Review of compliance

Nethermoor House Limited Nethermoor House	
Region:	West Midlands
Location address:	131 Chaseley Road Etching Hill Rugeley Staffordshire WS15 2LQ
Type of service:	Care home service without nursing
Date of Publication:	November 2011
Overview of the service:	Nethermoor House provides accommodation with personal care for 19 older people.

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

Our current overall judgement

Nethermoor House 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 27 October 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We involve people who use services and family care workers to help us improve the way we inspect and write our inspection reports. Because of their unique knowledge and experience of using social care services, we have called them experts by experience. Our experts by experience are people of all ages, with different impairments, from diverse cultural backgrounds who have used a wide range of services.

People were satisfied with the support they received. Comments included, "I don't mind it here", "It seems alright to me" and "staff are excellent".

People were having their health and personal care needs met and there was an opportunity for people to take part in some activities. People's independence was promoted. Some people helped with baking, washing up and with polishing.

People got on well with the staff and staff knew about the care people needed. We did see that currently the service was short staffed. Sometimes people needed to wait for care and the staff were focused on undertaking care tasks. They had little time to spend with people and to talk with them.

What we found about the standards we reviewed and how well Nethermoor House 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 are generally treated with respect and their privacy and independence are promoted.

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

People are having their individual health and personal care needs met.

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

People are protected from abuse and their rights are upheld.

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

Staff are not provided in sufficient numbers and do not have the training and support to make sure people's needs are fully met.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 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
We spent time talking with people who lived at the service. An expert by experience took part in the inspection and talked to five people about their experience of living at the home. They also spoke to one relative who was visiting. People told the expert by experience that their families visited the home to check that it was suitable to meet their needs. People said that they were unaware of their care plans and could not recall being involved in their development. The manager said that discussions were held with people and their relatives about people's care needs and preferences but these discussions were not recorded. We did see that the records did contain people's likes and dislikes and included how they liked their care to be provided. Staff we spoke to could tell us about people's likes and dislikes. We rasied with the manager of the need to make sure that people were fully involved in planning their care.

We saw that people's independence and choice was generally promoted. People were encouraged to do as much for themselves as possible. For example we saw that people were provided with only as much support as they needed to eat independently. We also saw that one person did not like to eat with others and they were supported to eat in the lounge. The expert by experience was told that two people helped with the washing up after lunch and did some baking. They also helped to fold the washing and do some polishing. One person said that they chose when to get up and go to bed.

Another person said that people were invited to attend the monthly church service that took place in the home. Several people said there was no choice of meal and we only saw one main meal provided at lunchtime. We raised this with the manager and were told that there was a choice and she would ensure that all the choices were put on a menu and made aware to the people that lived there.

People that were able to told us that they were involved in choosing what they did. There had recently been a 40's day and people had been fully involved in the day. We saw that the poster for the event had been completed by someone living at the service. People had also been involved in choosing to go to Wales for a day trip. One person also told us that they had chosen to go to the cinema on their birthday.

We observed that people were generally treated with respect and the expert by experience felt that staff were genuinely caring. However we did feel that the staff were task focused and this meant that at times people's dignity and privacy were not fully promoted. This was because the home was short staffed when we visited and staff were under pressure to complete care tasks and did not have the time to spend time talking with people.

Other evidence
The examination of care records confirmed that an assessment was completed before people moved to the service. The information gained and an assessment on admission informed people's plan of care.

We spoke to care staff and they were aware of the importance of treating people with respect and of promoting their rights to privacy and dignity. They were aware of how to maintain people's privacy when undertaking personal care tasks. Staff were able to tell us about how people liked their care given and about their preferences. They told us that they found it difficult when they were short staffed to give people the time they needed.

Our judgement
People are generally treated with respect and their privacy and independence are promoted.

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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People said they were satisfied with the support they received. Comments made to the expert by experience included "I don't mind it here" and "It seems alright to me". A relative also said they were happy with the care provided. One relative did comment on the staff shortages but still felt that their relative was getting the care they needed.

Through a process called 'pathway tracking', we looked at two plans of care, spoke with staff about the care people received and observed staff when they provided support. Pathway tracking helps us understand the outcomes and experiences of selected people as we look at documentation relating to identified people, observe the care given and speak to the person receiving care. This information helps us to make a judgement about whether the service is meeting the essential standards of quality and safety. People had care plans in place and we saw evidence in most instances of ongoing review and evaluation. Ongoing assessments were in place covering such areas as nutrition, continence, falls and skin care. We also saw where needed that there were plans in place to support people's communication and dementia care needs. Plans were person centred and identified people's specific needs and preferred routines. Risk management systems were in place to support people safely.

We saw that people were supported to have their personal and health care needs met although they sometimes needed to wait. We observed people being supported with personal care tasks and with eating their meals. People confirmed and we saw evidence that people were supported to have their health care needs. We saw evidence of health care staff visiting including a chiropodist and optician.

There was evidence to confirm that people took part in activities. We saw evidence of two people reading and one person drawing. We also saw a staff member leading some singing. Due to the current staffing levels we were concerned that those that needed support to have their social needs met were not always able to receive this.

Other evidence
We spoke to staff supporting people and there were aware of people's individual needs. They were aware of how people liked their care to be provided and were aware of people's individual routines. Staff said that because they were short staffed they could not spend much time speaking and interacting with people. One staff said that when they were only two staff on duty they did not have much time to spend supporting the more dependent people to undertake activities. The home did not have an activities co-ordinator so any activities were completed by the care staff.

Our judgement
People are having their individual health and personal care needs met.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
One relative told the expert by experience that they thought the home provided a safe place for their relative.

Other evidence
The staff we spoke to were aware of types and signs of abuse. Staff were able to tell us about how they gave people choices and respected their decisions. They said they had received training in keeping people safe. They know what to do if they saw anything that concerned them. We spoke to the manager and she was aware of safeguarding issues and the referral process. She provided information that she had worked with other agencies to address a potential safeguarding issue.

The service has a robust process in place to look after people's money. They assured us that the system would be regularly audited.

Our judgement
People are protected from abuse and their rights are upheld.

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
We observed that the staff on duty got on well with the people living at the service. The expert by experience observed a genuine affection by the staff for the people living there and that people appeared fond of the staff. The expert observed a care worker interacting with a person who had advanced dementia. The care worker stroked her face and the resident responded by stroking the care worker's face. There was an obvious affection between the two.

We felt that the staff on duty knew people well and knew their needs. However we observed several times when people needed to wait for care. For example we observed one person waiting for the toilet and another waiting some time to be moved to an easy chair. One person said "It's under staffed but they are good".

Other evidence
The manager told us they were short staffed and they were in the process of recruiting staff. She told us that they at times used agency staff to make up the shortfall. She told us that she was working with the care staff to make sure that care staffing levels were maintained. This had affected her ability to maintain the management tasks.

The manager had put in place a system for individual staff supervision and staff meetings to support staff to work effectively with people. However these processes had not been maintained due to the manager undertaking care tasks.

The service could not evidence that all staff had received the necessary training to

support and protect people. This included food hygiene, safeguarding, fire safety and moving and handling. Some staff told us they had received training in working with people with dementia care needs but again the service could not evidence who had attended this training.

Our judgement
Staff are not provided in sufficient numbers and do not have the training and support to make sure people's needs are fully met.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: Staff are not provided in sufficient numbers and do not have the training and support to make sure people's needs are fully met.	

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 7 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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA