of their liberty, had been made.

Accidents and incidents were not consistently recorded and there was no analysis of events taking place that would ensure lessons were learnt and risks to people were reduced. Professional advice was not always sought in response to people's changing needs.

People were not always treated with dignity and respect and the environment did not promote people's dignity.

Care records did not provide staff with the information and guidance required to meet people's needs. People were not routinely enabled to contribute to their care plans that would enable them to live their lives as they wished.

There was a lack of management oversight by the provider to check delegated duties had been carried out effectively by the registered manager. Staff felt unsupported and not listened to. Quality assurance systems in place had failed to identify a number of concerns that were found during the inspection. Information collected in audits including accidents and incidents, safeguarding concerns and complaints were not analysed for any trends.

Relatives and some people were happy with care provided and were satisfied with the service received. However, other people were not happy with the care and level of service provided.

Because of our concerns, we have rated the home 'Inadequate'. This means the legal requirements and regulations associated with the Health and Social Care Act 2014 were not being met. The overall rating for this service is 'Inadequate' and the service has been placed in 'Special Measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If there is not enough improvement and there is still a rating of inadequate for any key question or overall, we will consider the action we need to take in line with our enforcement procedures, to bring about improvement. This could include action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration and, if needed, could be escalated to urgent enforcement action.

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

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.

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.

People were supported by staff who did not have the training or skills to manage the risks to them on a daily basis and keep them safe from harm. People did not receive their care in a timely manner. Staffing levels were not based on people's needs and had not been increased in line with occupancy levels. Opportunities were missed to learn lessons from accidents and incidents. Recruitment processes in place could not guarantee that people were supported by staff who were competent and well trained in their role.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the relevant training, skills and support to provide people with effective care. Requirements of the MCA and DoLS were not fully understood and people were at risk of being unlawfully deprived of their liberty. Professional advice was not always sought in response to people's ongoing healthcare needs.

Is the service caring?

Inadequate

The service was not caring.

People described some staff as kind and caring but did not have the time to spend with them. Staff did not have the skills to support people when they became agitated and distressed. Care provided was task focussed and people were not treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

Staff did not always respond to people in a timely manner and

their response to incidents was reactive rather than proactive. People were not routinely involved in their care plans or reviews. Care records were not up to date and did not provide staff with the information they required in order to meet people's social and healthcare needs. Complaints were recorded and investigated but not analysed and reviewed to see what lessons could be learnt.

Is the service well-led?

Inadequate

The service was not well led.

Systems and processes in place did not provide staff with the tools to do their job effectively and safely. Records did not reflect people's care needs and there was no analysis taking place of incidents or accidents that would ensure appropriate actions were taken to reduce risks to people. Staff raised concerns but these were not acted upon. Management systems were in effective in identifying where improvements were required. There were a number of shortfalls in relation to the service people received, which meant people received care and treatment that fell below required standards.

Nethercrest Residential 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 04, 10 and 11 October 2017. The first two days of our inspection visit were unannounced, on the third day the registered person knew we would be returning. The inspection was carried out by three inspectors.

The inspection was a responsive comprehensive inspection following a number of concerns we had received from the provider and a whistle-blower regarding people's well-being and safety.

Before the inspection took place we looked at our own systems to see if we had received any concerns about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection of the home.

We spoke with 15 people living at the home and three relatives. We spoke with the Nominated Individual, the new manager, the head of quality assurance, four members of care staff, the maintenance man, the cook and a visiting healthcare professional.

As some people were unable to tell us their views of the service, we used a Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We used the information the provider sent us in the Provider Information Return. This is information we

require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We looked at 13 care records, two staff recruitment files, and seven medication records. We also looked at records kept on accidents, incidents and complaints as well as staff training records and audits completed to assess the quality of the service provided.

We held a meeting with the provider on the final day of our inspection to determine what actions they planned to take, following the concerns identified.

We have reviewed the information received from the provider following our inspection visits, as part of the inspection process.

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2016 Safe was rated as 'Requires Improvement' because there were not always enough staff to meet people's needs and staff did not always manage the risks to people to keep them safe. We have rated Safe as 'Inadequate'. This was because we identified several breaches of the regulations, there were not enough skilled and experienced staff to ensure people's safety and people were not receiving safe care and treatment.

We found that people were at risk of harm. We observed that staff were unsure how to support people safely and were not following people's moving and handling guidelines. We asked a member of staff how they had supported a named person to move from their bed to their wheelchair. They told us, "We use the slide sheet to get [person] up. We fold it and put it under their bottom and then they can weight bear." This contraindicated what was recorded in this person's care records which indicated they should be hoisted by two members of staff. We observed staff to support a person from a chair to a wheelchair. The staff supported the person using poor moving and handling techniques, resulting the person falling back onto the chair. We reviewed this person's risk assessment and it stated this person required two people to support them in all transfers. Therefore the person was not being supported in line with their risk assessment. We also found following this incident, this person was supported to their room by one member of staff. This person told us there was only one member of staff available to support them instead of the required two. They told us, "I'm a two person lift, only one [care staff] came in. They had a hell of a job to lift me and down on the floor I went. I had a hell of a bump." The inspector had overheard this taking place and had heard the person cry out, "You're breaking my leg." The provider reported this incident to the safeguarding team for investigation.

We found that people were not being supported in accordance with their catheter healthcare plans. We found one person had not had their catheter bag changed in line with their risk assessment, placing them at risk of infection. We found that another person had their catheter bag changed but staff had failed to follow appropriate guidance to ensure it was fitted appropriately and safely. This resulted in an indentation in their skin and the risk of causing the person pain and distress. A visiting healthcare professional advised inspectors that another person had their catheter incorrectly fitted resulting in pain, discomfort and distress. Training records seen indicated that staff had not received training at the service in how to carry out this procedure.
We found there were inconsistencies in people's care records as detailed guidance was not available in each person's records for staff to follow when caring for people's catheter. This meant the provider had failed to ensure that staff had access to the required guidance and training to ensure they could support people with their catheters safely.

We reviewed how people were supported with pressure relief to prevent sore skin. We found that one person had a pressure sore grade 3. The persons care plan contained conflicting guidance for staff to follow with regard to the frequency of their pressure relief. For example, some records stated two hourly pressure relief, others stated hourly. This person was resistant to personal care which meant staff were not always able to support them to have regular pressure relief as recommended in their care records. Staff were not aware of

how to safely manage this situation and care records seen did not provide staff with the guidance to support the person to receive pressure relief. This meant the person was at risk of not receiving the care they required to provide pressure relief.

People were placed at risk of harm and distress because staff did not have access to guidelines to direct them when supporting people with behaviours that could be challenging. A member of staff told us, "Some residents we can't manage. We had reported this to the previous manager". On 10 October 2017 we observed three incidents with respect to people living in the home. The first incident involved a person throwing a drink over another person. Staff responded to the incident, by offering support to both people, but staff had not intervened to prevent the situation from escalating. We observed another person strike a member of staff as they tried to support them. This person was verbally and physically aggressive towards staff. We observed at one point, three members of staff try to support this person but they were unsure of what to do to ensure the person and themselves were safe. We observed another person become distressed and agitated when staff tried to support them with personal care. The person was resistant to this support resulting in them striking out and scratching a member of staff. Care records we reviewed did not provide staff with detailed information about people's anxieties, the triggers of people's agitation and distress and how these should be managed to reduce the risk of harm to themselves, other people and the staff. We found there was inconsistent recording of such incidents and no analysis of these events which would assist staff in understanding why people became agitated or distressed. In addition to this staff had told us they had not received any training about how to support people with behaviours that could be challenging.

The provider told us in their Provider Information Return (PIR) that they analysed incidents and accidents but we found no evidence of this. We saw that accidents and incidents were recorded inconsistently. There were a number of incidents where people had unwitnessed falls but there was no evidence which would show that these incidents had been looked into, that lessons had be learnt or preventive measures put in place to reduce the risk of harm. We saw that accidents and incidents were not always recorded at the time they occurred. For example, where people displayed behaviours that were challenging or aggressive.

This is breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Safe care and treatment

People told us they thought there needed to be more staff in the home and our observations confirmed this. We noted that support was task focussed as opposed to person centred. We observed people were left in the communal areas without support or supervision and staff response times to call bells were poor. We saw at lunchtime, one person calling out, "Is that my cup of tea? Can I have that cup of tea?" several times. Staff were busy supporting other people but no one answered and the person became upset because staff were not responding to them and offering reassurance.

People provided us with examples of having to wait for call bells to be answered. One person told us, "Sometimes I've had to wait an hour, up to an hour and half and sometimes it's been longer than that. I've turned it [call bell] off. It's a waste of time." Another person said, "Makes no difference pressing the buzzer. I'm frightened to, they say I'm a nuisance." We saw a person had pressed the buzzer at 9.20 am and staff did not have the opportunity to support them until 10.00 am. A member of staff acknowledged the delay and told us, "I know [person's name] is still buzzing, we would have been there earlier but we had to deal with an incident." A relative told us, "I think they could do with more staff." They added that they had noticed one person kept asking to go to the toilet, they told us, "They [staff] kept saying, 'we'll take you in a bit'. They did come in the end." Another relative commented, "They are possibly understaffed. I was here the other day and the phone just rang and rang." Both relatives spoken with told us that on the days of the inspection, that 'there were staff everywhere', adding, and 'It's not always the case.' A member of staff told us, "It's been a

good home but I think we've got the wrong residents. We had 28 residents in January and it was nice and a pleasure to come to work, but in the last few months they've filled the beds but the staffing levels have stayed the same."

We observed other incidents which indicated that staffing levels were not sufficient to meet people's needs and ensure people were protected and kept safe from harm. We also observed one person's care plan identified that the person was a risk of choking and staff were to observe the person when they were eating. We saw that there were not enough staff on the floor to do this and the person was not monitored whilst eating their lunch. A member of staff told us, "Everyone is stressed out; we are trying to do our best. You just don't have the time."

People who chose to remain in their rooms told us they felt lonely and isolated as staff did not have enough time to spend with them other than to bring them drinks, food or to complete welfare checks.

Staff told us there was not enough staff to meet people's needs and a staff member told us, "I cannot provide the care I would like as there is not enough staff on duty." We discussed staffing levels with the new manager. On 10 October 2017 she told us that staffing levels had been increased since our last visit to one extra member of staff on each shift. She told us that a dependency tool was in place to assess people's individual dependency levels but staffing levels were not based on the dependency levels of the people living at the home. We also noted that the information held with regard to people's dependency levels was inaccurate and was not reflective of their actual needs. For example, we noted one person's behaviour scored as 'one out of 11' indicating occasional episodes of behaviours that may challenge. However staff advised that this person's anxiety was quite frequent and we observed this during the inspection.

This is breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had failed to ensure there were sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs.

Staff told us that prior to commencing in post, they were required to provide references and complete a check with the disclosure and barring service (DBS). The DBS check would show if a prospective employee had a criminal record or had been barred from working with adults. Records seen confirmed these checks had taken place.

People told us they felt safe in the home. A relative said, "I think [person] is safe here" and another said, "I've never seen anything bad happened to anybody and I am around a lot."

Staff were able to describe the types of abuse people were at risk of and understood their responsibilities for reporting any concerns. We saw where a safeguarding concern had recently been raised, it had been reported and responded to appropriately. However we saw other examples of practice which indicated that staff did not always recognise and respond to abuse, for example an incident where a person threw a drink over another person and also poor manual handling practice which left people at risk of harm.

We saw that medicines were stored safely and securely. People told us they received their medicines on time. We observed staff supporting people to have their medicines, talking to them and telling them what the medicine was for. We saw that the medicine round lasted a couple of hours. Staff told us that systems were in place to ensure the correct amount of time had lapsed before the next medicine was administered and we saw evidence of this. We looked at the medicine records and noted that the medicine administration records had been completed accurately and the amount of medicine administered matched what had been recorded. We saw daily audits in place to ensure the correct amounts of medicine were administered and

signed for. Where medicines were to be given on an 'as required' basis we saw there was guidance in place for staff informing them of the circumstances in which they should be administered. A member of staff told us, "We will try everything else first before we give medication." However, for one person, the guidance was missing. Staff were able to tell us the circumstances in which this medicine should be administered and the protocol was written and in place by the end of the inspection.

Inadequate

Is the service effective?

Our findings

At our previous inspection in September 2016, Effective was rated as 'Requires Improvement' as staff had not received timely updates to training and training was not always specific to the needs of the people living at the home. Also, there were no systems in place to ensure people's dietary requirements were met. We have now rated Effective as 'Inadequate'. This was because systems were not in place to ensure the requirements of the Mental Capacity Act 2005 [MCA] were being met and people were unlawfully deprived of their liberty. Also, staffed lacked the knowledge and training to meet people's specific care needs.

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. Where people have capacity, a mental capacity assessment is not required.

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 MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met.

An effective system was not in place to ensure the requirements of the MCA and DoLS were being met. The provider told us in their provider information return [PIR] that no one living in the home had an authorised DoLS in place. However, we found that authorisations had been agreed to deprive people of their liberty, but this information had not been passed on to all staff. For example, not all staff were aware of which people where subject to a DoLS authorisation and if there were any conditions imposed on these. This meant staff would not be aware of what actions they needed to take to reduce the impact of the deprivation so that their care was delivered in the least restrictive way possible. We found the provider was not meeting the conditions on some of the authorisations we saw. For example, for one person a referral should have been made to a nurse specialist to provide advice and guidance to staff when supporting them with personal care. We did not see any evidence this action had been undertaken. For another person staff were to record all personal care provided and the times the person refused this care and the action taken in response to this. We saw that staff recorded what personal care was offered but additional information as required by the condition was not recorded. Where people had a DoLS in place their care records had not been updated to reflect the restrictions placed on their liberty and information about the relevant persons representative was also not recorded as required.

We found that staff did not work in accordance with the principles of the MCA. For example we found that a DoLS application had been submitted for a person that had capacity to make decisions. This person's liberty was being restricted as staff assumed they did not have capacity to make their own decisions and restrictions were being placed on them as they were prevented from leaving the building when they wanted to go outside. Following our inspection, we were informed that staff were following guidance from

professionals in relation to this person's capacity as opposed to completing their own decision specific capacity assessment. Another person told us, "I do not know the code to go outside and I have to ask staff to open the door for me as they will not me the code". We discussed this with the manager and the code for the door was then provided to this person to enable them to go outside when they wanted to. Both of these examples show that staff did not have the information they needed so that they knew how to support people so that their human rights were met.

Staff we spoke with did not have a full understanding of the MCA and DoLS and how this legislation impacted on their role. Training records showed that not all staff had completed this training to enable them to have the skills and knowledge to support people appropriately.

We could not be confident that people's consent was routinely obtained prior to being supported and observed occasions when people's consent was not gained. For example, we saw staff supporting a person to transfer from their chair to a wheelchair and staff had not asked for their consent prior to supporting them and they did not explain what actions they were about to take. This meant the person was supported with equipment without their permission.

This is breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staff spoken with told us that they required more training. They told us they were concerned that they did not have the skills to meet all the needs of all the people living at the home and support them safely. We looked at training records to help us determine what training staff had received. We saw and staff confirmed, that they had not received training in catheter care or how to support people who were distressed or agitated. We saw that 23 out of 38 staffs practical moving and handling training was overdue. We were told by the operations director that management had recognised the need for staff to receive updated practical moving and handling training. However, where people had received training we saw that they did not implement the training provided. For example, arrangements had been made for one member of staff to complete four days training in manual handling the week before the inspection, with the intention of being responsible for training other staff in the home. When we spoke to this staff member they gave us incorrect information as to how they would support a person with their manual handling needs.

One member of staff told us, "I don't think people are cared for properly. I walk out the door crying because I can't do my job properly." They went on to describe the lack of training when it came to managing people's behaviours that could be challenging, adding, "I've had no training for this type of situation." Other staff spoken with confirmed they had not received training in how to support people who were distressed or agitated and one member of staff described how they were assaulted by one person whilst trying to support them with their care. This meant people and staff were put at risk of harm.

People felt staff had the skills to meet their needs. One person told us, "There are some good staff, mature staff are better, more skilled." One relative said, "I think the staff are trained as good as anybody."

A visitor said, "Staff lack supervision and direction" and we observed this. For example, allocation sheets in place that would inform how each shift was run were unhelpful and ineffective. They were designed with allocating staff break times and manual tasks and not with the needs of the people living in the home. Staff were not deployed to ensure that someone was available in the communal areas at all times in order to respond to people's needs and ensure people were kept safe. Throughout the inspection we observed periods of time where communal areas were left unattended. We asked staff how they organised each shift to ensure people's needs were met in a timely manner. Staff told us they split themselves between the floors but there was no oversight of the shift with regard to who was supporting particular people. One member of

staff told us, when discussing how shifts were run, "We don't know where to run first, even if you try and plan." We saw staff working hard, reacting to situations but they were unable to be proactive in their approach. This meant the poor organisation of each shift left people at risk of harm. We saw that staff supervision was inconsistent, but had recently been re-introduced by the new manager. Staff were unsure when they had last received an appraisal and in staff files looked at we could find no evidence of such meetings.

We saw that people were offered a choice at mealtimes and all spoken with told us they enjoyed the food on offer. We spoke with the cook who was knowledgeable about people's dietary needs and personal preferences. At our last inspection, we observed that not all staff were aware of people's dietary needs. At this inspection, we noted that this was still a problem. For example, a member of staff bought one person a cake. The person told them, "I'm a diabetic, I can't have it." We observed that people chose where they wanted to have their lunch. Some people were supported to sit in the dining room. However, we observed one person had been taken to the dining room in their wheelchair and left at the table sideways on. The manager saw this and spoke to the person, apologised and arranged for staff to support the person to sit in a chair at the table. We saw other people had chosen to sit in the lounge area to eat and had tables placed in front of them, but staff had not ensured that these tables were placed close enough to the person which resulted in food falling into people's lap, impacting on the amount of food that people could then eat.

We found that people were not always supported to maintain good health and have access to healthcare services. For example, we found fluid charts in place were inconsistently completed and could not be confident that all people were given enough fluid to maintain their health. We saw that for one person, their care records recommended they should drink a specific amount of fluid per day. However, their fluid intake was not being recorded or monitored as recommended. This meant there was an immediate and ongoing risk that their health may deteriorate without being noted by the staff. We found that professional advice was not always sought in relation to changes in people's needs. For example, we found that one person had suffered a high number of falls since they had been admitted to the home. There was no evidence to indicate that this information had been analysed with a view to obtaining additional guidance and support. There was no evidence to suggest that for people who were resistant to personal care, had been referred to specialist services. For example a dementia nurse who may have been able to provide staff with the information required to support people safely and effectively. This meant we could not be assured that the person had received the appropriate support from health care professionals to reduce the risks to their health, safety and wellbeing as a result of falling.

One person told us, "They [care staff] are looking after me alright. They work hard, they are really good with me." Relatives told us they were kept informed if their loved was ill and the doctor needed to be called. A relative told us, "They did let me know about [person] problem and they got the doctor out and we are waiting for a scan." On 11 October 2017 we observed a number of people were taken ill with cold like symptoms which had been recognised by the senior staff on duty. The service accessed the local Telemeds service to provide initial guidance and support. This resulted in requests being made for visits from the local GP and some people were admitted to hospital for further treatment.

Inadequate

Is the service caring?

Our findings

At our last inspection in September 2016, Caring was rated as 'Requires Improvement' because staff did not always communicate effectively with people to ensure they were given a choice. We have now rated Caring as 'Inadequate'. This was because we identified there was a breach in regulations and people were not always treated with dignity and respect .

The providers systems and processes that were in place did not ensure that people were cared for. For example there were not enough staff deployed throughout the home to ensure people's need were met in a timely and dignified manner. Staff did not have the skills or knowledge to keep people safe.

People told us and we observed that people were not always treated with dignity and respect. For example, we heard a member of staff comment to a person who was distressed, "I thought you was going to be a good girl today" in an attempt to provide support and reassurance. We also heard a staff member say, "Get up. Get up" their tone was firm and abrupt, whilst supporting a person in their room. We observed one person had spilt their tea down them. The person's cardigan was changed but staff had not changed their blouse which was wet and stained. The inspector spoke to the manager and asked that staff support the person to change their wet blouse which shows that did not maintain people's dignity. We observed two people who required support to wipe their noses and despite several staff seeing this they failed to act to support the person until a visiting hairdresser had to intervene and ask staff to support people in order to maintain their dignity. On two separate occasions we found a person walking in the communal areas without trousers on, only their underwear. They were looking for a member of staff to support them. We observed that staff did provide support to this person when they saw them.

We observed staff support a person to transfer from a chair into their wheelchair. Staff did not engage with the person or explain to them what was happening to them. The visiting healthcare professional bought to our attention that staff had changed one person's catheter bag but had not cleaned it properly and it had faeces on it. These examples meant that the provider could not guarantee that people were consistently treated with dignity and respect whilst receiving care and treatment.

A relative told us how their loved one liked to have a shave every day, but that this did not happen regularly. They also described a situation where their relative had dressings placed on their legs which meant it was difficult for them to take their trousers off. They told us they had purchased new trousers to accommodate this but that they weren't used. This resulted in staff not being able to remove the trousers without them being cut. Staff asked the relative if it was ok to cut the trousers to remove them. The relative told us, "I thought they [care staff] were going cut along the side of the seam. They didn't. They just cut across the leg and made them into a pair of shorts and left the edges frayed. When we visited on Tuesday [person] was wearing them then and when we visited again on Sunday they were still wearing them, even though we had bought other trousers. It didn't seem right for them to be sitting there like that for so long, their appearance is important to them." The relative told us, "I will speak to [manager's name] I think she will put it right, she's a very nice lady."

We saw at lunchtime, some workmen had been bought in to do some work on kitchen door. People were being bought into the dining room for lunch, and drilling was taking place. There were wires hanging from the ceiling onto the floor and people walking around, causing a potential trip hazard. We saw two other people walking round taking measurements. At no point was there any consideration to the fact that these people were in peoples' home, in their dining room, and they were about to have their lunch. We spoke with the handyman who was overseeing the work and said it needed to be done as priority. The inspector told them to stop the drilling whilst people were having their lunch. The manager was unaware of the reasons for the work or the other visitors until the inspector questioned the visitors and informed the manager of what was happening. This lack of organisation and acknowledgement meant that people were not treated with dignity and respect.

We found people were not always clean and the equipment that was in use at the home was not always clean. We found people had mats in place in their bedroom near to their bed which were soiled. Some people were observed to have dirty fingernails and hands. This presented a risk of cross contamination and infection. We found the environment did not promote people's dignity, carpets were stained and some rooms were very bare and lacked any form of personalisation.

This is breach of Regulation 10 (1a) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Dignity and Respect

People told us that some staff were kind and caring and we observed some good interactions which evidenced this, but we also saw a number of interactions that did not demonstrate that people were held in high regard. A relative told us, "They [care staff] do keep [person] showered and shaved and treat them with dignity and respect." However, a member of staff told us, "I would not place a member of my family here, it needs improving."

The provider told us in their Provider Information Return, 'We encourage residents to express themselves and share their wishes and concerns and we will help them to achieve their remaining dreams'. However, we found no evidence of this. For example, one person told us, "It doesn't matter what you want, they [staff] won't let you have anything." They told us they had asked for a needle and thread because they wanted to turn up their trousers and were told they couldn't have it because of 'health and safety'. They added, "They let me have the needle eventually but I had to keep on at them." They told us how much they enjoyed a particular hobby, but were told they wouldn't be allowed to have the glue they needed to carry out their hobby. They said, "I've been ever so disappointed." We raised this with the manager who told us she would ensure that the person had the tools they needed to carry out their hobby.

We saw that care delivery was task led and not person led. Staff routines took priority and care staff had little opportunity to sit and chat with people or pass the time of day with them. On a number of occasions we observed staff walk through communal areas where people were sat, or walk around people who were walking around, without acknowledging them that showed no regard for people

We saw that people were not supported to maintain their independence by the physical environment they lived in. For example, there was no signage available that would help people orientate around the building. Some people's bedroom doors did not have their name or a familiar object or picture on them to enable people to locate their bedroom independently. Some bedrooms we visited lack colour and had not been personalised to enable the person to feel comfortable in their surroundings.

Inadequate

Is the service responsive?

Our findings

At our last inspection in September 2016, we rating Responsive as 'Good'. At this inspection we have rated Responsive as 'Inadequate' because people were not involved in the development of their care plan or reviews of their care. People's care needs had not been reassessed and their care records did not hold the most up to date information regarding their needs. Care records did not sufficiently guide staff on people's current care, treatment and support needs placing people at risk of inappropriate care.

We noted that systems to ensure people or their relatives were involved in the planning of their care were not effective. We saw that a number of people had been admitted without a complete pre-assessment which would provide staff with the information required to meet the person's needs. For example, one person who had been at the home a short amount of time exhibited a number of behaviours which the staff were not equipped to deal with. Guidance was not available in the person's care plan to support and direct staff on how to manage and respond to behaviours of aggression. Staff told us they had not been made aware of the person's particular needs and had raised concerns regarding this as they felt they did not possess the skills to support them safely and effectively. We saw that another person's pre-assessment had highlighted that they displayed, 'verbal, challenging behaviour' and gave an example of this which would indicate that the person may become physically aggressive. A member of staff told us, "We weren't aware [person] could be aggressive." They told us, and records confirmed there was no behaviour care plan in place or advice and guidance for staff to follow to ensure they assisted this person safely without risk of harm to them or the person. Another person had been admitted to the home who's pre-assessment stated they could become 'anxious and shout a lot'. Staff voiced concerns that they had not been told the extent of the person's needs and that they struggled to find ways to support them safely.

We saw that people's care records did not always contain up to date and accurate information. Not everyone spoken with were aware they had a care plan or could confirm they were involved in the development or review of it and records seen confirmed this. Care plans were inconsistent in the information held regarding people's diverse needs, their likes, dislikes and preferences. This lack of detail meant that staff did not always know to how to provide care in a way that met people's individual needs and preferences and could not guarantee that people's rights were being protected.

Some staff had worked at the home for many years and were able to tell us about the people they cared for and what was important to them. There were agency staff working in the home and other staff had been brought over from the home's sister home to support the staff group. These staff did not have the same level of knowledge of people when supporting them. Agency staff had not had the time to read every person's care plans to ensure they had knowledge of people's needs, and in response to this, after the first day of inspection, the provider told us they had introduced 'one page profiles' of each person living in the home to support new staff and agency staff. However, on the second day of inspection, we saw that information was missing on some of the completed profiles. For example, for one person, there was no mention that they had a pressure sore and required regular pressure relief and no mention that they were at risk of choking so people were placed at the risk of harm because staff didn't have knowledge about people's needs or accurate information when meeting their needs.

We saw that information was not always available to staff to ensure they knew how to safely and effectively support people. We saw where people may exhibit distressing behaviour, this was not always identified, or if it was, there was no description as to what this looked like, what the potential triggers were or very little information to guide staff on how to support the person and possibly alleviate their distress. We saw in one person's care plan that staff should sit and talk with the person when they became anxious in order to reduce their anxiety. We did not observe staff following this guidance in a timely way to prevent them reaching a high state of anxiety and had not taken any action to distract them to prevent it from escalating.

People's care needs had not been reassessed and their care records were out of date. Staff described how two people living at the home had deteriorated over time and they struggled to meet their needs. Staff told us these concerns had been raised with the previous manager. We saw that for these people, their care needs had not been re-assessed and analysed in to provide staff with some insight into how to support people in line with their changing care needs. We saw that staff continually reacted to situations without any guidance or support. For example, one person became distressed and agitated when staff attempted to support them. Staff told us this happened on a regular basis but opportunities to learn from these events were lost as they were not always recorded and if they were, the findings were not analysed.

On the first day of inspection we observed little going on in the communal areas. Two televisions were in the lounge area, both showing the same programme. Unfortunately, even though they were in the same room, the sound was slightly out of sync. For a person sitting between the two televisions, this could be confusing as the sound was continually echoed which was quite unpleasant. We saw one person enjoy watching the television but many others just stared into space. The same channel was on all day. We asked who chose what programmes were on and a member of staff told us, "We always have channel three on, I don't know who decides, it's just always on when we come in." One person told us they were "Bored" and another said, "There's nothing going on in the day." A relative told us, "I have seen singers here before and they play bingo. I bring newspapers in and [person] used to enjoy doing puzzles. [Person] seems quite happy when I visit."

On the second and third day of the inspection we saw that singers had been bought into the home to entertain people. We saw that people enjoyed this, people commented on the increased numbers of staff and the difference this had made. The lounge area appeared to be livelier and people were engaged with what was going on. We saw that one television was on and subtitles were displayed to enable people to enjoy the programme over the sound of other activities taking place. The activities co-ordinator also arranged a game of bingo, but there were not enough staff available to ensure everyone present was supported to participate in the game. One person told us they preferred to spend time in their room as, 'there was no one downstairs to talk to'. They spoke positively about staff, but told us, "They are short [staffed] and always rushing about." They told us they were bored and were disappointed that staff did not have the time to come and have a chat with them. Another person told us they preferred to stay in their room, as they enjoyed their privacy. They told us there were some good staff who they could have a sensible conversation with. Another person told us, "I would love to be able to walk out of here" and told us it was nice to have someone [the inspector] to talk to. The inspector explored the reasons for the person's comments and they told us they weren't happy at the home.

There was a complaints process in place and where complaints had been raised formally they had been responded to but there was no analysis in place or evidence to suggest lessons were learnt to prevent a reoccurrence. One relative told us, "If I raise a point it's dealt with. They have the best intentions" and another relative said, "I have had to raise a few things that needed to be done, I reminded them [staff] that [person] needs an extra blanket on their bed." They told us the extra blanket was provided. We saw where complaints had been raised formally they had been responded to but there was no analysis in place or evidence to suggest lessons were learnt.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in September 2016 we had rated Well Led as 'Requires Improvement' as there was no registered manager in post and audits in place to monitor the quality of the service had not identified the issues we raised at the inspection. At this inspection we found the home continued to require improvements in these areas. In addition, we found a number of breaches of the regulations. We found the home was not well led and people were at risk of harm. We have rated Well led as 'Inadequate'. This meant the service has been placed into 'Special Measures'.

When we arrived at Nethercrest Residential Home the home was being run by a manager who had been in post two days. The registered manager, who had been responsible for both Nethercrest Residential and Nursing Homes, had been dismissed from their post and support was being provided to the new manager by the provider's head of quality assurance.

The home has had a history of not being able to retain a registered manager to provide leadership and direction to the staff team. We had rated the service 'Requires Improvement' since February 2016 when it was when it was first inspected under this providers registration.

We found that effective governance systems were not in place to ensure the quality and safety of the service. There were a number of shortfalls that the provider's processes had not identified to ensure timely and appropriate action was taken. For example, we found the audit process had failed to identify that staff lacked knowledge about people who were subject to a DoLS and ensure the principles of the Mental Capacity Act 2005 (MCA) were being followed. We did not see any evidence on audits where this area was looked at to ensure staff had the knowledge required of them to support people in line with this legislation. In addition we did not any evidence that the provider had monitored that staff were working in accordance with the conditions imposed on people's DoLS.

Audits had failed to identify that records and risk assessments were not up to date and did not reflect people's current care needs. Systems and processes in place had not identified these failings and the effect they were having on the people living at the home and the staff who were supporting them.

The providers systems to monitor the care and treatment provided had failed to identify that staff were not completing records contemporaneously and this meant they recorded inaccurate information and their validity could not be relied upon. A staff member told us that the previous manager was very much focussed on the completion of records; even if they weren't a factual reflection of the care that was delivered. Although we were unable to corroborate this, we did observe an occasion where we could not be assured that the records were factual. For example, we saw that for one person, records showed they had been provided with 'juice' at 12.35 pm but at 12.38 pm the inspector had visited the person in their room, found them crying out for a drink. The inspector found there was no juice in the room, therefore we could not be assured that the person had been provided with a drink at 12.35 pm. We also found that staff had failed to record a number of incidents when a person had been aggressive. This lack of recording meant that staff were unable to learn from the incidents, analyse them and learn from the information gathered in order to

respond to people's changing needs. This meant that the provider's systems and processes had failed to identify the impact of a lack of up to date and accurate records and how these affected the quality of care delivered at the home.

The provider's audits had failed to ensure they had oversight of the management of the new admissions into the home. In addition, audits had failed to identify that people were admitted whose needs could not be managed by the current staffing levels and skill mix of the existing staff group. This meant the provider was unaware of the challenges faced by staff within the home.

The provider's audits had not ensured that concerns raised by staff regarding the workings of the home were addressed or responded to leaving staff feeling unsupported, demotivated and not listened to. Staff had told us they had raised concerns regarding physical and verbal aggression displayed by people but that the provider had not taken any action to mitigate the risks to staff.

The provider's systems to monitor staff competencies with regard to moving and handling people were not in place, resulting in people being placed at risk of harm. We found that staff training and supervision was not consistently provided to all staff to ensure they supported people safely and effectively. We found where there were concerns regarding staff competency levels this information was not passed on to the manager.

Systems and processes in place had failed to ensure sufficient numbers of qualified staff were on duty at all times, placing people at risk of harm. People's dependency levels were not always correctly recorded and were not used to assess staffing levels in the home. Staff allocation systems in place were ineffective and staff were unable to be proactive in their approach to meet the needs of the people living in the home.

Accidents and incidents were not consistently recorded and filed. They were not analysed to identify any patterns and trends which would help identify lessons to be learnt and actions to take to make improvements and reduce risks. Care records seen did not effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

A variety of audits took place on a monthly basis to assess the quality of the service provided. However, the information gathered in the audits was not fully analysed and had failed to identify a number of concerns raised during the inspection. For example, we looked at the maintenance records and found a number of jobs had remained outstanding for some time.

This is breach of Regulation 17 (1a, b, c) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Good Governance agree

We found the systems in place to monitor the quality and safety of care people received were not effective. The provider's own quality assurance systems had failed to identify that notifications for five people had not been submitted to the Commission, as is required by law.

This is breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009 (Part 4) Notifications of incidents

A member of staff said, "We have had a lot of management turnover" and went on to describe the impact this had on staff. They told us that staff morale was low. They told us they had raised concerns in the past with the former manager regarding staffing levels, but the response had been for staff to 'make time' [to do your work] and 'do your paperwork'. One member of staff said, "I am aware of the whistleblowing policy, but I don't want to lose my job." This meant that the culture in this home was not open and staff were not

confident to raise concerns

After the first day of inspection the registered manager was dismissed and an interim manager put in place to provide leadership. Staff spoke positively about the new manager in post and described her as 'approachable' and 'visible'. We saw that since being in post they had held meetings with staff and conducted and unannounced spot check during the night to check that people were safe and well. We saw that the manager and provider were now aware of the shortfalls within the home and trying to put steps in place to provide safe care and treatment for people received care and treatment that met their needs and maintained their dignity.

Following our first visit on 4 October 2017, the provider had responded with a number of actions they were putting in place to address concerns raised. This included placing a voluntary stop on admissions, providing an additional member of staff on each shift and a review of all care records.
The provider advised they would be producing a 'pen picture' of each person living in the home. The intention being that it would provide all staff, including agency staff, with an instant picture of people and their basic needs. However, we found that these were not fit for purpose as some information was missing on forms seen.