Care Quality Commission

Nethermoor House Limited

Nethermoor House

Inspection report

131 Chaseley Road
Etching Hill
Rugeley
WS15 2LQ
Tel: 01889 584368
Website: www.friendlycare.co.uk

Date of inspection visit: 5 August 2015
Date of publication: 27/11/2015

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 5 August 2015 and was unannounced. Nethermoor House provides residential care for up to 19 older people. There were 19 people using the service at the time of the inspection, some of whom were living with dementia.

The service had a registered manager. 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.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed. Risk assessments and care plans did not reflect people's current support and care needs and people did not always receive their planned care. People were not always kept safe and their welfare and wellbeing was not consistently promoted.

Summary of findings

Some people who used the service were unable to make certain decisions about their care. The registered manager and provider could not show us that under these circumstances the legal requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were being followed.

People told us they liked living at the home and were satisfied with the environment and staff and the staff were kind, caring and helpful. Staff had a good knowledge of people's individual care needs but made assumptions on behalf of people in regard to choices and options.

People were not consistently supported with their personal preferences because of routines and institutional practices. People were at risk of not receiving their prescribed medication in the correct way.

People told us the staffing levels were adequate but additional staff would be beneficial to provide the care and support to people. Staff were provided with a range of training subjects; however some staff had difficulty with transferring the theory into practice.

People told us they enjoyed the food that was provided and they had sufficient to eat and drink each day. People had access to a range of health care professionals and were supported to attend appointments when required.

Social, leisure and recreational activities were arranged, people were not always offered the choice to participate or not in the entertainment.

People who used the service and their relatives told us the management were open, friendly and receptive. People knew that any complaints they had would be dealt with appropriately. Systems were in place to assess the quality and safety of the home, but at times there were delays in making changes and improvements.

You can see what action we told the provider to take at the back of the full version of the 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?
The service was not consistently safe. Risks to people's health and wellbeing were not consistently identified, managed and reviewed. Care records relating to people's care and support needs were not always accurate or readily available. People were at risk of receiving unsuitable and unsafe care.

Requires Improvement

Is the service effective?
The service was not consistently effective. The legal requirements of MCA and DoLS were not being followed. Decisions were being made by the registered manager and staff without due consideration or involvement of the relevant people.

Requires Improvement

Is the service caring?
The service was not consistently caring. Staff were aware of and knew the likes, dislikes and preferences of people. However, people were not always offered choices and options because at times staff made assumptions on their behalf.

Requires Improvement

Is the service responsive?
The service was not consistently responsive because people's individual needs and preferences were not always considered. Recreational activities were available for people; however people's preferences and interests were not incorporated into the care and support plans.

Requires Improvement

Is the service well-led?
The service was not consistently well led. Quality monitoring systems were in place but action was not always taken to ensure improvements were made in a timely way.

Requires Improvement

Nethermoor 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 was 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 5 August 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. The expert by experience had personal experience of using or caring for someone who uses this type of care service.

We looked at the information we held about the service. This included notifications the home had sent us. A notification is information about important events which the provider is required to send us by law. The provider had completed a Provider Information Return (PIR) prior to the inspection. This 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 used this information to formulate our inspection plan.

We spoke with eight people who used the service; some people were able to tell us their experience of life at the home. Some people were unable to, so we spent time in the lounge areas and observed the interactions between people.

We spoke with two people (relatives and friends) who visited the home, the registered manager and three care staff. We looked at the care records of five people and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Staff told us that some people were at risk of falling due to poor mobility and being unsteady on their feet. Risk assessments had been completed when a risk had been identified. People at high risk of falls had assistive technology such as sensor mats and chair sensors for use in bedrooms and communal rooms. Assistive technology monitors the movements of people and alerts staff when people move out of their chairs or leave their bedroom.

People needing chair sensors, sometimes chose to sit in a different chair. Staff told us that was okay because people could sit where they chose. The chair sensor was not moved with the person when they moved to a different seat. We saw that one person had fallen, (they had been provided with a chair sensor and a sensor mat in their bedroom), which resulted in them sustaining an injury. The risk assessment had been reviewed but had not been changed to identify the additional measures needed to reduce the risks for this person. We witnessed one person fall and saw a number of near misses where people were at risk of falling. People continued to fall and were at risk of harm and sustaining injury even though the service had implemented the use of assisted technology.

We saw one person became very agitated and distressed during the course of the morning. Staff were in attendance and tried to reduce the person's anxiety, with limited success. We asked staff how they supported people through these periods of distress. One staff member told us: "I just use a calm approach, try a different staff member supporting the person. I'd just be calm and use my common sense, we've not had any specific training about how to manage behaviours". The risk assessment recorded that the person could be 'verbally and physically aggressive to staff', however there was no care or management plans to guide and instruct staff on the actions they should take.

Staff told us that some people were at risk of developing sore skin due to immobility. A member of staff told us: "People have mattresses and cushions to help prevent pressure sores and some people have creams, the district nurse tells us what to do and we just follow their advice". Another staff member said: "Some people are at risk of having pressures sores. We put cream on; I think its [name of cream] and [name of cream] that's kept in their bedroom. We don't have to write it down anywhere. We just know if it's in their room we have to put it on". We saw creams and lotions that had been prescribed for people were being used and applied on other people. Risk assessments had been completed for people who were at risk of skin damage; these had been reviewed but not updated when changes were apparent. There was no recorded information of the care delivered.

Some people had been prescribed medication that had very specific instructions about when and how to take the medicine safely. Staff told us and we saw on the medication administration record that a person had been prescribed such a medication. Staff told us how they administered this tablet to the person; their explanation did not correspond with the instructions. This person was at risk of harm because this medicine was being given incorrectly.

Some medication needed two members of staff to administer and to sign a register to indicate that the medication had been given correctly. These medications were recorded in the register, however we saw on occasions only one staff member had signed the register when the medication had been administered. This was contrary to current guidance to ensure people received their medication safely.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff we spoke with had a good understanding of safeguarding and protecting people from harm. All staff said they would report any concerns to the registered manager: "I'd talk to my senior, document it and talk to the manager as well". The manager told us that safeguarding was discussed with staff at the team meetings. All staff had been provided with a booklet that explained the procedures and directed and informed them of the actions they should take.

Relatives told us that staffing levels appeared to be 'adequate most times' when they visited. One relative said there had been times when they felt there were not enough staff available. Some staff told us the staffing levels were sufficient for them to provide the care and support people required. However another staff member told us: "There are enough of us to make sure that people have food and drinks and go to the toilet and things like that but we don't have time to spend with people to just sit and chat to them". We did not observe any delays when people requested help.

Requires Improvement

Is the service effective?

Our findings

People were not always involved in decisions about their care and treatment. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where applicable, decisions were made in people's best interests when they were unable to do this for themselves. Some people who used the service would at times find it difficult to make informed decisions about their care and treatment. No capacity assessments had been completed to establish a person's decision making abilities and best interest decisions were being made by the registered manager and staff.

The registered manager told us no one at the home currently required a DoLS application and people were not subject to any restrictions. However we saw that most people spent the majority of the day in the communal areas and did not leave the immediate safety of the ground floor area. People were restricted to move freely around the home and garden as most doors were locked. Gates were fitted to the staircases to stop people accessing their bedrooms.

We saw on a number of occasions, people getting up from chairs, we heard staff say: "Where are you going? Sit back down". We saw one person walked around the ground floor, looking for the exit; we saw staff redirect them to sit down in the lounge. We looked at this person's risk assessment and it recorded, '[The person] will try to get out of outside doors and try to go into the lift. Therefore they have supervision in communal areas and assistance of one carer with all care needs'. The registered manager told us that this person did not have the capacity to make certain decisions and would be unsafe to leave the building alone due to their vulnerability and lack of insight into their condition. No mental capacity assessment had been completed to determine the person's capacity to make decisions, their consent to these arrangements and whether this course of action was in their best interest and in the least restrictive way.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received on-line training in various topics and subjects. We received mixed views about the effectiveness of this form of training. One staff member said: "I've done Dementia training on-line. It didn't help me to know what to do in situations, I just do what I think is right". Another commented: "The on-line training is good because it highlights some points you may not have thought of". The registered manager told us that all staff had a training account where they can access the on-line training. We saw that there were many topics and that staff had accessed them. We looked at the training accounts for staff which demonstrated they had completed training in medication and challenging behaviour. A staff member said: "We've not had any specific training about how to manage behaviours. I just use a calm approach and use my common sense". Another care staff member said they had not had medication training in this employment as they did not need to give medication. However, the registered manager said that medication and managing challenging behaviour were part of the online training and that staff had completed them.

Staff told us they had supervision every three to six months in some form. Some said they had a one to one supervision and others said they completed self-assessment forms. One member of staff told us: "Supervision is helpful, we get praise when we are doing something well but we also get told if there's things we could do better". The registered manager told us every member of staff had 'some form of supervision' every three months. Supervision meetings gave staff the opportunity to discuss work related issues, their individual training and development needs and obtain information and guidance about people's support needs.

People who used the service told us they enjoyed the food. One person said: "The food is very enjoyable". Another person said: "It's Top of the Pops, good; I get lots of ice cream". We observed the lunchtime meal. There was a set menu and we saw the staff made assumptions about people's preferences. People were not offered a choice of meal; staff did not ask people what they wanted to eat. The care plan for one person guided staff 'to show choices visually to support decision making'. The food was served and placed on the table in front of the person. No visual choice was offered. People requiring a soft diet received this with all the food items pureed together, which did not allow for food preference, individual food flavours or for any discussion about the meal.

Some people who used the service had complex needs requiring specialist care and external professional advice. People were supported by a range of health and social care

Requires Improvement

Is the service effective?

professionals which included regular GP consultations, optician, chiropody and district nurses. Staff told us that some people's mobility was poor which had resulted in people sustaining injuries. The registered manager took the necessary action and made referrals to the falls specialist team for the people identified as being at risk. One person attended a dental appointment, they told us a taxi had been booked and they were ready to go to their appointment.

Requires Improvement

Is the service caring?

Our findings

Some people were supported with making choices and decisions about everyday issues. Care plans guided staff to support decision making, especially for people who struggled to make their own decisions, with 'encouragement and prompting'. We saw some staff made assumptions about what people liked and disliked and did not give people the opportunity or time to choose for themselves. However, some people were supported with making choices and decisions about everyday issues. One staff member said: "I help people to make choices by prompting them and encouraging them, for example, I always open the wardrobe door when I am supporting people to get dressed and show them what they can choose from, it helps them to be able to see it rather than just being asked".

Most people told us the staff were kind and caring. A person said: "The staff are great". Relatives reported the staff were 'Okay'. One person was very unhappy, we spent time with them and listened to what they had to say and tried to offer reassurance. The person was a little happier and settled following our conversation.

We observed caring interactions between staff and people who used the service. We saw a staff member get a personal photograph album out for one person, they showed them the pictures of places they had been on holiday in the past and asked them questions about their memories. We saw another staff member painting a lady's nails, they were chatting, and the lady thanked the staff member. She was very pleased with the manicure and happily showed other people her painted nails.

People's privacy was respected. Staff were careful to ensure bathroom, toilet and bedroom doors were closed when people required support with their hygiene needs. A member of staff told us: "When I support people with personal care I always make sure the door is closed so it's private and make sure the person is comfortable".

Relatives said they could visit at any time although they had been asked to avoid the lunchtime period. They went on to say that if they wanted to visit at lunchtime to support their relative with their meal they felt sure this would be permitted.

Requires Improvement

Is the service responsive?

Our findings

The care and support provided to people was not always responsive to their individual needs. For example, staff told us: "We're not allowed to put [person who used the service] to bed on the evening shift. We put about 10 people to bed to help out the night shift, and the night staff have to get people up in the morning, about six people". The registered manager told us and we saw there was a routine where everyone was supported to the toilet before lunch. We saw people were compliant with this practice and did not complain or refuse.

Some care plans included people's preferences and what time they liked to go to bed and get up in the morning. One staff member said they had not read people's care plans. They told us they knew people's preferences by just getting to know the person: "I ask people what their preferences are but some people can't talk to you, so you just do what you think is best for them". People were not consistently supported with their personal preferences because of routines and institutional practices.

Recreational and leisure activities were arranged and provided by the care staff in addition to their care duties. During the morning, little structured activity was provided for people as care staff were busy attending to the personal care and support needs of people. In the main lounge, background music was playing through the television. We observed several people were dozing in their chairs and some people told us that they liked to have a sleep during the day.

During the afternoon, a singer performed in the lounge. We observed part of the show and whilst it was clear that some people were enjoying the show, others were dozing throughout the performance. People were not offered the choice of whether to remain in the lounge and to participate in the entertainment or to go to a quieter area within the home. A relative told us people usually liked the singers, particularly when they sung older songs from the 1940's and 1950's and would often sing along. However, they continued to say that many people would not have known some of the more 'modern' songs that were being performed that afternoon.

Staff we spoke with were not aware of a specific complaints procedure but all said they would speak to the senior in charge or the registered manager if anyone raised a complaint to them. The registered manager told us there was a complaints procedure that staff should be aware of. The registered manager confirmed that no complaints had been made recently. There was a suggestion box situated at the entrance to the home should anyone wish to make a suggestion anonymously.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us and we saw that checks and audits were completed regularly throughout the year to assess the quality and safety of care the home provided. The checks included accidents and incidents, fire safety and equipment. The registered manager confirmed the checks were sufficient to quickly identify any areas of concern that may affect the running of the service. However, we saw that a medication audit had been completed where an issue had been identified that needed action. This issue had not been rectified.

We saw there was a lack of consistency in involving people and/or their representatives in making decisions about their care and support needs. People did not receive individualised care and the information recorded in the care plan was not consistently carried out in practice. Staff were kind in their approach but sometimes focussed on the task and not the individual. Staff worked to set routines each day regardless of people's individual choices and preferences.

In June 2015 questionnaires were distributed to people who used the service. Some people had the support from staff to complete them. People commented on the environment, the food, and whether their care and support needs were met. People had the opportunity to make additional comments if they felt the need. One person responded to most questions as being satisfied with life at the home. They made an additional comment that they would like to go out more. The registered manager told us any comments were considered and action taken when it was needed.

Most staff said the registered manager was approachable and supportive. One staff member said: "All the staff are great, we get along and we help each other out, it's a good place to work". One person said the registered manager was not approachable and at times was 'unconcerned' with how they were feeling. People who used the service told us they knew who the registered manager was; they were able to name her. One relative told us about the positive way the registered manager had helped them with planning a person's admission to the home. They had been invited to the home to have lunch and to get a feel of the home prior to making the decision to move in.

Staff knew about the whistle blowing policy and the way they could raise their concerns when they felt the need to do so. One staff member commented they had raised concerns through the whistle blowing procedure and was satisfied with the support offered from the registered manager and how their concerns were dealt with. Staff meetings with the registered manager were arranged at intervals. The latest meeting with staff discussed staffing and work related issues. One staff member told us they thought the meetings were useful.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not safeguarded from abuse and improper treatment.

The enforcement action we took:
We have asked the provider to send us a report that says what action they are going to take.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way.

The enforcement action we took:
We have asked the provider to send us a report that says what action they are going to take.