Nethercrest Care Centre (Dudley) Limited

Nethercrest Nursing Home

Inspection report

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06 October 2017

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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 and 06 October 2017. The inspection visit was unannounced on 04 October 2017; we then announced our return on the 06 October 2017 to continue our inspection.

Nethercrest Nursing Home provides nursing and residential care to older people including some people who are living with dementia. Nethercrest Nursing Home is registered to provide care for up to 41 people. At the time of our inspection there were 27 people living at the home. Two people were in hospital. The home was divided into two floors; there were 13 people on the top floor of the home and 14 people downstairs. Most of the people on the top floor of the home were cared for in bed.

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. These concerns included people sustaining fractures, people being dehydrated and having unexplained bruising. We have also shared this information with partner agencies.

There was not a 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 visit 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. The service was being run by an interim manager during our inspection.

At our last inspection in November 2016 we rated the home as 'Requires Improvement'. We found people's needs were not always met in a timely way during busy times of day. We also found people were not given choices consistently and privacy was not always respected. In addition, audits completed by the registered manager had not been effective in identifying the issues raised in our inspection, information had not been analysed to identify trends or patterns.

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 placed at risk of harm. There were more than 25 identified safeguarding concerns at the home, which were being investigated by the provider, that they had identified during a two week period (up to and following) our inspection visit. This meant some people had been receiving unsafe care.

There was not always enough staff with the right skills and competencies to ensure people were supported safely at Nethercrest Nursing Home. There was a large amount of agency usage for nursing staff, which meant staff did not always know people well. This was as a direct result of a number of recent staff dismissals at the home. This coupled with a lack of up to date record keeping meant people's needs were not being met and placed them at risk of harm.

The facilities and environment of the home required improvement; especially in regard to a part of the home having no hot water, and toiletries, to ensure people were protected from the risk of infection.

We found staff practice was not always sufficient to ensure people received safe and effective care. A lack of effective management and deployment of staff meant people were not always supported in a timely way, or had time to spend with staff when needed.

We found people were not always supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The registered manager and provider had not acted in an open and transparent way and had not consistently notified the CQC and the relevant authorities of accidents and incidents that occurred at the home, and safeguarding concerns had not always been investigated or referred to other agencies in a timely way. There was a lack of analysis following accidents and incidents to identify how these could be prevented in the future.

There was a lack of management oversight by the provider to check delegated duties had been carried out effectively by the registered manager. Quality assurance procedures were ineffective and had failed to identify the concerns that we found in a timely way. There was a culture in the home that was accepting of the neglect of people; people did not always receive the care and treatment they needed in a timely way.

Some relatives told us they felt their family members were safe and were satisfied with the service their family member received. However, most people at the home were unable to tell us how they felt, due to their complex health needs.

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 so 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.

Following our inspection visit, the provider decided to close Nethercrest Nursing Home and to ensure during the closure procedure, that people were cared for safely.

You can see what action we have taken and told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not up to date which put people at risk of harm. Where people were identified at risk of harm, measures were not always taken to keep people safe. Safeguarding procedures were not always followed to investigate issues where these were identified. Staff were not consistent and did not always deliver safe care to people. Procedures required improvement to ensure people had basic equipment they required.

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. The provider did not always ensure people were treated in accordance with the Mental Capacity Act (2005). People were not always provided with the nutrition they needed. People were not always supported to maintain their health and referred to external healthcare professionals when a need was identified.

Is the service caring?

Inadequate

The service was not caring.

The providers systems and processes did not ensure that people were cared for by staff that treated them with respect and dignity and maintained their privacy. Some permanent staff were kind and caring, and knew people well. However, people were unable to make choices about how they lived their daily lives. Staff did not always support people when they became anxious, or unwell.

Is the service responsive?

Inadequate

The service was not responsive.

Staff did not always respond to people when they needed support. Records did not show people's life histories and what

was important to them so people were not always able to receive person centred care. However, some permanent staff knew and understood people's preferences, likes and dislikes and how they wanted to spend their time. There was minimal physical and mental stimulation for people if they were cared for in their rooms. Complaints information was not analysed and reviewed to see where lessons could be learned.

Is the service well-led?

Inadequate

The service was not well led.

People were not cared for in a way that protected them from avoidable harm. Where people and staff raised concerns these were not investigated and acted on straight away to keep people safe. The provider and registered manager's management system was ineffective in identifying where improvements were needed, and where procedures were not followed to always keep people safe. 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 Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 and 06 October 2017. The first day of our inspection visit was unannounced. We inspected the home with two inspectors.

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

Before the inspection visit we looked at our own systems to see if we had received any concerns or 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.

To gain people's experiences of living at Nethercrest Nursing Home, we spoke with two people and four relatives of people who used the service. We spoke with the nominated individual, two members of care staff, a nurse, the interim manager, the head of quality assurance, and observed the care provided to people

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

We looked at four people's care records in detail to see how they were cared for and supported. We also looked at a range of records related to people's care such as medicine records, daily logs, food and fluid charts and risk assessments.

We looked at a range of documents produced by the interim manager and provider which demonstrated how quality assurance was undertaken at the home, and what issues they had identified as part of their on-going improvement planning.

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

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2016 Safe was rated as 'Requires Improvement' because there were not always enough staff to meet people's needs. We have now 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.

The registered manager had been absent for around two weeks prior to our inspection visit. An interim manager had been appointed by the provider, and had taken over the day to day running of the home, during the registered manager's absence. On our arrival, the interim manager told us everyone who lived at the home was being assessed to see whether they had any injuries or bruises, or needed medical assistance. This was following a number of concerns that had been raised at the home by a whistle-blower, and concerns that had been identified by the interim manager during their observations in the previous two weeks.

These concerns included an incident where one person had been taken into hospital with a fracture. The person's injuries had not been identified and treated following a fall at the home. It was estimated the person had not received medical attention for six days. The nurse in charge at the time of the fall had subsequently been dismissed from the home. However, other staff at the home had not raised the lack of treatment for the person as a concern straight away. The provider had now reported the incident to the safeguarding team and other regulatory bodies for investigation.

We found another person had an accident at the home, and had not received medical attention for up to three days. This person was also in hospital receiving treatment for a serious injury. This incident had also been referred to the safeguarding team and CQC by the provider. The incident was also being investigated.

Following an assessment of all the people at the home, which included checking people for injuries, and for their general health; the provider and interim manager told us they had discovered a number of additional safeguarding concerns and allegations of abuse, that were being referred to the safeguarding team and CQC for investigation. These injuries suggested that people had been subject to substandard and neglectful care over a period of time.

The provider was made aware of concerns as they had been bought to their attention by a whistle-blower. These concerns led to a number of allegations of abuse being identified. Allegations included (but were not limited to); people being untreated for identified pressure sores, people not receiving personal care to keep them clean and free from infection. People not having their clothes changed daily. Fluids were not always available for people in their bedrooms. People being found in bed with their clothes on, instead of their night wear. Records being falsified regarding the personal care people received.

The provider told us that although they had identified some concerns at the home, and had acted at that time to place an interim manager at Nethercrest to assist the registered manager, they had not identified the concerns around neglect, or the scale, which were highlighted by the whistle-blower. The provider had put

in place a whistle-blowing service, to encourage staff to speak openly about their observations of care at Nethercrest Nursing Home in response to the first allegations of abuse. This had encouraged staff to highlight more areas of concern at the home, which the provider had begun to investigate.

We spoke with staff about their understanding of potential abuse. Staff could describe different types of abuse and told us they understood their responsibilities to protect people. Staff said they had been trained and told us if they saw anything of concern, they would tell a manager. However, we found there were a number of incidents at the home which were not being recognised by staff in their day to day interaction with people, which called into question their understanding. As some staff were agency staff, we could not access records to confirm they had adequate training in safeguarding people from abuse.

We found people were not always given enough fluid to maintain their health. We saw some people displayed behaviour that was difficult to manage and were abusive to each other and staff. Behaviours could escalate into aggression and violence. These interactions were not being documented so that the incidents could be analysed, to put into place strategies that would minimise these incidents, and support staff to manage these incidents to keep people safe.

We found some concerns had been raised with the registered manager and these had not been addressed by them. This led to one member of staff using the Whistle-blower policy to report their concerns. Another member of staff had contacted CQC to raise their concerns.

The provider continued to check people's safety during the inspection and following our visit the provider confirmed they had identified a significant number of potential safeguarding concerns that were being investigated. They advised us that these would all be notified to CQC.

We found this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse.

On the first day of our inspection visit we saw some people were being supported using a 'PEG' (a tube which is passed into a person's stomach as a means of feeding). We were concerned that one person using this equipment was not being adequately monitored to ensure their 'PEG' was being kept clean, and to prevent infection. We raised this with the interim manager who was also unaware of this poor practice and stated they would review the person's wound straight away. On the second day of our inspection visit we found three people had been referred to a doctor, as their 'PEG' site required review, to ensure the sites were clean and not infected. Three people were prescribed topical cream following these referrals.

We looked at how wounds such as pressure sores were being treated and managed at the home. We saw one person had a grade two pressure sore on their foot. The person's care plan stated they should have their dressings changed every two -three days. We found the last entry on their wound charts was dated 27 August 2017. We were unable to establish whether the person's wound had been treated appropriately and had been redressed since that date. Due to the person's health care needs the person was unable to tell us when their dressing had been last changed. There were no consistent nursing staff to discuss the person's treatment with and confirm when the dressing was changed. We raised this with the interim manager who was unaware of this, and stated they would review the person's wound straight away. This meant the person was at risk of not receiving the care they required and their wound deteriorating further.

We observed some of the communal areas of the home during our inspection visits, and saw how people and staff interacted with each other. We saw staff did not always step in to manage risks to people's safety. For example, on the second day of our inspection visit we saw one person was agitated and constantly

called out for help. They were sitting amongst other people at the home in the lounge area, where staff were working. The person was not answered by the staff in their vicinity. A few minutes later the interim manager came into the lounge room, and went to the person and asked them if they needed anything. Following their conversation, staff were instructed to try and get the person to drink and eat their breakfast, and to interact with them. Every few minutes the person continued to call out for help when they were left without staff support. There were insufficient staff to provide the support that this person needed.

A few minutes later, as staff approached the person they became violent and aggressive and tried to grab at a staff member. We spoke to staff about this person and they told us the person had not slept well the night before, which may contribute to how they were feeling. One member of staff said they often became agitated following personal care. However, care records did not document these observations or record that they had a bad night's sleep the night before. We reviewed the person's records to see how staff were advised to manage the risks to their safety and the people around them, and also how they recognised the triggers of the person's agitation and aggression. We found the records did not give staff instructions around how the person's behaviours could be managed, to reduce the risks to themselves and people. In addition, there were no records of when the person had become agitated, so that staff could monitor and track incidents to analyse what may be causing the person's agitation. This meant staff would not consistently be aware of the some of the triggers that may be causing the agitation. In addition, staff were not always trained in how to support people with dementia or challenging behaviours.

We witnessed further incidents where people were aggressive towards staff, and staff seemed unsure how to respond. One staff member told us, "Where [Name] does hit out at staff there are no records kept of this, or the action taken. This is a daily occurrence."

We observed one person trying to get out of their bed without staff assistance. They were teetering on the edge of their bed, and were at risk of falling and injuring themselves. This was because staff had not responded to them calling out for help. They required staff to assist them to move around, as they were at high risk of falling. The person had a mat on the floor near the side of their bed, to minimise the risk of them injuring themselves if they fell out of bed. When we reviewed the person's records there was no risk assessment in place to assess whether bed rails or other actions were appropriate, to prevent the person from falling. This meant the provider had failed to take action to assess the risk of falls and take appropriate action.

We were concerned that positive action had not been taken to assess why some people who were identified at risk of injuring themselves and others, or of falling, continued to have these risks unmanaged. We could not find records of what interventions had been considered, to minimise the risk of potential injuries for some people. We found the provider's policy was to record all accidents and incidents when they occurred. However, we found that the records were not accurate and did not record all the incidents that had happened at the home. There was a lack of analysis of accidents and incidents, to help prevent similar incidents from happening again.

We found this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

We found there was a lack of permanent nursing staff at the home. The provider told us they were recruiting for new staff, which included permanent nurses and care staff. On the first day of our inspection visit there was more than 50 per cent of the staff team employed from a recruitment agency. This showed the provider relied on high usage of agency staff, which meant staff do not always have knowledge of people's needs. One person's relative told us, "People do have to wait for support due to staffing numbers, as so many

people need support of staff." A relative told us, "There have been a few staff changes recently and lots of new faces."

In response to the advice of the interim manager, the provider had recently increased staffing levels at the home. They now employed two extra members of care staff in the morning and afternoon. This meant people on the top floor were supported by three to four care staff, and a nurse. The same complement of care and nursing staff was in place on the ground floor. The provider had also brought in extra management support to assist the interim manager in running the home and investigating some of the concerns that had been identified. There were two consultant managers at the home, one was a quality assurance manager and another was an operational manager.

However, one staff member told us, "I think there have been times that people haven't always been safe. Mistakes are made due to staffing numbers, having no breaks impacts on concentration levels; using a lot of agency staff means they don't know people." Staff also told us there was often more than two agency staff working at the same time, along with other care staff. One staff member told us, "[Name] was on the floor (laying down) today. An agency staff member was right by them and didn't act."

We had concerns about staffing despite the increase in staffing levels. There was a lack of clinical supervision at the home. The post of clinical lead/deputy manager was vacant. This meant nursing staff were not sufficiently supervised to ensure consistent care was provided to people, when they needed nursing support. The provider had acted to reduce the impact of this vacant post, by the second day of our inspection visit. They had appointed a new clinical lead (who started work at the service on the 05 October 2017). They were a registered nurse, and the provider hoped this would provide the nursing team with leadership for the foreseeable future. They told us the interim manager was also a registered nurse.

Our concerns also related to a lack of effective management of care staff. For example, nursing staff were asked to supervise care staff during their shift. However, no permanent nursing staff were employed at the home during the day. Therefore, it was difficult for agency staff to understand the care and support needs of people, or how knowledgeable staff were in meeting those needs, especially as records were not up to date. The registered manager had historically used agency staff to cover staff vacancies on the nursing and care team, which meant the staff team was inconsistent and did not get to know people well.

We saw the deployment and management of staff at times had potential to put people at risk. For example, we saw throughout our inspection visit staff were not always in place to keep people safe and meet their health and support needs. There were periods throughout the day where parts of the lounge and communal areas of the home, where people sat, were left unattended. This was in part due to the layout of the home, which had many different areas for staff to monitor, and some people sat out of sight of the main lounge area. One staff member said, "The place is very chaotic, some of this is about insufficient staff and a lack of direction."

We found people often called out for assistance from staff, but staff were not always available to support them straight away. One staff member said, "Sometimes people do not get the care they need, due to a lack of staff. People do not always have the turns (re-positioning to prevent pressure sores from developing) they require or incontinence pads changed when they are wet." They added, "Sometimes fluids aren't pushed like they should be." This meant that people were at risk of acquiring pressures sores and becoming de-hydrated.

We found this was corroborated by the records we reviewed. For example, we found one person had a risk assessment and care plan in place which described how often the person should be moved and re-

positioned by staff, as they were at high risk of developing pressure sores. The person already had a pressure sore which was being treated. The records stated the person should be re-positioned every two hours. We saw that during the previous night, prior to the second day of our inspection visit, the person had been assisted by staff at 24.00, 03.00, 06.00, and 09.00 which was every three hours and not following the regime that had been put in place to minimise the risk of skin damage.

One staff member told us, "We continually have to report where care has not been delivered to the manager, this is to request that they take some action." They stated action was not always taken following their concerns. They said, "One lady gets very upset, she screams and gets frightened. We were told to leave her in bed (due to lack of staff) she can't walk but did move, we reported (to the registered manager) she had pressure sores, but they continued to be cared for in bed despite being unable to lie on their side."

Several people in the lounge area required support to mobilise, and were not near a call bell to easily request staff to assist them. Other people at the home had limited understanding or communication, and could become confused which meant they may not be able to use a call bell. People with confusion were also at risk of getting up from their chairs, as they may forget they are unable to stand on their own without support. This placed people at risk of falling if staff were not present to assist them. We reviewed the accident and incident records, which documented a number of falls at the home which were un-witnessed by staff.

Our observations showed us staff were 'task focussed' and did not always have time or take the opportunity to sit with people and engage them in conversation.

We asked the provider whether a dependency tool was in place to assess the numbers of care and nursing staff that were needed, to support people at the home. We were concerned because approximately 18 people were cared for in bed at the home, only one person did not need two staff to assist them to mobilise, and sixteen people required assistance to eat. The provider told us this type of tool was used, people had an individual dependency assessment that scored their support needs, these added together indicated how many staff were required each day, and on each shift. However, the provider told us the registered manager had not used the tool to calculate staffing levels, and could not explain why.

The provider had breached Regulation 18 as there was insufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs.

Most people we spoke with and their relatives told us they felt safe at Nethercrest Nursing Home. One person told us, "I am happy here." A relative said, "I would be quite happy to stay here."

The provider told us in their Provider Information Return (PIR) that recruitment checks included following up on references and completing other checks and we saw this was the case. Staff told us that prior to starting work, they had been required to undergo checks to ensure they were safe to work. The provider's recruitment process demonstrated they took measures to try and ensure new staff were of 'good character.' Two recently recruited members of staff told us they had a DBS check which the home completed and they had to wait for their references to be returned before they were offered employment. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

We found people did not always have the equipment they needed to ensure they received care and support that met their needs. Staff told us there was a basic lack of everyday items at the home, which included crockery for people to drink from, and toiletries. On the second day of our inspection visit we saw some toiletries had been purchased to mitigate this.

We reviewed some staff meeting minutes dated August 2017. Staff and the manager had discussed the need for more pressure cushions (to be used on chairs) to be brought to Nethercrest Nursing Home. This was because there was not enough pressure cushions available for all who needed them. Staff had raised their concerns as they were unable to bring people out of their rooms, and seat them in a chair, as without the use of a cushion they would have been at risk of developing pressure sores. We found on the day of our inspection visit people were mostly being cared for in bed on the top floor of the home, and were not encouraged to leave their bedrooms. We saw one person with a pressure sore in the lounge area, who was not using a pressure cushion and placed them at greater risk of further skin damage.

We found the provider did not always provide a safe environment for people at the home. This was because we found there had been no hot running water in some bedrooms at the home for several days prior to our inspection visit. This meant people were unable to wash in hot water unless staff obtained hot water from another room or part of the home. We saw staff did not always take the trouble to obtain hot water to assist people with personal care and washing, but used 'wet wipes' as an alternative. In addition, one staff member told us before the interim manager had been appointed there was a lack of protective clothing, which staff should use when providing people with personal care. This meant people were put at the risk of infection and cross contamination.

We found medicines were mostly administered and stored safely. Only trained nurses administered tablets and liquid medicines to people. Medicines were kept below the manufacturer's recommended temperature to ensure they continued to be effective. The home held controlled drugs (medicines that require extra records and special storage arrangements because of their potential for misuse) for people in a lockable cabinet.

Some people were prescribed medicines on a when required/as needed basis. Protocols were in place for most medicines, to guide staff on when to administer 'as necessary' medicines'. However, the recording of the application of topical creams was not always up to date. One staff member told us, "We have to apply creams. There are no charts for us to sign to say this has been done. Creams were being applied to people that were not prescribed them." This meant there was no record of whether people had their creams applied as prescribed.

The clinical lead had conducted a full medicines audit by the second day of our inspection visit. The audit had identified some actions that needed to be taken to ensure medicine management continued to be safe, actions included the recording of when creams were applied. We were assured actions would be taken where these had been identified.

Inadequate

Is the service effective?

Our findings

At our previous inspection in November 2016, 'Effective' was rated as 'Requires Improvement' as we found the provider did not always have up to date and accurate assessments of people's Deprivation of Liberty Safeguards (DoLS) information, so that staff knew who had a DoLS in place. People were not always given a choice of what food they ate.

At this inspection visit 'Effective' was rated as 'Inadequate'. This was because we could not be sure people were receiving enough food and fluid to maintain their health. People were not always referred to healthcare professionals when required, which resulted in people's health being compromised.

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. However, we found most people at the home appeared to lack the capacity to make all their own decisions. Mental capacity assessments had not always been conducted to establish which decisions needed to be made in their 'best interests', and who should be consulted to make such decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the registered manager had submitted applications that were required to restrict people's freedoms to the local authority. Although some people had a DoLS application in place, and some people had an approved application, when asked staff and managers were not aware of people's appointed representatives (RPR), to ensure DoLs were being monitored appropriately.

We saw some people were having their movements restricted at the home. For example, some people were unable to move around the home or go out on their own without staff support. Some people were being cared for in bed. One person asked to be able to get up, and was encouraged several times to stay in bed. We saw some people had bed rails to prevent them from falling out of bed, other people's movements were monitored by staff as they had pressure mats in place, which alerted staff to when the person moved around their room. One member of staff told us, "Two people are being restricted in their movements whilst they are in bed. Wedges are placed around them so they cannot move." The staff member understood this was restricting people, and no assessment had been conducted to ascertain whether this was in the people's best interests.

Care plans showed that where people had the capacity to consent to their care and treatment they had sometimes signed to do so. However, where people lacked the capacity to sign consent to all aspects of their care, we found people's relatives had sometimes been asked to consent instead. We brought this to the attention of the interim manager, we explained that family member were unable to 'consent' to care and

support unless formal arrangements were made through a lasting power of attorney for them to do so. Care records did not always show who had these types of arrangements in place.

We found this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed two mealtimes during our inspection visit. Some people ate in the dining room, and other people were assisted to eat in their bedroom. The atmosphere in the dining room was not always calm. People shouted out for help from staff, which was not always responded to. This was because staff were busy supporting other people. The dining room and lunchtime service appeared disorganised. We saw the dining experience for some people was lengthy, as most people required assistance to eat and drink. On one of the days of our inspection we saw the lunchtime meal was being served for more than two hours, from when people were seated at the dining tables. The evening meal was then due to be served with just a three hour gap between mealtimes, which could affect people's appetite for their evening meal.

One person's relative told us they thought the food was good, and commented that their relation had put weight on since being at the home. People seemed to enjoy the food they received. However, it was unclear how people were involved in choosing what they ate each day, as people were not shown visual choices of food before it was served. It is important that people with short term memory loss or dementia are shown visual choices of food to be able to make an informed choice and to understand the options available to them.

We looked at how the monitoring of people's fluid and food was managed at the home, as some people were at risk of de-hydration or were at risk of malnutrition. The provider had charts in place for staff to record how much food and fluid people consumed each day. Care records showed that people had a target amount of fluid they should consume each day, to ensure they did not become de-hydrated. This was worked out by the nursing staff based on the person's weight, and the fluid they normally ingested.

We saw one person who was at risk of de-hydration, and had a pressure sore, which required staff to encourage them to take fluids. The person's records stated they required 1430ml of fluids each day to stay healthy. Records from the 05 October 2017 showed the person was given only 800mls of fluid. The person appeared to be de-hydrated with dry lips and mouth when we visited on the 06 October 2017.

In another person's records it stated they should have around 1990ml fluid per day. We checked to see how much fluid they had received for the previous four days. All of the four days documented between 770ml and 120ml per day, all were below the identified target amount.

We observed an additional three people who looked as though they were de-hydrated. People had cracked and dry lips, one person had a yellow tinge to the roof of their mouth, another person had dark urine. We saw people did not always have drinks in their reach.

In addition, we found staff did not always record the amount of food or fluid people consumed accurately. We saw staff recorded when people had a drink, but only estimated how much fluid had been taken. Where people had a lower level of fluid than the target, some handover notes that the nurses used said, "encourage fluid intake" in response to low levels of fluids. The nurses did not document any other actions that were taken, for example, to check whether people were de-hydrated or required an immediate medical referral. The interim manager confirmed before our inspection visit, they had identified fluid intake as an area of concern and were drawing up different charts to improve the recording of food and fluid.

During our inspection visit we also identified some people who were at risk of weight loss, they looked visibly frail and underweight for their height. Some people were wearing clothes that fit them loosely. One person's charts showed they did not always eat the food they were offered. We saw from some people's care records that they required their weight to be regularly monitored to ensure they were eating enough, or to identify whether they required medical intervention. We found people's weights had not been regularly monitored each month. We brought this to the attention of the interim manager. They told us people were now being weighed monthly, and people's weights were being recorded and compared to analyse whether people were losing or gaining weight.

On the second day of our inspection visit in response to the concerns we raised, the interim manager had conducted a hydration assessment for everyone at the home. This highlighted three people were de-hydrated. Medical referrals were being made to ensure people received the correct nutrition going forward.

We found this was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us how their relation was not always supported correctly by staff to move around. They said, "[Name] can't weight bear, staff have to use a hoist with a belt, but sometimes I have seen them lift [Name] with their arms." We saw the whistle-blower had raised concerns with the provider about people living at the home who had unexplained bruising. The provider told us unexplained bruising had been investigated, and some people had been found to have finger mark bruises, potentially from staff using incorrect manual handling techniques

We found people did not have their own manual handling slings. This is good practice to prevent staff from using an incorrect size of sling, and to prevent cross contamination. One member of staff told us on the last day of our inspection visit, that these had now been ordered for people, to ensure staff used the right sling.

We observed where people were offered assistance to move using a hoist, staff used this equipment appropriately to effectively and safely move people. Staff reassured people about what they were doing to avoid people becoming anxious.

The provider had a policy in place to induct new staff when they started work at the home. This induction included new staff working alongside more experienced staff to gain the practical skills they needed to support people. A training programme was also in place that included courses that were relevant to the needs of people at the home. We asked one member of staff whether their induction had been useful. They told us, "I didn't really have a proper induction; I just had three or four shifts working alongside other staff." Another member of staff told us they had done some internal training on manual handling techniques, which was followed up with learning on the computer. They had also done some training in safeguarding adults from abuse. However, they stated "Induction wasn't good but my previous experience (in care) was helpful." Whilst another member of staff told us about some staff who did not have the skills they needed to support people saying, "A member of staff here doesn't understand hoists or medicines." We advised the staff member to raise this with their supervisor straight away.

We looked at training records to help us determine what training staff had received. We found the registered manager had set up a staff training database showing the training staff had completed, and when refresher training was due. However, the database had last been updated by the registered manager in May 2017. It was therefore difficult to establish whether staff had received the training they needed to support people safely. The provider told us staff training records were up to date in individual staff files.

We did not have confidence staff had received essential training when required, or their practices were being monitored and assessed by the provider to ensure staff put into practice what they learned. For example, we saw staff had not identified some of the safeguarding concerns about people and reported these to the manager for action. We found staff were not aware of the appropriate way to support people with behaviours that challenged. This showed the staff were not always competent in providing some aspects of peoples care.

Following our inspection visit the provider confirmed several people had been identified as having bruising to their skin, which was unexplained. In some cases the provider had identified the bruising as finger marks. This indicated that staff may be using poor manual handling techniques to assist people to move. One person reported, "They are rough with me and push me."

People were not always referred to other healthcare professional if there was a change in their health, or following accidents. We found one person had a history of falls, and following a fall on the 06 September 2017 their records stated they had no injuries and did not need medical attention. The person had subsequently been taken into hospital and found to have a broken hip.

One staff member said that people needed the support of the chiropodist at the home, but this had not been organised. We found following our inspection visit, several people had been identified as requiring referrals to health professionals. For example, one person suffered from a retracted limb, where their hand was closed. One staff member had reported that the person's hand required attention, as they felt this might be infected. Also their nails were long, and were digging into the person's hand. A referral has now been made to treat this but it is of concern this had not been actioned by staff prior to our inspection.

The environment at the home did not offer people with dementia support to orient themselves, and to be stimulated. For example, there was a lack of directional signage around the home which could have helped people to understand their environment more easily. Walls in corridors and around the home were not adorned with pictures, or reminders of the outside world. We saw two people in their bedrooms. Their bedrooms lacked colour, and did not have treasures and items from home, that would help them to feel comfortable. People did not have items such as pictures and objects that might help them recognise their rooms.

Inadequate

Is the service caring?

Our findings

At our last inspection in November 2016 Caring was rated 'Requires Improvement" because people were not always given choices about their care. At this inspection it Caring has been rated 'Inadequate '. This was because the providers systems to ensure people received safe and effective care were inadequate. Staff were not taking appropriate action to keep people safe, and seek medical attention when required. We were aware that some people had been left in soiled clothes for periods of time that was uncaring and undignified.

Some people told us they felt individual staff were caring and kind. One person's relative told us, "The staff do a marvellous job."

However, one staff member told us, "I would not want my relation here", we asked them why, "It's undignified, staff don't wipe people's hands and face after food, people are left in dirty clothes." Another staff member said, "Today is the first day (for ages) everyone had had a wash before dinner."

We saw that people were not always treated with dignity. We observed one person who called out for help. We saw they were not fully dressed and their underwear was visible. After staff responded to their calls for help, we saw they remained in their underwear for another hour before staff offered to dress them.

Another person we saw had their skirt pulled up, showing their underwear to people, staff and visitors. This did not protect their dignity. In addition we saw the person was wearing clothing that was dirty. We saw staff did not respond to protect the person's dignity.

We found people were not always clean. A visiting professional told us they observed one person on a Saturday at the home; they again saw them at the home on the Monday and saw they were wearing the same clothes as on their previous visit.

Some people were observed to have dirty fingernails and hands. This presented a risk of cross contamination and infection. A staff member told us they had raised with the registered manager the lack of person hygiene equipment and toiletries not being available for people, so that staff could assist them to keep clean. They said they had previously used their own money to purchase toiletries.

The environment did not show that people were valued and treated with dignity. Around the home we found carpets were dirty, and the home smelt strongly of urine in a number of areas.

We found this was a breach in Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and Respect.

One staff member said, "I have knowledge of people, I sit and chat about things to learn the things they like to do, not all staff do this."

During our visits we saw staff spoke to people in a kind way when they assisted them with a task. However; we noticed opportunities for social stimulation were not always recognised or responded to by staff meaning that people sat for long periods of time with little or no interactions that did not promote their wellbeing. On a number of occasions we saw staff walk through communal areas where people were sat without acknowledging them.

Relatives and visitors told us they could visit whenever they wanted and said staff always made them feel welcome and offered them a drink. During two days of our inspection visit, relatives and visitors arrived at the service and spent time talking to the people they came to see. We saw when visitors arrived, people became more alert and engaged and were pleased to see them. Open visiting times helped people maintain relationships that were important to them.

Inadequate

Is the service responsive?

Our findings

At our last inspection visit, we rated Responsive as 'Good' At this inspection we have rated Responsive as 'Inadequate' because people were not always offered the stimulation they required to support their wellbeing, care records were not always up to date to provide staff with information about people's life history and preferences. People did not always get responsive care, when they asked for assistance.

We found people were not always supported to make everyday choices about how they lived their lives, for example, when they wanted to get out of bed in the morning. We saw one person trying to get out of bed unaided, as staff were nowhere nearby. The person called for help as they tried to move out of bed. No staff responded. We later saw that some staff did respond to the person's calls for help, but continued to place the person back in bed. From 10am to 11.09am three times staff responded to the person, but did not assist them to get up despite it being clear this is what the person wanted. At 11.09am two members of staff went into the person's room and helped them to get up and get dressed.

We found people were not involved in making decisions about their care and support and their preferences were not sought or respected. For example, One relative told us that people were not always supported to get up when they wished, saying, "We have previously visited and found [Name] in bed at 11.30am, I think this was because they were too busy." Relatives told us their family member usually preferred to get up early, and their health was better in the mornings.

Some staff responded to people's requests for assistance and support quickly. For example, we observed one member of staff assisting someone when they mentioned they were cold, by getting them a blanket. However, many people had to wait for support from staff, they did not receive their care in a timely way. For example, people waited for meals, shouted for help to move and had to wait to get up. This showed the staff were not responsive to people's needs and preferences.

We found this was a breach in Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

One person's relative said, "We visit every day, to ensure [Name] has someone to talk to (because other people at the home don't have the same communication skills to interact with them." From speaking with people and our observations on two inspection days, we could not be sure action was taken to ensure people who stayed in their bedrooms were not isolated socially. Everyone on the top floor of the home had limited mobility, and some people were cared for in bed. This meant they did not always leave their room to take part in social interaction, and organised activities at the home.

There was an activities co-ordinator to arrange events and support people with their hobbies and interests at the home. People did not have activities plans in their care records, to show which activities they enjoyed, and whether they enjoyed social interaction. We did not see the activities person support people in their rooms during our inspection visit. We saw a lack of staff interaction with people who were being cared for in bed, staff spoke to people when they assisted them with personal care or eating, but these interactions were

'task focussed'.

There was a lack of objects and interesting items around the home, to encourage people with dementia to be interested and stimulated, and to engage in the environment and people around them.

We saw that when people were engaged in group activities at the home, most people were happy to join in. In the afternoon there was a planned activity in the lounge area on both days of our inspection visit. We saw some staff joined in with the afternoon activity on the second day of our inspection visit, people had percussion instruments and were encouraged to make music and sing. Whilst group activities were on-going people did not shout out, or show signs of anxiety which indicated they enjoyed what was on offer. One person's relative told us, "[Name] has told us about crafts, and taking part in games." They added, "They are able to do what they want. There is also an upcoming planned trip to the theatre."

Systems to ensure people, or their relatives, were involved in planning their care were not effective. We found people's care records were not always up to date and accurate. People could not tell us, and records did not always show, whether they had been involved in planning their care. People's records did not always have detailed information about their background, formative years, family, work life, interests and hobbies. This demonstrated that information had not always been obtained from people's family to help plan their care. There was not always consistent information on people's preferences, likes and dislikes so staff knew how to provide care in a way that met the person's individual needs and preferences. There was no assessment which took account of peoples diverse needs which meant the provider was not ensuring they protected people's rights.

We reviewed the care records of one person who had a foot injury, had osteoporosis and were at risk of developing kidney problems. There were no care plans in place to instruct staff on how these conditions should be treated or managed. Care records did not provide guidance so that staff could offer a consistent approach to meeting people's needs. This type of information is vital to provide safe care that supports people's health, especially as agency staff may not know people.

The interim manager assured us a quick guide to each person's needs and health conditions would be written up, so that agency staff and permanent staff could see 'at a glance' the care people needed. On the second day of our inspection visit we found the interim manager had written up 'resident profiles' for each person at the home. These also included up to date photographs so that agency staff were able to identify people but these needed further detail so people could be confident that staff knew their needs.

Nursing staff attended a daily 'handover' meeting at the start of their shift to exchange information about people at the home. They told us this assisted them in keeping up to date with people's health and care needs. This was important as there were no permanent nursing staff employed at the home during the day, and therefore information provided at handover was vital to keep staff up to date. We also noted that as care records were not up to date, handover records were needed to ensure staff knew about changes to people's needs, and could respond to those changes.

However, it was not clear how these handover messages were communicated to all staff who worked at the home. For example, we found one person was at risk of choking, and had been prescribed thickener for any liquids they consumed, to prevent them choking. A member of staff told us, "[Name] has thickener in their drink. I think they should be monitored when eating due to the risks. Only some staff get to know these types of things as instructions are not passed down to us." They added, "Things like when someone changes from using a stand aid to a hoist, these are not handed over either."

There was information about how to make a complaint or provide feedback about the service available in the reception area of the home. People and relatives told us they knew how to raise concerns with staff members or a manager if they needed to. We saw where a recent complaint had been made, and an investigation had taken place by the registered manager to resolve the complaint. However, all the complaints received at the home in the last six months had not been investigated and resolved. In addition no monitoring or analysis systems were in place to monitor complaints for any trends and patterns. We saw that if monitoring of trends and patterns had been in place, this may have highlighted a lack of good leadership and management.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we had rated Well-led as 'Requires Improvement' as people were not consistently given choice or had their dignity respected and there were concerns raised by people about staffing levels at the home. 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 and safeguarding concerns that were under investigation. We found the home was not well-led and people were not safe at Nethercrest Nursing Home. We have rated Well-led as 'Inadequate'. This means the service had been placed into 'Special Measures'.

When we arrived at Nethercrest Nursing Home the home was being run by an interim manager. The provider's nominated individual (referred to as the provider) was also on site at the home, and there was a regional manager also working at the home. The provider's nominated individual told us, this was because they had a number of on-going concerns at the home which they were looking into. The provider was open and honest with our inspectors, about the on-going concerns at the home.

The home has had a history of not been able to retain a registered manager to provide leadership and direction to the staff team. The home also had a history of requiring improvements following CQC inspections. We had rated the service 'Requires Improvement' since November 2015.

We found the registered manager had failed to supervise staff adequately to ensure people received safe care and treatment. We saw there had been irregular supervision meetings with staff, to monitor their performance. Records showed staff supervisions had not been held regularly since March 2017. The registered manager had held staff meetings with different groups of staff, for example, the nursing team. We found minutes of one staff meeting, where it was documented the registered manager had identified care records were not up to date, and weekly wound charts needed to be completed by the nursing team. The registered manager had given staff a deadline to complete this work of four days. However, there was no evidence to suggest this action had been subsequently reviewed to ensure improvements were made.

When we completed our inspection, we found there was no longer a registered manager employed at the home. The provider told us the registered manager had failed to escalate issues to the provider according to their policies and procedures, and had been dismissed from their position. The provider then employed a clinical lead to work alongside the interim manager. This was to ensure management support was available at the home seven days per week. There was also an 'on call' number for staff to ring if they needed to, which meant leadership advice would always be available to staff.

Where incidents and accidents resulted in people requiring treatment from other healthcare professionals, it is the registered manager and provider's legal responsibility to notify us. We found the registered manager and provider did not always notify us of important events as they should and without delay. For example, information brought to the registered manager's attention and later to the attention of the provider by a whistle-blower, had not been immediately notified to CQC and the safeguarding team for investigation, or acted upon by the registered manager to reduce the risk to people. From the information gathered on our inspection the first issues that were raised with the registered manager were at the beginning of September

2017. The provider's audit systems had failed to identify that the registered manager was not fulfilling their legal responsibilities.

In another example of the provider and registered manager not notifying CQC of a safeguarding concern, we found a relative had complained about jewellery and clothing going missing, which remained unexplained for four months before our inspection visit. The registered manager had not reported this allegation to CQC or safeguarding for investigation.

We found systems to monitor the quality and safety of care people received were not effective. The provider's own quality assurance systems had failed to identify areas of safeguarding concern, and that people were not always cared for safely. Following the provider's own investigation the provider has now notified CQC and other authorities of unexplained bruises that were identified to three people at the home.

We found this was a breach in Regulation 18 Health and Social Care Act 2008 (Registration) Regulations 2009 (Part 4) Notification of incidents.

In addition, the providers auditing systems had failed to identify that the registered manager was not always following the principles of the Mental Capacity Act 2005 (MCA) to obtain people's consent to some aspects of their care. This did not protect people's rights to make their own decisions, where they could.

Records and risk assessments were not up to date, to ensure people received consistent care that met their needs. Systems and processes had not identified the impact of a lack of up to date records, and how these affected the quality of care delivered at the home. This was exacerbated because nursing and care staff were not always permanently employed at the home, which meant they did not know people's needs.

The providers systems had failed to ensure there were always sufficient qualified and skilled staff available to meet people's needs. We found that staff training and supervision, had not always been provided to staff, to ensure they supported people safely and effectively. In a further example, the systems had failed to identify that people's health needs were not monitored and people were left without support from health professionals.

There appeared to be an acceptance or 'culture' within the home that people were not always receiving the care they needed. Staff were aware that people were receiving poor care and their needs neglected. For example, staff told us that some people did not have their needs met for hydration, personal hygiene and pressure care. Although some staff had reported this, there appeared to be an acceptance that there were insufficient staff to meet everyone's needs and staff were doing the best they could in the circumstances. Comments from staff included, "Morale is low. The running of the home feels very chaotic", "There is constant criticism of staff, but there is no support to improve" and, "There is no leadership. Seniors do not understand their role. There is no direction from nurses."

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

The provider had already started to take action when we arrived for our inspection visit to investigate concerns at the home. They had also acted to prevent future admissions during this time. The provider advised the local authority that they had stopped admitting new people to the home on 18 August 2017.

The provider had written to people and their families to complete a quality assurance questionnaire to gather feedback. They also made a decision to open a dedicated hotline for staff to use, to provide staff with

an opportunity to give feedback in a secure and anonymous way. Since opening the hotline one member of staff had raised a number of concerns which were being investigated.

The provider already planned a number of improvements at the home, which included extra staffing resources, block booking of some staff from an agency to ensure continuity of staff for the following few weeks. In addition, a full deep clean of the home was planned. A training schedule was being put into place, to support staff in key areas such as fire, first aid, and moving and handling.

The provider has agreed to share with us any actions they put in place to manage the home.