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Netherclay House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Netherclay House is a residential care home for 42 older people, some of whom are living with dementia. There are 35 bedrooms, as well as five apartments in the grounds.

At our last inspection on 13 and 17 August 2015, we rated the service as good. At this inspection we found evidence continued to support the rating of good in four key questions. From our ongoing monitoring of the service there was no evidence that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Since our last inspection, the registered manager had left. Another manager was appointed but they did not apply to register with the Care Quality Commission (CQC). They then chose to work in another service. This means the service has been without a registered manager for 18 months. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager has been in post since 23 October 2017, the management team said the aim was for the manager to apply to register with CQC in early 2018. We will be writing separately to the registered provider about this matter.

People visiting, living and working at the home gave us positive feedback about the management team. People said they could speak with staff if they had a concern and were confident actions would be taken, if required. There was a strong commitment to staff training, which included recognising and reporting abuse, and increasing the staff team's knowledge and skills. There were sufficient numbers of suitable staff to keep people safe and meet their needs. Recruitment practices ensured people were supported by appropriate staff. Medicines were well managed.

The staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (2005) (MCA). Where people lacked capacity, mental capacity assessments were completed and best interest decisions made in line with the MCA. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Staff supported people to be involved in making decisions and planning their own care on a day to day basis.

People were supported to maintain a balanced diet. People were positive about the food at the service. People were supported to follow their interests and take part in social activities. The provider employed a designated activities coordinator. They ensured each person at the service had the opportunity to take part in activities and social events which were of an interest to them. People said staff treated them with dignity and respect in a caring and compassionate way.

Care plans reflected people's needs and gave staff clear guidance about how to support them safely. Care

plans were individualised. People were referred promptly to health care services when required and received on-going healthcare support.

The premises were well managed to keep people safe. There were emergency plans in place to protect people in the event of a fire. There was a quality monitoring system at the service. People's views were sought through meetings, reviews and questionnaires to continuously improve the service.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Effective	**Good**
Is the service caring? The Service remains Caring	**Good**
Is the service responsive? The service remains Responsive	**Good**
Is the service well-led? The well led domain is now Requires Improvement because of the delay in registering a manager with the Care Quality Commission.	**Requires Improvement**

Netherclay House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Netherclay House provides care and accommodation for up to 42 people. At the time we visited, 35 people lived at the home; four of whom were on a respite stay. The inspection took place on 8 December 2017 and 3 January 2018. The first day was unannounced and carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who is living with dementia. We announced the second day of our visit because of the time period between the two days. On the second day only one adult social care inspector visited.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

We met people who lived at the service and received feedback from seven people who were able to tell us about their experiences. Some people using the service were unable to comment on their experience of life at the home. We spent time in communal areas observing staff interactions with people and the care and support delivered to them. We used the Short Observational Framework for Inspection (SOFI) in the unit. SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We spoke with three visitors and ten staff to ask their views about the service, plus a visiting health professional. We also reviewed the service's own quality assurance system.

We reviewed information about people's care and how the service was managed. These included three people's care records along with other records relating to the management of the service. This included three staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. We also looked at people's medicine records and the systems in place for

managing medicines, and we checked how they were administered to people.

Good

Is the service safe?

Our findings

The service continued to provide safe care to people. People said they felt safe and shared examples with us, "The staff are fantastic. There's nothing they won't do for you. If they hear you stir in the night they ask 'would you like a cup of tea?' I haven't got to worry about anything" and "There's a call bell by the bed. A pendant alarm is optional. There's never a long wait. The night staff are excellent. They say 'ring if you want me or a cup of tea'."

There was always sufficient staff available to meet people's needs. People said they also felt safe because there were enough staff on duty who knew how to support them, which was reflected by the staff rotas. For example, "You get the odd change over, but some have been here for a long time. They are so attentive and so caring, it makes you feel safe and confident" and another person said they felt "Very safe. Someone being here all the time." Records showed the staff team was stable. People told us staff practice showed they were competent; people described staff as "well trained" and quick to respond to their needs without rushing them. Staff were trained in safeguarding and had a good understanding of how to respond to safeguarding concerns. Staff checked with people before admitting visitors to ensure it was someone they wanted to see and felt safe with.

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. For example, disclosure and barring service checks (DBS). These were carried out before potential staff were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

Risks to people were recorded and reviewed with measures put into place to reduce assessed risks. Staff identified which people need extra support to help reduce risks to their health, such as falls. Where people were at risk of fall, their risk assessment identified what equipment was needed to keep them safe. People's care plans contained a variety of risk assessments for issues such as mobility, skin integrity, nutrition and hydration including any special dietary requirements or food allergies and dislikes. Environmental risks were assessed to ensure safe working practices for staff, for example, to promote good moving and handling techniques through training and observation of staff practice.

The service had good systems in place to safely support people with the management of their medicines. There were regular reviews of medicine policies, which ensured current best practice was incorporated into the policy and provided up to date guidance for staff. Medicines were stored appropriately, including those needing additional security. Medicine records (MARs) were well kept and provided an audit trail if there was a medicine error. Systems had been adopted to reduce the risk of errors, including photographs of each person receiving support with their medicines and information regarding known allergies. Staff told us that there had been no medicine errors in the previous six months. They were able to tell us what would happen in the event of a medicine error to prevent recurrence and share learning. Medicine audits were conducted on a monthly basis and MARs charts were checked weekly to help keep people safe.

One person was having medicines administered covertly. There is a process that must be followed prior to

the administration of covert medicines. Namely that a mental capacity assessment is conducted and recorded. If the person is assessed as lacking the capacity to make a decision regarding their medicines then a best interest meeting is held involving staff, family members and external professionals. The person's GP had authorised the administration of covert medicines as being in the person's best interest, although a review date had not yet been recorded. A review date ensures that covert medicine administration only occurs when necessary and is not a permanent option.

People were supported to retain their independence. Two people were self-medicating and risk assessments had been completed with review dates set. These reviews helped to keep people safe and ensure that they still wanted to/were able to self-medicate. Medicines given 'as required' are known as PRN medicines, staff had been prompt to contact a person's GP to ask for a review when the person requested this type of medicine on a regular basis. Staff said they felt confident in the safety of the systems and that their training had prepared them for the practicalities and responsibilities of their role.

Staff had access to policies and training to help ensure good infection control procedures were followed. A staff member said the staff "are nagged at constantly about infection control." This included the use of personal protective equipment (PPE) such as gloves and aprons. Staff confirmed there was a plentiful supply of PPE and knew the importance of separating soiled and clean laundry. They felt well supported in their role, for example, "I have had training on infection control. We are a team of six. We have all the equipment that we need to do the job. I have brilliant support from the seniors. We know how to do effective hand washing."

Good

Is the service effective?

Our findings

The service continued to provide effective care to people. People said they were provided with effective care and support by staff who were skilled and understood their needs. They said this was because they were "well-trained" and knew how to support people without making decisions on their behalf. People looked comfortable and at ease with staff. A relative said "staff are friendly, kind, considerate and professional."

Staff praised the quality of support and training they received to enable them to perform their role. For example, "my induction lasted a week before I actually did anything. I learnt all about abuse, safeguarding, fire, what to do, manual handling then I had shadowing here. They made sure I was happy and comfortable doing the job ... When learning how to use the hoist the trainer got in the hoist to tell us how it felt. The trainer is brilliant. It's a good place to work and people are well looked after. I get supervision regularly." There were good systems in place to ensure staff were competent. For example, staff training to dispense medications involved both face to face training with the home's trainer and on line training with the pharmaceutical provider that involved booklets with questions and answers. Regular competency assessments were conducted to ensure continued good practice.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity to make decisions MCA assessments and best interest decision meeting records were available. The manager kept a record of all DoLS applications made along with copies of authorisations.

Care workers clearly understood the importance of empowering people to make as many of their own decisions and choices as possible. For example, people told us "I wash myself...They always ask if I need help. They don't come in and say 'we are doing this or the other'" and "I have a shower. They usually come in the morning and say 'do you want a shower today'. Someone always escorts you there and will stay in there if you want them to. At the moment I don't need any help. I am independent at the moment with washing and dressing." We saw how a staff member was inclusive in their approach during a gentle exercise session, recognising when people needed additional support or a clearer explanation or demonstration. They listened to people's views and managed the session at people's chosen pace by observing facial expressions and body language.

Records showed people were offered a varied diet. For example, people told us "They give you a choice of food. You can have what you want. They listen. The china is clean, it's all clean. I have water in my room. If we have a visitor, they bring tea and cakes for your visitors" and "Yes, I like the food. There's not a very big choice, but on the other hand it's very nice." People were supported with drinks and snacks throughout the day, including regular drinks during an exercise session.

Care records confirmed people had access to external health professionals when required, such as GPs. A visiting health professional said "It's a lovely place, the staff are so helpful and it's such a good environment.

I have no concerns I think they are very good here...They treat the residents as individuals and it is not a workplace, it is people's home." Care plans contained a wealth of information such as medical history, continence, nutritional needs, medications, multi-disciplinary team notes and GP notes. Records showed staff were quick to make arrangements to support people with their outpatient appointments.

Netherclay House provided spacious communal areas with a selection of furniture to meet people's individual needs, such as specialist dining room chairs. Signage was in place for people to navigate their way in the home, such as toilet signage and exits. Staff explained how they would provide information in a different format if information needed to be simplified or enlarged. We shared with them that one person had requested a larger print for the home's newsletter as they could no longer read it. Staff said they would take action to ensure people knew other formats could be made available to ensure information was accessible. Records showed that staff ensured people had access to hearing aids and glasses to help them participate in the life of the home.

Good

Is the service caring?

Our findings

The service continued to provide a caring service to people. People and relatives gave us positive feedback about the care provided in the service. We saw staff were kind, considerate and caring. One person told us "I could not have wished for better. My daughter brought me in a picture and I left it on my bed, and when I came back they had hung it up. They are friendly and kind. Yes, you can talk to the staff." Another person told us "I haven't come across anyone who is not pleasant." Relatives told us they felt welcomed and staff recognised people needed privacy when they received visitors.

We observed care workers showed affection throughout their interactions with people. They were friendly and warm in their conversations with people, crouching down to maintain eye contact and touch to communicate. People were cared for by care workers who knew their needs well. People were treated with dignity and respect. For example, "They always knock before they come into the room. I think they are well trained" and "I could not speak more highly of them."

There was an unhurried atmosphere in the home that allowed people time to make their way around the house and supported their independence. We observed staff knocking on people's doors prior to entering. People gave us examples of how staff were polite and respectful, such as when they supported them with personal care, for example "I am not very good at standing. They stay with me. I don't feel embarrassed." Staff were familiar with the specific needs of the people they cared for and could describe how they met people's individual care and emotional needs.

Staff were respectful in their interactions with people and people looked at ease with them. Staff practice and care records showed care workers supported people to meet their choices and preferences. People were supported to be as independent as possible and staff said they encouraged people to do as much for themselves as possible. For example, eating meals or getting washed.

People's social history had also been recorded in their care plan. This gave a 'pen picture' of a person's life history, their interests, likes and dislikes, activities or interests that they had enjoyed. We saw staff used this information as a prompt when communicating with people whose memory and communication skills may be deteriorating. For example, we saw a gentle interaction by a staff member with a person whose communication had become limited due to their stage of dementia. The person responded well to the music playing, tapping their fingers and humming. The staff member used the person's love of music and previous social history to engage with them, which resulted in them dancing together.

Good

Is the service responsive?

Our findings

The service continued to provide responsive care to people. Where possible the manager or deputy would visit the person to assess their needs and discuss their wishes and ways they wished to be supported before they moved to the home. They would also talk with family and other care givers, if appropriate. This information was then used to develop a care plan. We looked at care plans for people with varying needs; this included a person on a short stay whose pre admission assessment had been completed. This ensured staff were fully briefed on a new person's care needs prior to their arrival.

Each person had a care plan that was tailored to meeting their individual needs. We saw these were reviewed on a regular basis so staff had detailed up to date guidance to provide support relating to people's specific needs and preferences. People's care and support was planned in partnership with them. For example, people had signed their care plan. This is important because it signifies that the care plan is developed with the individual and has their agreement. Daily records showed staff were responsive to people's needs as they provided a clear account of how the person had been supported and documented any changes to their health or emotional well-being. Staff could tell us how they supported a person with increased health care needs.

People said the service was responsive to their needs. They told us they felt the service provided personalised care. For example, one person's mood had become low after moving to the home as they no longer attended an external social group and said they missed their friends. Staff contacted the group and asked if the person could attend if care staff arranged transport for them. Staff from the home conducted a comprehensive risk assessment, involved family members and arranged for the person to attend the group. The person's mood dramatically improved after this and they continued to enjoy the company of old friends and the activity that had been so important to them.

The provider had a clear complaints process in place for people, relatives and visitors to the service. People told us staff were approachable and they felt confident concerns or complaints would be addressed. For example, one person said "There was a very noisy neighbour in the room next to me...It was resolved...If there's something I am unhappy with I go to the seniors but it rarely happens. They are very quick and efficient in their response." People said a regular residents' meeting also gave them the opportunity to share their opinions on the running of the service. All complaints were logged, investigated and responded to in a timely and sensitive manner, where necessary discussed with staff as lessons learnt during supervision or team meetings.

People were supported to maintain hobbies and interests. The activity co-ordinator knew people's preferences and interests. The newsletter showed there were regular planned and varied activities including entertainers coming in to the home, exercise, music, cake making, art and crafts. People explained why they liked the range which was on offer telling us the staff member in charge "does it well."

Requires Improvement

Is the service well-led?

Our findings

Since our previous inspection, the registered manager had left the service. Another manager was appointed but they did not apply to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Steps had been taken to keep people, their relatives, staff and visitors up to date with the management arrangements at the home, including an informative letter. An acting manager started on 23 October 2017, they were an experienced member of staff and had worked at the home for four years so were well known to everyone at the home. When we met them, they were on a trial period with the aim to register them with the CQC in early 2018. However, the service had been without a registered manager for 18 months. By having a manager registered with CQC, the service can demonstrate the person is appropriate to the role. We will be writing separately to the provider about this matter.

People knew who the manager was, they said the manager was "very approachable" and "she's lovely, very supportive." Staff were also positive about current management arrangements.

There was a comprehensive quality assurance system in place, which was overseen by a range of staff who had a range of roles for different aspects of the service. We saw feedback from people and their families about the quality of care, including "Thank you for doing such a great job with X, It really is a weight off our mind to know she is being looked after so well."

The management team had created a 'We will...' statement of what steps had been taken had been published to reassure people their feedback was important and acted upon. This was sent out to questionnaire respondents. For example, action had been taken to address issues such as ensuring care plans were written in plain English. Health professionals were also asked for their opinion on the service, there was a high response rate which included many positive comments, including 'staff going the extra mile' and maintaining people's privacy and dignity. Regular meetings were held for staff and people living at the home to influence the service, with minutes kept. The views of people living at the home were valued. For example, there had been occasions when people living at the home had the opportunity to feedback their views on prospective staff.

The premises were well managed to keep people safe. There were emergency plans in place to protect people in the event of a fire. There were a range of regular environmental safety audits. Due to a staff member recently leaving, staff took steps during the inspection to re-allocate their tasks regarding some aspects of the environment, such as hot water checks. There were accident and incident reporting systems in place at the service. Accidents in the home were monitored and ensured staff had acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider had displayed the rating of their previous inspection on their website and in the main entrance of the home, which is a legal requirement as part of their registration.