Review of compliance

Nethermoor Care Home Limited Nethermoor Care Home	
Region:	East Midlands
Location address:	50-52 Bridge Street Killamarsh Sheffield South Yorkshire S21 1AL
Type of service:	Care home service without nursing Care home service with nursing
Date of Publication:	February 2012
Overview of the service:	Nethermoor Care home is situated in the centre of Killamarash and is registered to care for thirty-four people. Nethermoor is close to shops and there is local transport to the city of Sheffield

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Nethermoor Care Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 31 October 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People told us they liked living at the home, and they were pleased with the home. People said they were happy but it was noisy sometimes. One person we spoke with said they enjoyed watching TV in their room.

Families of the people we spoke to were satisfied with the care and support they received. One person told us "staff are caring for my relative well, and they are trying to get him motivated." We were also told "they always keep in contact and there is good communication between the home, family and friends."

We were told that that "the care staff are around when I needed them."

What we found about the standards we reviewed and how well Nethermoor Care Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who use the service are supported to make informed choices about their care, treatment and support needs, ensuring their privacy and dignity are promoted and respected.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People do not always receive the care and support they need as care plans and records are not completed in sufficient detail to show individual needs and requirements for their care.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People were not fully protected from abuse by safeguarding arrangements as there were gaps in staff training and the policy on safeguarding was not clear , which could leave people vulnerable and at risk.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People living at the home were supported by staff who were chosen for their suitability for the job, but poor practice may leave people unprotected and at risk of harm.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider has not based the staffing levels on peoples assessed or dependence needs. This may leave people vulnerable and at risk.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People living at the home must be cared for by staff who are properly supported to do their work in a safe environment

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People who use the service may not always be safe due to the inconsistencies in the quality monitoring of the audit and recording system operated by the provider.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect

the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People we spoke with told us they received care in line with their needs and wishes. They told us care staff knock before entering their bedrooms and call them by their preferred name.

We were told that people and their families are consulted about any changes to their care plans and the care people receive. The care plans we saw had been signed by the person concerned, their families or their representative.

Other evidence
We observed that care staff were patient and respectful with residents. We observed staff approaching and explaining to the people how they were going to assist them and waiting for a response before helping them. One care record we looked at detailed how the care staff would maintain the person's privacy and dignity when undertaking personal care

People we spoke to told us they had not received any information about the home prior to admission but that someone from the home did come to see them before they moved in.

All of the care records we viewed contained a care needs assessment from the placing authority and there was evidence of this being reviewed.

At the time of our inspection the home has seventeen residents, three of whom require nursing care the remaining fourteen were receiving personal care.

We saw that all the people who received a service currently were white and that there was no one who had a different first language other than English or religion other than Christianity. We discussed with the staff the how diverse needs would be met in the service and they were able to give examples of how the service would meet a variety of dietary needs; for example, where they would they get any special dietary requirements from and there were always vegetarian options available. They also said they would access specialist information from other professionals.

Our judgement
People who use the service are supported to make informed choices about their care, treatment and support needs, ensuring their privacy and dignity are promoted and respected.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us they liked living in the home. They said "you get all the help you need but it is noisy sometimes". People also told us "staff will do anything to help you".

Families of the people we spoke to were satisfied with the care and support they received. One person told us "staff are caring for my relative well, and they are trying to get him motivated." We were also told "they always keep in contact and there is good communication between the home, family and friends."

Other evidence
During our inspection we observed staff interacting with people and noted that staff knew the people well and that people appeared satisfied with the care they received. However, the care planning did not consistently reflect this.

The care plans of the three nursing residents were viewed by us and the nurse advisor for the Primary Care Trust PCT). We noted a number of concerns in the care plans and records maintained by the home.

- Care files not indexed and no chronological order of information.
- No tracking of people with dementia care.
- No Mental Capacity Act assessments on file for people receiving nursing care.
- Care plans for people who require nursing care are written for personal care only.

• End of Life plans not in place.
• Strategies for dealing with people with challenging behaviours not documented.
• No evidence of ongoing evaluation of care plans however, we did observe a review undertaken in conjunction with the placing authority for one person.

This information is important to ensure that care is planned and delivered in a way that meets peoples changing needs and that risks are minimised. For example, one persons care plan we looked at stated that two staff members were required to mobilise them but this was not always adhered to. All of theses issues were raised with the provider during the visit.

We were told that people have access to a range of health care professionals and that if people need to see the Doctor then visits are arranged. All of the people were registered with the local surgery and in addition receive support from other professional for example opticians, dentists, and occupational therapist.

The home has adopted The Butterfly Approach, a model of person centred care that training staff how to increase their interactions with people and a specific approach to the dementia care environment. This is termed "filling up the dementia care environment" with sensory, comfort, cognitive, fun and art items to name a few. A relative told us they felt there was little evidence of this in practice. We were told that they try to arrange activities and in-house entrainment for the people to enjoy.

Our judgement
People do not always receive the care and support they need as care plans and records are not completed in sufficient detail to show individual needs and requirements for their care.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People generally felt safe at the home and were aware of who to speak with if they had any concerns

Other evidence
Staff told us they had received training on safeguarding vulnerable adults. This was delivered by the company in-house training officer. Some staff had undertaken additional half day local authority training on safeguarding. However, some staff we spoke with told us they had not received update training on safeguarding since their initial training in 2008-2009. The training records confirmed this. In order for people to be protected it is important that all staff are reminded of their responsibilities and know what to do if abuse is suspected. The most effective way to do this is through regular update training.

Some new staff had commenced working at the home without receiving training in safeguarding. It is essential that all staff receive regular updates on safeguarding to ensure people are protected.

We viewed the homes policy on safeguarding which is kept in the policy and procedures file. Staff we spoke with confirmed they had seen this. They were able to tell us what the policy on safeguarding was and how the procedure for dealing with incidents of abuse involves the social services department. .

Displayed in the office was a different policy on safeguarding. On closer inspection of

this policy we found it was an extract from a poster informing staff about the Mental Capacity Act. This was brought to the attention of the provider during the inspection as we were concerned that the home did not know the difference between the Mental Capacity Act and safeguarding vulnerable adults.

We were told there had been no referrals made under the home's safeguarding vulnerable adults procedures to the local safeguarding board.

Staff told us they do not carry out any form of physical restraint

Staff spoken with told us they were aware of the homes policy on whistle-blowing and that any concerns they had would be reported on.

Whilst we were reviewing residents care records we found a statement which said, "we have to detain people for their own safety." This was brought to the attention of the provider The training records showed that three staff had undertaken training on the Mental Capacity Act in 2010. However staff we spoke with had not undertaken any training on the Deprivation of Liberty Safeguarding (DOLs).

We also noted that incidents which involved the care, welfare and safety of resident, had not been reported to the relevant regulatory bodies or to the placing authority.

Our judgement
People were not fully protected from abuse by safeguarding arrangements as there were gaps in staff training and the policy on safeguarding was not clear , which could leave people vulnerable and at risk.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are minor concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
People told us they liked living in the home. They said "you get all the help you need but it is noisy sometimes". People also told us "staff will do anything to help you".

Other evidence
All staff we spoke with confirmed they had Criminal Records Bureau (CRB) checks and had not commenced their duties prior to clearance.

Staff files had no index to assist or guide the person checking the staff records. All recruitment files were checked against Schedule 1 of the Essential standards of quality. The recruitment records should contain the following information

- Proof of identity including a recent photograph.
- Criminal Records Bureau check.
- Application and medical form.
- Evidence of training.
- Employment history.
- Previous employment in connection to working within the health and social care sectors.
- Two references, one from the most recent employer.

We viewed several staff recruitment files which showed the homes recruitment procedures had not always been followed. The procedure stated two references are

required on application. In the staff records we viewed a member of staff had been appointed on one reference only. We also noted that not all staff were providing the full date, month and year when supplying their employment history. In most cases it was only the month and year and in some cases only the year. There were no interview notes to confirm that any gaps in employment history had been followed through.

Our judgement
People living at the home were supported by staff who were chosen for their suitability for the job, but poor practice may leave people unprotected and at risk of harm.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People told us they liked living in the home. They said "you get all the help you need but it is noisy sometimes and the staff "will do anything to help you".

Other evidence
We were told by the staff that in the morning there is one registered nurse and three carers on duty and in the evening there is one registered nurse two carers.

We looked at the rotas from the beginning of September 2011 which confirmed this arrangement. The provider had the previous week's rotas from September 2011 electronically on computer. No other working copies of those weeks were available. The rotas were very precise in the staffing numbers and showed that gaps had been filled by either agency staff or staff working extra hours. The paper working rota for the week beginning the 31 October 2011 had alterations and crossings out and in some cases Tipex, so you could not see what the shift arrangements had originally been. We did not see any evidence which supported that staffing levels had been measured against people's care needs and dependence levels.

We were told by staff that some residents were got up early and put to bed late due to the differing staffing levels.

In the staff meeting minutes' of the 28 September 2011, the provider stated "that the ratio is met following CQC policies." The CQC does not have a policy on staffing, the regulation requires provider's to take appropriate steps to ensure there are sufficient

numbers of staff. This includes a carrying out a needs analysis and risk assessment as the basis for deciding staffing levels. We were unable to ascertain on the day of our visit how staffing levels had been determined and if a needs analysis and risk assessment had been completed.

Staff reported that they had been informed that no more staff appointments will be made until the number of people at the home increases.

At the time of the inspection, there was no registered manager in post and there were several care posts vacant. The provider told us that the home had advertised the position of registered manager and they had received twenty five applications and expected to make an appointment soon.

The provider was acting as registered manager in the meantime. He does not have a care background and told us he was not involved in care related issues and focused on management only.

We were told by some staff that on occasions the provider had intervened with a person by taking them into the main office following an aggressive outburst. We were told by several staff that they felt these actions were inappropriate and could subsequently have an adverse effect on the person's future behaviour.

Our judgement
The provider has not based the staffing levels on peoples assessed or dependence needs. This may leave people vulnerable and at risk.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Families of the people we spoke with were satisfied with the care and support they received and told us that "staff are caring for my relative well, and they are trying to get him motivated." We were told that there are a lot of activities for the residents to do."

Other evidence
We viewed staff training records which indicated that all staff had completed the mandatory training required. This includes training on areas such as health and safety. However, we noted that several staff required refresher or update training in some of these areas. This was brought to the attention of the provider.

We were told that several staff had undertaken training in dementia care in 2009, based on The Butterfly Approach, a model of person centred care for people with dementia. The training builds on five key principles and is based around the environment created for the people. The provider told us the this approach was reviewed on a television programme about dementia.

We talked to staff about the training they had been given. Some staff we spoke with told us they held or were in the process of completing National Vocational Qualification (NVQ) level 2 or 3. However, some told us they had started work without induction training and had not received training in safeguarding vulnerable adults, Mental Capacity Act and Deprivation of Liberty safeguards (DOLs).

The inspection had been carried out in a response to concerns brought to our attention regarding support for staff. Proper support for staff is essential to ensure peoples

health and welfare needs are met.

Staff also told us that they had not had regular supervision, in some cases this went back several months and in one instance over a year. Staff were aware of the number of supervision they should receive per year.

We were also told by staff that certificates in their training records did not always confirm that they had necessarily undertaken that training. We asked the staff member to clarify this statement the staff member told us they had not completed a particular course, but received a certificate to say they had.

Staff we spoke with during the visit described situations where they had not felt supported to do their work. As we were leaving the home, comments were over heard by the inspector which supported the staffs concerns.

Our judgement
People living at the home must be cared for by staff who are properly supported to do their work in a safe environment

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The people and relatives with spoke with did not provide us with any comments in relations to this particular outcome.

Other evidence
According to the home's policy there is a procedure for self assessment and audits which is described as, "Arrangements for the periodic and auditing of the homes quality management systems to be performed internally by staff." It is not clear from the policy statement as to the content of these audits and the procedure involved. For example it was not clear to what extent the views of people at the home, families, staff, other professionals and stakeholders' are taken into account as part of this process.

We were told that in the absence of a registered manager the provider was undertaking these audits.

We were told that the previous registered manager had a meet with families in July where they raised some concerns. These concerns included lower staffing levels at weekends and families having to help out, food being brought to people who were asleep and left in front of them, staff taking their breaks at the same time. The registered manager agreed to look into the concerns at that time but left the home before these were addressed.

The provider had a further meeting with families on the 21 September to discuss the concerns raised in July and what they had done to address them. Smoking was also

identified as an issue at that meeting. The home did not record theses concerns as complaints. We discussed these issues with the provider, he did not acknowledge that these issues should be considered as complaints.

Following on from the September meeting the provider sent out a short questionnaire to families who were unable to attend that meeting. This was to gain feedback on the improvements implemented since the July meeting. The questionnaire asked thirteen questions and families were asked to rate their answers as very satisfied, satisfied, not satisfied. We viewed the nine completed questionnaires'.

Comments varied from "not applicable to us as my relative only attends three days a week" to "very satisfied or satisfied." One relative stated "they had seen a difference, hope you can keep staff happy don't want to lose any more".

The provider called a staff meeting on the 28 September 2011, were these issues were brought up. At the meeting, the provider listed the changes which were going to implement in response to families concerns. At the end of the meeting the Provider thanked the staff for all of their hard work and commitment. The staffs reply to this was "its was the first time in along time that they had been thanked". No other documented evidence was provided during the inspection regarding further follow up with relatives of the changes implemented.

Our judgement
People who use the service may not always be safe due to the inconsistencies in the quality monitoring of the audit and recording system operated by the provider.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People do not always receive the care and support they need as care plans and records are not completed in sufficient detail to show individual needs and requirements for their care.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People were protected from abuse by the home's safeguarding systems ,but the lack of clarity and training on safeguarding of vulnerable adults could leave people vulnerable and at risk.	
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: People living at the home were supported by staff who were chosen for their suitability for the job, never the less poor rercuitment practice may leave people unprotected and at risk of harm.	

Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: Inconsistencies in staffing levels and lack of effective management may leave vulnerable people at risk.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People living at the home must be cared for by staff who are properly supported to do their work in a safe environment.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People who use the service may not always be safe due to the inconsistencies in the quality monitoring of the audit and recording system operated by the provider.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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