Barchester Healthcare Homes Limited

Newington Court

Inspection report

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Date of inspection visit: 06 October 2015
Date of publication: 04/03/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection was carried out on 06 October 2015. Our inspection was unannounced.

Newington Court provides accommodation, residential and nursing care for up to 58 older people. The main building has three floors and accommodates people who have nursing care on the ground floor and top floor. The middle floor has a separate 'Memory Lane Unit' for people who live with dementia and nursing care needs. There is a separate annex called Falcon Place which provides residential care. The home has a garden and courtyard areas available for all of the people. On the day of our inspection there were 49 people living at the home. People had a variety of complex needs including people with mental health and physical health needs and people living with dementia. Some people had limited mobility and some people received care in bed.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People gave us positive feedback about the home. People felt safe and well supported and the food was good.

Effective recruitment procedures were not in place to ensure that potential staff employed were of good character and had the skills and experience needed to carry out their roles.

There were not enough staff deployed to ensure that people received care and support in an effective and timely manner. This added to some people's distress and anxiety when their behaviour was ignored.

Topical medicines administered were not adequately recorded to ensure that people received them in a safe and effective manner.

The training staff received did not give them the skills to support people effectively. For example, care staff administered prescribed creams but had not received training to do so.

People were not always treated with dignity and respect or provided with personalised care. Staff were not responsive to people's needs or choices. People were not provided with meaningful activities.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service. Records were not always accurate and complete.

Staff knew and understood how to protect people from abuse and harm and keep them safe. The home had a safeguarding policy in place which listed staff's roles and responsibilities.

People's safety had been appropriately assessed and monitored. Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as falls, mobility and skin integrity. Control measures to mitigate such risks were in place.

The home was suitably decorated. The home was adequately heated and was clean.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority and had been approved.

People had choices of food at each meal time. People were offered more food if they wanted it and people that did not want to eat what had been cooked were offered alternatives. People with specialist diets had been catered for. The cook had a good understanding of how to fortify foods with extra calories for people at risk of malnutrition.

People were supported and helped to maintain their health and to access health services when they needed them.

People and their relatives knew who to talk to if they were unhappy about the service.

Relatives and staff told us that the home was well run. Staff were positive about the support they received from the senior managers within the organisation. They felt they could raise concerns and they would be listened to.

Communication between staff within the home was good. They were made aware of significant events and any changes in people's behaviour. Handovers between staff going off shift and those coming on shift were documented.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff deployed in the home to meet people's needs.

Effective recruitment procedures were not always in place.

People's topical medicines were not well managed and recorded.

Risks to people's safety and welfare were managed to make sure they were protected from harm.

Staff had a good knowledge and understanding on how to keep people safe from abuse.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff did not have all the essential and specific training and updates they needed. Staff did receive supervision and said they were supported in their role.

Staff were aware of the Mental Capacity Act 2005. Where people's freedom was restricted Deprivation of Liberties Safeguards were in place

People had a choice of food and were complimentary about the food.

People received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not always treated with dignity and respect. People's confidential information was securely kept.

People were consulted about how they wanted their care delivered.

Relatives were able to visit their family members at any reasonable time.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not always provided with personalised care and did not have access to activities to meet their needs.

People's and relatives views were gathered and acted on.

The home had a complaints policy; this was on display in the home. The provider had responded to complaints in an appropriate manner.

Summary of findings

Is the service well-led?

The service was not consistently well led.

Systems to monitor the quality of the service were not effective.

Records relating to people's care and the management of the service were not well organised or complete.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

Requires improvement

Newington Court

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 06 October 2015 and was unannounced.

The inspection team consisted of three inspectors. Before the inspection, we reviewed previous inspection reports and notifications before the inspection. A notification is information about important events which the home is required to send us by law.

We spent time speaking with seven people. Some people were not able to verbally express their experiences of living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people and observed care and support in communal areas. We spoke with five relatives. We also spoke with 15 staff including, nursing staff, the cook and the registered manager.

We contacted health and social care professionals to obtain feedback about their experience of the service.

We looked at records held by the provider and care records held in the home. These included 11 people's care records, risk assessments, eight weeks of staff rotas, six staff recruitment records, meeting minutes, policies and procedures, satisfaction surveys and other management records.

We last inspected the service on the 03 November 2014 and there were no concerns.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at Newington court. One person told us they felt, "Absolutely safe and secure". However, one person said that there was not enough staff. One person was not able to use their bell call system. The person told us that they have to wait for staff to come to them; they told us that they were not able to call out, "They wouldn't hear". They explained at night they have to get into a comfortable position as they won't see anyone until morning. The care records at night evidenced that night staff had checked on the person.

Relatives told us that their family members received good, safe care. One relative told us, "Mum thinks it's brilliant, clean, tidy and everyone is friendly". Another relative said, "The service is perfect". One relative said, "It's always clean".

Recruitment practices were not always safe. The registered manager told us that robust recruitment procedures were followed to make sure only suitable staff were employed. All staff were vetted before they started work at the service through the Disclosure and Barring Service (DBS) and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Nursing staff registration with the Nursing and Midwifery Council (NMC) had been checked and monitored to ensure that only registered nurses were employed. Staff employment files showed that references had been checked. Five out of six application forms did not show a full employment history. One staff member had a gap of seventeen years. Interview records did not evidence that these had been investigated by the provider.

The example above were a breach of Regulation 19 (2) (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff deployed on shift to keep people safe at all times. On the day of our inspection there were four care staff and one nurse working in Memory Lane with 21 people. The staffing rota's evidenced that this was the normal staffing level for this unit. We observed that Memory Lane was loud and chaotic. One person was shouting at others, a staff member was sitting on a chair behind the person completing records, the staff member did not respond to the shouting and increasing volume and anxiety of the person. Another person who was in seated in the same room became distressed and repeating their words. When staff members were present and interacting with people in the lounge area the atmosphere was observed to be quieter and more relaxed. During the time period, relatives had arrived and were helping their family members to eat, during this period of interaction the atmosphere was calmer, quieter and people appeared more content and happy. One staff member told us that the noise, anxiety and chaos we had observed throughout the day on Memory Lane was typical of each day.

People living on the top and bottom floor of the building were supported by three care staff and one member of nursing staff. We observed that most people spent their time in bed. One person's care plan stated that they liked to get up on a daily basis and spend time in the lounge watching television. Their care records evidenced that they had only been supported to get out of bed once in 12 days. Two staff told us that some people were cared for in bed due to their health but some were due to their safety. They explained that it was due to the staffing levels required to support people to get out of bed. They told us that if a person had been supported to get out of bed the previous day, the opportunity would be given to someone else the following day. Another staff member told us that they did not have time to chat with people because their time was task orientated. They also told us that sometimes they have to support people to bed very early, just to be able to get everything done. The home had started to use a DICE tool which was a dependency rating tool to assess the level of staffing required for each area of the home. The registered manager was unable to evidence that they adjusted the staffing levels to meet people's needs. There were not enough staff deployed to effectively meet people's needs.

The examples above evidence this was a breach of Regulation 18 (1) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed a nurse administering people's medicines during the morning medicines round. The nurse checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were asked if they were in pain and whether they required PRN (as and when required) medicines. Medicines were given safely. The nurse

Is the service safe?

discreetly observed people taking their medicines to ensure that they had taken them. However, medicines records for people who were prescribed creams and other topical solutions were not accurate and complete. For example, the topical medicines records seen did not always detail where the prescribed cream should be applied, how to apply it and the frequency it should be applied. The records detailed that people did not always get their topical medicines as they had been prescribed.

The examples above showed that medicines had not been properly managed. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were securely stored. The medicines storage areas were clean, tidy and well ordered. Temperatures of all medicines storage was checked and recorded daily, and these records were up to date.

Staff we spoke with understood the various types of abuse to look out for to make sure people were protected from harm. They knew who to report any concerns to and had access to the whistleblowing policy. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The registered manager knew how to report any safeguarding concerns.

Risk assessments had been undertaken to ensure that people received safe and appropriate care. Risk assessments included a list of assessed risks and care needs, they detailed each person's abilities and current care needs. Risk assessments corresponded with each section of the care plan. For example, one person received their care in bed. They had been assessed as being at high risk of falls, so bed rails had been fitted to prevent the person from falling. Bed rail checks were carried out frequently by staff who documented that they were working effectively. Risk assessments and care plans had been reviewed monthly or more frequently if people's circumstances changed. Staff were able to provide care which was safe and met each person's needs.

The premises were generally well maintained and suitable for people's needs. Fire extinguishers were maintained regularly. Fire alarm tests had been carried out. Staff confirmed that these were done weekly. Records showed that emergency lighting had also been tested regularly. Any repairs required were generally completed quickly. For example, staff had reported that one person's door handle was loose to their room. This was reported immediately to the handyperson who fixed this before we left. We observed that the areas of the home which had been assessed as unsafe for people to enter without support, such as the laundry room, kitchen, sluice rooms and cleaning stores were locked and secure. Gas and electric installations had been checked. The furniture had been checked to ensure that it was appropriate and flame retardant. Hoists and slings had been serviced.

The home was clean and tidy. Most areas of the home were free from offensive odours. One area of the home had a strong odour of stale urine. The cleaning staff told us that they had carried out extensive cleaning in this area and they were unable to remove the smell. The registered manager had ordered new flooring for this area, which would be easier to keep clean and smelling fresh.

Requires improvement

Is the service effective?

Our findings

People told us they were happy with the way staff looked after them. One person said, "The staff are good although I don't need to ask them for much". Another person said, "The staff are all lovely." People told us they were happy with the food. One person said, "The food is good and there's plenty of it".

Relatives told us that they were happy with the care given to their family members. One relative told us their family member had "Been here two years and the service is very good. We've not found anything wrong with it. They're well fed and most of the times they're clean". Another relative told us they, "Loved it" at the home and were very happy with the care given to their family member, they went on to say "The staff are wonderful. They [family member] were happier and more content than they had been in the last six years since their relative came to live at Newington Court". Relatives told us that the food was good and met their family member's needs. One relative told us, "He eats better than me".

Most staff had received training relevant to their role. However care staff had not undertaken medication training. Care staff had been administering prescribed creams without sufficient knowledge and support. Another member of staff had carried out interviews on their own and had recruited staff without being trained to do so. They had not received suitable training and support for them to safely carry out their role.

The examples above evidence a breach of Regulation 18(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records evidenced that people had been referred for physiotherapy assessment, speech and language assessment and dieticians when required, however advice had not always been followed. For example, one person's speech and language therapy (SALT) assessment detailed that they would benefit from using a communication aid to support them to communicate with staff. This had not been put in place. Follow up documentation from the SALT team evidenced that the home had not put this in place as staff had told them they knew how to communicate with this person. We spoke with the registered manager about this as agency staff were being used to fill sickness and annual leave, these staff would not know the person well enough to be able to communicate effectively. The failure to follow healthcare professionals advice meant that this person was at risk of isolation and at risk of their care needs not being met. A health and social care professional told us that the management team had not always followed advice given by health professionals in relation to using appropriate equipment to relieve pressure areas.

The example above evidences a breach of Regulation 9 (1) (a) (b) (c) (3) (b) (c) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records evidenced that 63 staff out of 71 had received training in safeguarding adults. Sixty nine staff out of 71 had received training on safe Moving and Handling Practice. All 71 staff had received training in Infection control. Staff told us that they received induction training when they started and this was carried out within three months. One staff member told us they "Had a workbook to work through" and that they shadowed other members of staff for about a month. Staff told us that they had three monthly reviews with the deputy manager or the in house trainer, in order to test her knowledge and competency. Another member of the nursing staff told us that they went through care staff manuals with them and checked their competencies and they understood what they were doing. There was evidence that training had been scheduled and planned. For example, the staff room had notice boards that had lots of information about up and coming training days and events. Additional training was available to the nursing staff to enable them to maintain their professional development.

Staff were able to ask for additional training if they needed it. For example, one nursing staff member told us that one person was having a lot of blood tests so they had asked to have training in relation to the procedure called Venepuncture training so that they could take blood rather than outside agencies coming into the home to carry these out. Venepuncture is the procedure for taking blood from a vein. Staff told us that they received formal supervision appraisal. Records evidenced that these had taken place.

Training records evidenced that 55% of staff had received training in dementia awareness; this meant 45% of the staff may not have the necessary skills to work with people living with dementia. The Registered Manager told us that this had been identified as a training issue and that the home had won a place on a pilot scheme for a new type of

Requires improvement

Is the service effective?

dementia training. Two days of training had been planned for heads of department. This was then going to be rolled out to senior staff and then the rest of the staff group. This was due to be completed by 02 December 2015.

Staff had received supervision from their line manager. Nursing staff supervised care staff and the registered manager and deputy manager supervised the nursing staff and housekeeping, kitchen and maintenance staff. Nursing staff were supported and supervised by the clinical lead nurse. This meant all staff received effective support and supervision for them to carry out their roles.

The manager and staff we spoke with had a clear understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They were able to explain to us the implications of the 2014 Supreme Court ruling. This stated that all people who lack the capacity to make decisions about their care and residence and, under the responsibility of the state, are subject to continuous supervision and control and lack the option to leave the care setting are deprived of their liberty. One member of staff told us that they would, "Always assume that people had capacity, but if this was in doubt then a mental capacity assessment would need to be carried out". One care plan we looked at evidenced that a DoLS checklist and application had been completed, with a mental capacity assessment and checklist had been completed with the staff member and person's relatives, along with the DOLs authorisation.

Some care plans did not evidence that mental capacity assessments had been carried out, although the initial pre-admission assessments stated a lack of capacity. The staff nurse on duty advised us that they were working through all the care plans to ensure that everyone had a capacity assessment that needed one. The provider audit had identified areas of improvement in relation to this. An action plan had been put in place which stated that improvements would be made by 16 October 2015.

There was plenty of food in stock in the kitchen. This included fresh fruit and vegetables. The chef had a good understanding of people's dietary requirements and regularly spoke with people about their likes and dislikes. The chef maintained a list of special requirements that people had such as a soft diet or pureed diet, as well as a list of people that were considered to be at risk of malnutrition. The chef told us that all food was fortified to add extra calories to people's food. They told us that they also catered for people who required a low fat diet.

The kitchen had recently carried out a pilot where people who needed additional support with eating and drinking would receive their lunches 30 minutes before other people, in order to allow staff to give them additional support. This has been successful and they continued to do this. One member of staff told us that the kitchen sent up a sample plate of the two lunch options available to people so that they can see what food was on offer in order to help them choose their meal. This enabled people with a cognitive impairment additional support to understand what meals were on offer. Staff told us that there were always snacks available and in the night people could have access to sandwiches and fruit. The catering team were also starting to prepare snack boxes that included cuppa soup, as the nights were getting colder, which meant people had access to hot and cold snacks to meet their needs .

People were supported to maintain good health and have access to healthcare services. Care plans evidenced that referrals had been made to the relevant health care professionals as appropriate. For example, one person's had been referred to the Mental Health Team because of changes in their behaviour and mental health. This showed that staff were aware of that person's individual needs and knew how to access the right support. People had seen their GP when required. This meant that people's health care needs were being well met.

Requires improvement

Is the service caring?

Our findings

People told us they found the staff caring and lovely. One person told us, "The staff are good" and another person told us that they "Love it here" and is "Happier and more content than I have been in the last six years". Another person told us "I love it here and the staff are really good". Another person said, "The staff are all lovely". One person said, "All staff are kind and caring here" they pointed out one member of staff and said "He's wonderful" and "They always knock when they bring me my hot chocolate at night, it's nice to have company, I am very content".

We also spoke to relatives who were visiting on the day of our inspection and they told us that the staff were caring and approachable. One relative said, "The service is very good, we have not found anything wrong with it" and "The staff are approachable". Another relative told us, "When the staff give care, they are caring". Another relative said, "I love it here, the staff are great and I feel my relative is safe".

Some people were unable to tell us about their care and support because they were unable to verbally communicate so we observed staff interactions with people. We saw that generally staff were responsive to people's needs. However, this was not always the case. We observed some care that was not respectful. For example, we observed a person living with dementia had become agitated and anxious and had started to shout at others. A member of staff who was sitting in close proximity to the person, did not respond or offer reassurance. The staff member carried on with writing notes. We also observed staff carrying out tasks such as propping people up with cushions and placing slings around people without communicating what they were going to do. This did not show that staff treated people with dignity and respect at all times.

This was a breach of Regulation 10 (1) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed some good care practice. For example, one member of staff sat with someone, who was tearful. The staff member held their hand and spoke gently in a caring manner. This reassured the person. Another member of staff chatted with a person in their room, gave the person a hand massage and painted their nails. Staff were proud of their work. One staff member said, "I treat everyone with dignity and respect and how I would like to be treated myself, give the best care I can". We observed that staff had good relationships with people, and communication was generally friendly and contained banter. One person told us that a member of staff had bought them some rubber ducks for their bath. They explained that they had been having a long standing joke with some members of staff about bath time. This showed that staff went above and beyond their job roles to support people.

People's bedrooms were decorated with their own furnishings. The doors to people's rooms had their names on and some doors contained memory boxes to remind people whose room it was. Thought had been given to individual bedroom settings where possible. For example, one person who loved gardening and looking at gardens had a bedroom that overlooked the garden and fields at the back of the home for this reason. People were able to bring in personal items to help make the bedrooms more personal and all were able to watch TV in their bedroom if they wished or in the lounge if they chose. All bedrooms had ensuite shower rooms and toilets which meant that people's personal care was carried out in the bedrooms. There were also assisted bathrooms on each floor of the home so that people who wished to have a bath could do so.

Some staff told us that although they always did their best to ensure people received good care, they would like to do a lot more of those "extra" things such as sitting chatting, or going out for walks in the garden or out in the community. Staff told us that these didn't happen often as there was not enough time and staff.

One member of staff said they thought the team was caring and thought about the person being at the centre of their support. They said, "We all know people inside out". This was evidenced in the care records which reflected a caring approach with lots of information about the person, their life and how they like to be supported.

There was a quiet room so people could use this for quiet reflection or for religious services if they wished to. People had opportunities to practice their religion. Holy Communion was offered once a fortnight to those people who wanted to participate. People's religious and cultural beliefs were met.

People's privacy was respected. We observed staff knocking on peoples doors before entering, even when the door was open.

Requires improvement

Is the service caring?

People's information was treated confidentially and their personal records were stored securely. People's individual care records were stored in lockable filing cabinets in the nurses stations on each of the floors to make sure they were accessible to staff. Staff files and other records not required on a day to day basis were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them.

Relatives confirmed they were able to visit their family member's when they wished to and stay as long as they wanted. We observed that relatives visited their family members throughout the day.

Requires improvement

Is the service responsive?

Our findings

People told us that the staff were responsive to their needs and that they knew how to make a complaint if they needed to. One person said, "I go to the balance clinic because I had falls". They also told us, "I've filled in a survey recently". They also told us that they chose not to participate in activities because they chose to spend their time with their relative". We observed that staff were not always able to be responsive to people's needs because they were busy carrying out tasks. One person had eaten their breakfast whilst being uncomfortable and wet. Staff had not responded to the person's personal care needs to ensure that they comfortable and treated with dignity and respect.

Relatives told us they knew how to make a complaint and they knew who to speak with. One relative told us, "My daughter would make any complaints if we needed to and we know who to complain to. Staff are approachable". Another Relative told us that they knew who to complain to but didn't always feel confident to do so. Another relative said that the Registered Manager had approached them about making a change in their family member's room to make it more comfortable for them, rather than relatives approaching the home on the issue. One relative told us that the staff were not always responsive to their family member's needs. They told us, "When you ask for help here you have to wait" and "Dad has been sat in a wet nappy since we've been here over an hour. They said they would give him breakfast then change him".

People had limited access to meaningful activities to keep them occupied and stimulated. The activities plan for the week was displayed on some notice boards within the home. There was one activities coordinator for all three floors and the separate Falcon Place unit, which was the smaller residential unit situated in the grounds of the home. The activities coordinator was on holiday on the day we inspected. We observed that the activities scheduled on the plan did not take place. For example, a film morning was advertised on the schedule, this did not take place. One person's care records evidenced that they had not been out of bed for 11 days. This person's care file evidenced that they liked to get up each day and spent time with other people in the lounge to watch television. One member of staff told us that they were concerned that people had limited opportunities to go out into the community. The activities notice board detailed that an entertainer and a 'Pets as Therapy (PAT) dog' visited the home once a month. PAT dogs can be cuddled and stroked to provide comfort and therapy. One person's activities records detailed that the activity they had participated in during the month as 'Enjoyed walking around the unit'. One person pointed to the mini bus in the parking area and said, "They have a mini bus there, but there's not a lot of point as there aren't the staff to use it enough".

Care records detailed how people should be supported to ensure they get the best possible care. However, staff following individual plans was not always consistent across the home. For example, we observed that some people did not receive the consistent and personal approach to their care as described in their care records. People who were distressed at times had become loud and noisy. Staff did not appear to notice and went about their tasks without checking to see what people wanted. This meant that people continued to be distressed and anxious which also affected other people's mood. We checked two people's care plans to check that staff were supporting them in a way which met their needs. We found that the care plans did not accurately detail how to communicate effectively with the person and did not detail how each person made choices. One person's care plan described that they will shout if they felt they were not being understood.

The examples above evidence this was a breach of Regulation 9 (1) (a) (b) (c) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with the registered manager about our concerns about lack of activity. During the afternoon we observed that a small group of people who lived on the ground floor were engaged in a singing activity. This was facilitated by the receptionist. The receptionist also gathered a blow up ball from the library and this was taken to people who lived in the memory lane unit. One member of staff spent a short period of time throwing the ball to engage people.

Care plans evidenced that people's care needs were being assessed and reviewed. People's care files contained pre-assessments, completed care plans and risk assessments. These had been reviewed on a monthly basis. Relatives told us that they had been involved in the assessment for their family member. One person told us that they had been involved and said that their relative had

Requires improvement

Is the service responsive?

been too. One care file contained a copy of a letter which had been sent by the registered manager to the person's relatives. This letter invited them to participate in a review of the person's care.

The provider had a complaints policy and procedures which included clear guidelines on how and by when issues should be resolved. The complaints and compliments procedure was on display in the reception area. Each person and relative received an information pack when they moved into the home with this information; along with details of the Local Authority, Local Government Ombudsman and the Care Quality Commission to whom they could go to if they were not happy with the response from the home. Staff were clear about their responsibilities to report concerns and complaints.

The provider had received three complaints in 2015. These had been resolved in a timely and satisfactory manner, with a response provided to the complainant. In one instance staff supervision had been carried out as a result of the complaint. This evidenced that the management acted upon information about the quality of care and had used this as an opportunity to learn and improve the service.

People were asked their opinions about the service they received. We saw posters asking for feedback about the food throughout the home. A 'residents' meeting had taken place on 9 July 2015. The minutes of the meeting showed that 13 people attended and two relatives. People were asked if they were happy with everything. Records did not evidence how the provider involved those people who received their care in bed in meetings in order to gain their feedback. All of those present were happy with the care they received and the food. The provider carried out an annual survey of people through a market research company. The surveys had recently been sent out to all people living in the home and the results were not available for us to view. One person confirmed they had "Filled out a survey recently".

The registered manager told us that the home had received a number of recommendations on the website www.carehome.co.uk. We checked and found that the home had received a number of positive recommendations in 2015.

Requires improvement

Is the service well-led?

Our findings

People told us that the service was well run. One person told us the service was "Absolutely well run". Relatives told us that the service was well run and that staff met people's needs. One relative told us, "When I get old I know where I want to come and live".

The registered manager and provider had audit systems in place within the home. The audits had failed to identify and action the areas of concern found during the inspection. For example, they had failed to capture that the recruitment records did not fully detail each employee's full employment history and reasons for gaps. The audits had not evidenced the concerns relating to people receiving care in bed because of staffing levels and people had not been supported to engage in meaningful activities to meet their needs.

We viewed the daily audits and checks completed by nurses. These were completed and submitted to the registered manager on a daily basis. These daily records had failed to identify gaps in recording of topical medicines. For example, nurses had ticked to show that topical medicines records had been completed by care staff but had not checked the accuracy of these.

Records were not always accurate, complete and contemporaneous. Topical medicines application records had not been completed adequately to give untrained staff sufficient direction to administer the medicines correctly and safely. One person's record did not show where the prescribed Cavilon cream should be applied. It did not record whether staff should apply this liberally or sparingly. It stated 'Apply to the pressure areas' but did not state on the body map where these were. The medicines record had been completed showing staff had generally administered the cream three times as day. The records showed that one person did not have their prescribed cream on the 16 September 2015 or the 18 September 2015. Another person's topical medicines application record showed that staff had administered the E45 cream generally twice a day. The record indicated that the E45 cream should have been applied three times a day.

One person had a risk assessment in place because they were at risk of falling. There was an enhanced risk assessment for falls in place, which had not been competed or signed. There was a diary list of falls which detailed that the person had fallen a number of times between May and September 2015. The completed accident and incident records kept by the registered manager did not correspond to the amount of falls the person had sustained.

The failure to operate effective systems of processes to monitor and improve the quality and safety of services and failure to maintain accurate and complete records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team at the home included a deputy manager, registered manager and the regional director. The regional director visited the home on a monthly basis to provide support for the registered manager and carry out monitoring. The registered manager told us that they felt well supported by the regional director and that they were available at any time by phone.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people who lived at Newington Court and to the management team. The staffing structure ensured that staff knew who they were accountable to. The nursing staff led each shift in the main area of the home and senior care staff led the shift within Falcon Place. Nursing staff and senior care staff told us that the deputy manager and registered manager were visible in the home and were approachable. Policies and procedures were in place to support the staff to carry out their roles effectively.

Staff meetings were held frequently. There were records of meetings held in September 2015 between the manager and nursing staff and meetings in July and September 2015 with the general staff team. These meeting records did not evidence which staff had attended the meeting. The minutes of the meeting showed that discussions had taken place about key areas of work such as poor practice, feedback from audits, sickness and absence, infection control, training, monitoring charts and planned charity events. The minutes of the meeting held on the 16 and 17 September 2015 evidenced that one member of staff had requested an extra member of staff on Memory Lane at night. The minutes recorded that instead of this it had been agreed to use the nurse from the top floor when medicines were being administered. This meant when this happened there was less staff on the top floor which may cause delays to meeting people's needs.

Requires improvement

Is the service well-led?

The registered manager held daily 'Stand up' meetings with all departments within the home to discuss the running of the home. These included members of maintenance team, catering and housekeeping team. This ensured that the registered manager was aware of any issues and concerns.

Staff told us they felt free to raise any concerns and make suggestions at any time to the registered manager and knew they would be listened to. Staff told us that they were aware of the home's whistleblowing policy. Staff felt confident to use this policy and they had reported concerns. Staff reported that communication was good within the home and meetings were regularly held so they could discuss concerns. Staff told us that the home had an open culture and communication was mainly good. Staff told us, "Barchester is a supportive organisation" and "The culture is open here and people and their families are happy to discuss things".

We did not always find there was an open culture of communication. The registered manager was not always receptive to answering questions. A number of times they told us that they wouldn't answer questions any further than they had done already for fear of recrimination. We found that the registered manager did not understand some of the tools and systems used by the provider. For example, the registered manager was not able to tell us how the dependency tool (DICE tool) worked. We questioned how the DICE tool informed the staffing levels because we had concerns about whether there were enough staff in certain areas of the home. The registered manager said "This is so new we need to understand it first" and made reference to not being a computer expert, this meant that the registered manager did not demonstrate fully that they had the skills and knowledge to lead and manage the service.

Handover sheets were used to ensure that important information was passed on when shifts changed at the home. This included information about people's medical needs and any action that needed to be taken such as referrals to the GP to ensure the care was consistent and communication was effective.

Weekly bulletins were sent to home managers from the organisation to make them aware of pertinent and important information. This included information about medical devices alerts and changes to regulations. Staff received information and news about other homes and services within the provider's organisation through a staff newsletter. This gave staff opportunity to get involved in different projects as well as providing career development within the organisation.

The registered manager had a good understanding of their role and responsibilities in relation to notifying CQC about important events such as injuries, Deprivation of Liberty Safeguards (DoLS) authorisations, safeguarding, any deaths and if they were absent from their role. The registered manager explained that they had good support from their manager and the provider. They received supervision meetings, monthly managers meetings, which enabled them to link up with other registered managers in the organisation to gain and provide peer support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive care and treatment that was appropriate, met their needs and reflect their preferences** Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.** Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People did not always have their medicines managed appropriately.** Regulation 12 (1) (2) (g)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to operate effective systems of processes to monitor and improve the quality and safety of services and failed to maintain accurate and complete records.** Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:
We served the provider and registered manager a warning notice and asked them to meet the Regulation by the 8 December 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had failed to deploy sufficient numbers of staff. Staff had not received appropriate training.** Regulation 18 (1) (2) (a)

The enforcement action we took:
We served the provider and registered manager a warning notice and asked them to meet the Regulation by the 8 December 2015.