Uday Kumar and Mrs Kiranjit Juttla-Kumar

Newlands Residential Home

Inspection report

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08 June 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 03 and 08 June 2016 and was unannounced.

Newlands Residential Home provides care for up to 17 older people some of whom may be living with dementia. The service is situated on the seafront at Walmer, near Deal, with accommodation on two floors. At the time of the inspection there were 10 people living at the service.

We carried out an unannounced comprehensive inspection on 17 February 2016. After that inspection we received concerns in relation to the safe care and treatment of people living at Newlands Residential Home. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings on those concerns. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Newlands Residential Home on our website at www.cqc.org.uk.

There was no registered manager at the service. The service had been without a registered manager for over five years even though a condition of the provider's registration is that there should be a registered manager. The provider was fully aware of their responsibility to have a registered manager because the condition was recorded on their registration certificate dated 29 September 2010. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was present on the first day of the inspection.

People were not consistently protected from avoidable harm. Accidents and incidents were not accurately recorded and prompt action was not taken to reduce the risks of further events.
Risks to people had not always been identified and assessed. When guidance was in place for staff to follow they had not consistently followed this to ensure people were safe. When staff had received advice from health care professionals this had not been consistently followed.

The premises and grounds of the service were not adequately maintained to ensure people's safety. Paths leading from fire doors were not clear for people to move through safely.

There were insufficient numbers of staff deployed and there were shortfalls in staff training. Staff did not have the skills and competencies to recognise when people needed further medical attention.

There was no manager to provide oversight and scrutiny of the day to day running of the service and the quality of the service delivered.

People received their medicines safely and were protected against the risks associated with the unsafe use and management of medicines.

People told us that they felt safe living at the service. People looked comfortable with other people, staff and in the environment. People said they would speak with the staff if they had any concerns.

This focused inspection has been carried out within six months of a comprehensive inspection. In line with CQC methodology the rating has been reviewed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the providers Uday Kumar and Kiranjit Juttla-Kumar to protect the health, safety and welfare of people using this service.

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.

People were not always protected from avoidable harm. Risks to people had not been consistently identified and assessed. Staff were not following available guidance to make sure people were safe.

The premises and grounds of the service were not adequately maintained to ensure people's safety.

There were insufficient numbers of staff deployed to meet people's needs. There were shortfalls in staff training including diabetes awareness. Staff did not have the skills and competencies to recognise when people needed further medical attention.

People received their medicines safely and were protected against the risks associated with the unsafe use and management of medicines.

There was no registered manager in post. There was no manager to provide leadership, oversight and scrutiny of the day to day running of the service.

Newlands Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered person 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 03 and 08 June 2016 and was unannounced. The inspection was carried out by two inspectors. We met and spoke with five people living at the service. We spoke with seven care staff, the cook and the provider.

We looked at how people were supported with their daily routines and activities and assessed if people's needs were being met. We reviewed five care plans and associated risk assessments. We looked at a range of other records, including staff rotas and training schedules. We also looked at medicines records and observed people receiving their medicines.

We did not ask the provider to complete a Provider Information Return because we carried out this focused inspection at short notice. This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we spoke with staff from the Kent local authority and had information from community nurses about what they had found when they visited the service. We reviewed information we held about the service and looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when a significant events happen, like a death or a serious injury.

We last inspected Newlands Residential Home in February 2016 when we found one new breach and five continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the providers Uday Kumar and Kiranjit Juttla-Kumar to protect the health, safety and welfare of people using this service.

Inadequate

Is the service safe?

Our findings

People said that they felt safe living at Newlands Residential Home. People looked comfortable with other people, staff and in the environment. People told us they would speak with care staff if they had any concerns. One person said they felt safe when staff supported them with their mobility.

At our last inspection in February 2016 the provider had failed to make sure that care and treatment was provided in a safe way to people. The provider had not assessed all potential risks to people and had not provided sufficient guidance for staff to follow to show how risks to people were mitigated.

At this inspection risks to people had not always been identified and assessed. When guidance was in place for staff to follow they had not consistently followed this to ensure people were safe. One person who was living with diabetes had a risk assessment/diabetes care plan in place. The risk assessment dated 18/02/2016 stated that 'Staff may be liable to disciplinary action if they do not ensure that this person's blood glucose level was maintained within healthy limits'. There was no record of what the limits were for this person. Health care professionals had recommended that this person's sugar levels be tested by staff twice weekly, before breakfast and supper. This was detailed in the risk assessments and to check the levels more often if there were any concerns. These checks had not been consistently carried out.

Records of when the person's blood sugar levels had been taken, covering a two month period, had gaps. This record showed that for a period of a month the person's blood sugar levels had not been checked. However, another form showed that some checks had been made during this period. Staff had completed two forms for the same period which did not have consecutive dates. Both records showed that on some dates the levels had only been taken once instead of twice and not twice weekly. Staff, therefore did not have clear records to competently monitor this person's blood sugar levels to ensure their health care needs were being met. From March to May 2016 the person's blood sugar levels ranged from 8.00 to 23.5 which indicated that this person's blood sugar levels were unstable.

The risk assessment clearly stated that 'If this person's blood sugar levels were not at the right level after all measures had been taken, the GP or diabetic nurse should be contacted'. There was no record to confirm what the range this person's levels should be and the staff had not sought medical advice or taken any action to ensure this person's blood sugar levels were safe. Staff had not signed to confirm who had tested the blood sugar levels and there were no daily notes available to confirm any checks had been made.

The increased risk to the person of unstable blood sugar levels had not been picked up by the provider or staff. This was discussed with the provider who took action to test the person's blood level which was 25.6. The doctor was contacted and this resulted in an increase to the person's medicine to stabilise their blood sugar levels.

Risks to people had not always been identified and assessed to ensure people were safe. One person did not have footplates on their wheelchair so their feet were on the floor. Staff told us that the person refused to have these in place as it was painful to their knees. There was no information recorded to confirm this

and no risk assessment in place to ensure staff took appropriate action to reduce the risk of the person's feet becoming trapped underneath the wheelchair when it moved. Another person's skin had been assessed by a health care professional who advised they needed to sit on a pressure relieving cushion as they were at risk of developing pressure sores. The person was sitting on a cushion but not the one recommended. Staff told us that the person had full capacity and had refused to sit on the new cushion but they had not recorded this decision and had not sought further advice about how to reduce the risks of pressure areas developing.

Staff had not consistently followed advice from health care professionals. Health care professionals had advised staff that a person needed to be re-positioned in bed every two hours to reduce the risk of pressure areas developing. The turn chart dated 2/6/2016 showed that the person had not been re-positioned every two hours as advised. Staff told us that the person was able to move themselves into different positions and they felt re-positioning them every two hours was not entirely necessary. There was no risk assessment in place to confirm this or to show what measures were in place to reduce the risk of this person developing pressure areas. Staff had not sought further advice from the health care professional to reassess this person's needs.

Care and treatment was not provided in a safe way for people because the provider had not assessed all potential risks to people and had not provided sufficient guidance for staff to follow to show how risks to people were mitigated. This is a continued breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient numbers of staff had not consistently been deployed. We had received information of concern that there were not enough staff on duty to provide a safe level of care and that staff were also completing cooking and cleaning duties during their shifts. Following these concerns we contacted the provider and they sent us a staff rota from 15/05/2016 – 12/06/2016. This showed there were regularly two care staff on shifts and that those staff were also covering cooking duties in the kitchen. At that time a manager was in post who was working with staff to cover the shortfalls.

Two people needed the support of two care staff. Other people were at risk of falls and needed staff to support them when they wanted to move around the service. Some people needed staff to support them with their meals. Staff, and the rotas, confirmed that there were occasions when only two care staff were on duty. When these staff were supporting a person who needed the support of two staff, this left other people without support. There were occasions when the senior member of staff was administering medicines and dealing with visiting health professionals which, reduced the number of staff available to meet people's needs.

On both days of the inspection there were three care staff on duty between 8am – 8pm and a cook from 8am – 2pm. The provider did not consistently deploy sufficient numbers of staff to take into account people's preferences of a male or female carer to support them with their personal care needs. Staff told us this added further pressure as, on some shifts, there were only two staff to get most people up or to bed. Staff said they were, "Run of my feet" and, "It ends up with two of us getting everyone up".

We looked at the current and future staff rota with the provider and they confirmed that there were gaps on the rota. The shifts that were not covered included, care, cleaning and cooking duties. We asked what action was being taken to address the staff shortages. The provider told us they were speaking to a recruitment agency to arrange cover for the shortfalls. The provider said they were recruiting for three care staff, a part time cook and a cleaner. The provider and staff confirmed that care staff were sometimes preparing meals, carrying out maintenance tasks and also cleaning the service because of staff shortages.

Staff told us that they 'struggled' when there were two care staff on duty but that they managed with three and one staff commented, "We all pull together to make sure people get the care they need".

There were two care staff on duty at night. The provider told us that this was sufficient and that there were no problems at night. Some people needed support during the night to use the toilet but at times had to wait for staff support or put themselves at risk due to a lack of support. One persons 'night progress report' noted on 01/06/2016 'Regular checks done during the night. Buzzed for toilet a few times. Took self twice without waiting for staff. Reminded to wait as is unsteady on feet'.

We looked at the accident and incident reports. There were six documented falls in the last four months. Four of the six falls were unwitnessed by staff and occurred between the hours of 3am and 6:30 am. The provider had not identified any pattern or emerging theme, for example, that most of the falls happened at night and that most were unwitnessed by staff. The provider had not taken action in response to the number and pattern of falls which had happened during the night, for example by reviewing staff deployment.

One person's daily notes noted, 'As staff was preparing supper a resident came in to tell us X had had a fall. Staff found X sitting on the floor next to the chair. As staff never saw the fall we're not sure whether slipped out of chair or fell'. Staff had not completed an accident form for this incident. Accidents and incidents were not consistently recorded and were not being analysed or checked by the provider in order to identify trends and take action to reduce the risk of further accidents.

Some people said the staff came quickly when they called them. People did not have call bells in the lounge and relied on each other to call staff for assistance if they needed. One person, sitting in the lounge, said, "I have had a lot of falls. I have a bell in my room but I don't have one here. If I need the staff I wait till they are in here or I get [another person] to get them for me". During the inspection one person went into the office to tell staff that a person in the lounge needed to use the bathroom. Staff then responded to see who needed the support.

Staff took time to sit with people and support them to eat their meal. Staff asked people if they were alright as they went about their duties. Staff told us they would like to spend more time with people.

At the last inspection in February 2016 the provider had failed to ensure staff had the appropriate training to enable them to carry out the duties. We reported there were shortfalls in training as some staff had not completed training on mental capacity and deprivation of liberty; health and safety; fire training and safeguarding. We also reported that staff had not completed training on diabetes awareness, a condition that some people were living with. Staff did not all understand how to care for a person with diabetes or recognise the signs that they may be unwell due to a change in their blood sugar levels.

At this inspection we looked at the staff training schedule and spoke to the provider about staff training. The provider told us that all but two members of staff had completed diabetes training. The training schedule contradicted this and showed that nine of the 11 care staff had still not completed training on diabetes. One staff told us they had completed diabetes training and two staff said they had not. Staff had not taken action when a person's blood sugar levels were unstable and did not demonstrate that they had the skills and competencies to recognise when people needed further medical attention.

Some staff had completed training on mental capacity and deprivation of liberty; however four care staff had not completed this. Care staff prepared food in the kitchen. Of the 12 staff on the rota only three staff had completed food hygiene training, one of whom was the part time cook. Some staff had completed

training on infection control. During the inspection staff wore aprons and gloves when required but did not change their gloves appropriately. For example, one staff wearing plastic gloves went from supporting people in the dining room with their meals to the lounge and fed fish in a tank and then returned to the dining area. Staff did not always follow good practice and national guidance. For example, some staff had long nails and wore nail polish. The National Institute for Health and Care Excellence (NICE) recommends that fingernails are short, clean and free of nail polish.

The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. The provider had not ensured staff had the appropriate training to enable them to carry out the duties they were required to perform. This is a continued breach of Regulation 18(1)(2)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection in February 2016 the provider had failed to meet the requirements of his registration with the CQC. The provider had failed to appoint a registered manager to manage the service. This was a continued breach of a condition on the provider's registration.

Since our last inspection the manager had resigned. There was no manager to provide leadership, oversight and scrutiny of the quality of the service at Newlands Residential Home. The provider was fully aware of their responsibility to have a registered manager. We have previously taken action against the registered person for having no registered manager. This action was withdrawn when a manager made an application to be registered with CQC. This application was subsequently rejected by CQC due to errors in the application. At our inspections in December 2014, June 2015 and February 2016 there was no registered manager in post and we reported that this was a breach of the provider's conditions of registration. An application to register a manager had been submitted following the inspection in February 2016. When the manager resigned they withdrew their application.

The provider had failed to have a registered manager in post. This was a continued breach of Regulation 5(1) of the Care Quality Commission (Registration) Regulations 2009.

At the last inspection in February 2016 one fire door, in the 'quiet area', was not working properly and had to be forced open by staff. At this inspection the fire door was not secure and could be opened from the inside. There was no alarm to alert staff when the door was opened so people could leave the building without being noticed. The pathway from this fire door had moss and plants growing through the paving which was a trip hazard. There were bushes overhanging which made the escape route very difficult to walk though.

The bottom pane of wired glass on a fire door in another corridor had been smashed. The door was not sitting correctly in the frame. There were large gaps between the door and the frame and the door appeared unsafe. Staff told us the door was "Pushed into place" and "Unsafe". There was a typed A4 sign on the door with 'Only open in an emergency' on it. We reported our concern to the local fire and rescue service. Staff said a new door had been purchased – this was in a box in the dining room. The provider told us they were contacting a local carpenter to fit the new door.

The grounds around the service were untidy and overgrown. The pathway at the side of the building was impassable with overhanging greenery. Paving had weeds and plants growing through that covered much of the path. Some people told us enjoyed spending time in the garden when the weather was pleasant. However; people were limited to sitting in one place at the front of the service and were not able to freely walk around the grounds due to the increased risk of tripping or falling.

At the rear of the service, where some people sat and smoked, there was old furniture including a mattress,

pillows and a freezer. Staff told us they were waiting for them to be removed. There were two yellow clinical waste bins in use. These should be kept locked so that people cannot access them easily. Staff told us these were kept locked. We checked the bins and one was full of clinical waste bags but was not locked.

On the first day of the inspection the carpet in one person's bathroom was very dirty and smeared with dark stains. Staff and the provider confirmed this was blood and the provider told us this would be cleaned using a hand held cleaner to ensure the work was not intrusive to the person in the room. On the second day of the inspection the carpet had not been cleaned.

The provider had not ensured that the premises were safe. This is a continued breach of regulation 12(1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had completed training on safeguarding people from harm and abuse and they knew the signs of possible abuse. The training schedule confirmed that most staff had completed this training. Staff said they would report any concerns to the senior on duty because there was no manager at the service. Senior care staff told us they were aware of safeguarding procedures and would not hesitate to contact the Kent local authority safeguarding team by telephone. Contact numbers, including out of hours details, were displayed in the office for staff to refer to. The provider told us they would notify relevant authorities should an incident occur which needed to be reported. The provider was not at the service every day and staff did not know how to alert authorities or CQC other than by telephone. Staff did not know what paperwork to complete should they need to report incidents by post or electronically to have a documented record.

Staff were aware of the whistle blowing policy and the ability to take concerns to agencies outside of the service. Not all staff felt confident they would be listened to if they raised a concern with the provider or that their concern would be fully investigated to ensure people were protected.

People received their medicines safely and were protected against the risks associated with the unsafe use and management of medicines. Only staff that completed medicines management training and had their competency assessed supported people with their medicines. The provider told us they had arranged for a local pharmacy to further assess staff competency.

People told us they received their medicines when they should and were happy the staff managed their medicines. People said, "Staff sort all my medicines out. I don't have to worry about it" and, "Staff ask me if I need any pain relief. They look after me".

Medicines were stored securely. Medicines were disposed of in line with guidance. When medicines were stored in the fridge the temperature of the fridge was taken daily to make sure the medicines would work as they were supposed to. The medicines trolley was clean, tidy and was not over stocked.

Staff said stock of medicines was checked and rotated, by night staff, to ensure medicines did not go out of date. This was confirmed by records of stock; however, there were no other records of medicines audits or staff competency checks since the manager resigned.

Medicine Administration Records (MAR) charts showed that people received their medicines according to the prescriber's instructions. Medicines were given to people at their preferred times and in line with the doctor's prescription. Staff explained what medicine a person was taking, patiently waited for them to take the medicines, and then signed the MAR. Staff told us they were aware of changes to people's medicines and read information about any new medicines so that they were aware of potential side effects. Changes to people's medicines was 'handed over' to staff on the next shift to ensure people received their medicines

correctly.

Some people were given medicines on a 'when required basis'. There was guidance for each person who needed 'when required medicines'. When people needed creams to keep their skin healthy and intact, staff recorded this accurately.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The provider had failed to have a registered manager in post.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people because the provider had not assessed all potential risks to people and had not provided sufficient guidance for staff to follow to show how risks to people were mitigated. The provider had not ensured that the premises were safe.

The enforcement action we took:

Cancellation of registration