Mr & Mrs J P Robinson

Newland House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 21 and 23 December 2015 and was unannounced. This meant the staff and registered provider did not know we would be visiting.

Newland House provides care and accommodation for up to 30 people requiring nursing or personal care. On the day of our inspection there were 22 people using the service.

The home had a registered manager in place. 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.

Newland House was last inspected by CQC on 16 May 2013 and was compliant.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Thorough investigations had been carried out in response to safeguarding incidents or allegations and accidents and incidents.

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

Staff training was up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

The home was clean and suitable for the people who used the service however could be more suitably designed for people with a dementia type condition.

People were protected from the risk of poor nutrition.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered provider was working within the principles of the MCA.

People who used the service, and family members, were complimentary about the standard of care at Newland House.

Staff treated people with dignity and respect and helped to maintain people's independence.

The home had a programme of activities in place for people who used the service.

Care records showed that people's needs were assessed before they moved into Newland House and care plans were written in a person centred way.

The registered provider had an effective complaints policy and procedure in place. People who used the service knew how to make a complaint.

The service had links with the community and other organisations.

The registered provider gathered information about the quality of their service from a variety of sources and was in the process of implementing a new quality assurance system.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service and the registered provider had an effective recruitment and selection procedure in place.

Thorough investigations had been carried out in response to safeguarding incidents or allegations, and accidents and incidents.

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

Is the service effective?

Good

The service was effective.

Staff training was up to date and staff received regular supervisions and appraisals.

People were protected from the risk of poor nutrition.

The registered provider was working within the principles of the Mental Capacity Act.

The home was suitable for the people who used the service however could be more suitably designed for people with a dementia type condition.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and people were encouraged to be independent.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their

wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

Risk assessments were in place where required.

The home had a programme of activities in place for people who used the service.

The registered provider had an effective complaints policy and procedure in place. People who used the service knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

Staff told us the registered manager was approachable and they felt supported in their role.

The service had links with the community and other organisations.

The registered provider gathered information about the quality of their service from a variety of sources and was in the process of implementing a new quality assurance system.

Newland House

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 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 21 and 23 December 2015 and was unannounced. This meant the staff and registered provider did not know we would be visiting. One Adult Social Care inspector, a specialist advisor in nursing and an expert by experience took part in this inspection. An expert by experience is a person who has personal experience of using, or caring for someone who uses, this type of care service.

Before we visited the home we checked the information we held about this location and the registered provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and the infection control team. No concerns were raised by any of these professionals.

For this inspection, the registered provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the registered manager about what was good about their service and any improvements they intended to make.

During our inspection we spoke with 11 people who used the service and two family members. We also spoke with the registered manager, three care staff, a domestic staff member and the activities coordinator.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for six members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

We spoke with people who used the service, and family members. Everyone we spoke with said they felt safe at the home. Most people told us there was enough staff on duty. Two people told us, "Sometimes they're a bit pushed, could do with a couple more" and "Sometimes they're very busy but we don't suffer". People also told us that staff usually responded to the call bells in good time, both during the day and at night. Family members also told us there was enough staff at the home.

We discussed staffing levels with the registered manager and looked at staff rotas. We saw there was one senior member of staff on duty during the day and either three or four care staff. The home also employed domestic and kitchen staff. The registered manager told us staff vacancies and absences were covered by the home's permanent staff and they did not use agency staff. We asked staff whether there were plenty of staff on duty. They told us, "Enough at the moment." We observed there was a sufficient number of staff on duty and call bells were answered promptly. This meant there were enough staff with the right experience, skills and knowledge to meet the needs of the people who used the service.

We looked at the recruitment records for three members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

The home is three terraced houses converted into one. We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home was generally clean although a side table in one of the lounges required cleaning. On the first day of our inspection visit we noticed there was an odour of urine in one of the small lounges however the odour was not there during the remainder of our visit.

Communal bathrooms, shower rooms and toilets we looked in were clean and free from mould. Appropriate soap and paper towel dispensers were on the walls and cleaning rotas were up to date. We saw domestic style radiators had guards and window restrictors, which looked to be in good condition, were fitted in the rooms we looked in.

We saw hot water temperature checks had been carried out and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014. We saw that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date.

Risks to people's safety in the event of a fire had been identified and managed, for example, a monthly

inspection of doors and escape routes took place, the fire alarm was tested weekly, fire extinguishers were tested annually, the emergency lighting was tested monthly and we saw a copy of the most recent local fire authority fire safety audit carried out in September 2015. All these checks were up to date.

The service had an emergency evacuation procedure in place, which included a list of people who used the service, their room number, level of mobility and whether any mobility aids were used.

This meant that checks were carried out to ensure that people who used the service were in a safe environment.

Risk assessments were in place for the home and included aggression and violence towards staff, contractors on the premises, external walkways and security, moving and handling, lone working, laundry, cleaning and fire safety.

We looked at the safeguarding file, saw a copy of the registered provider's policy and copies of safeguarding alert forms. Safeguarding records contained details of action taken, details of who was informed, for example, local authority safeguarding team, and copies of statutory notifications sent to CQC. Staff we spoke with understood how to keep people safe.

We looked at accident and incident records and saw a monthly audit was carried out of all accidents and incidents to identify any trends. Accident reports contained detailed information on who had the accident, where and when it occurred, what action was taken and whether any referrals took place. For example, we saw one person had experienced a fall resulting in a cut to the nose. We saw this person had been referred to the falls team for additional support and a falls risk assessment was in place. A family member told us action had been taken to prevent their relative from falling during the night. This meant the registered provider followed procedures and carried out checks to ensure people who used the service were safe.

We looked at the way medicines were managed. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

The home used a pharmacy managed barcode medicines management system, namely the Proactive Care System (PCS), to administer medicines, manage stock and record clinical readings. During a medicines round, the user scans each person's barcode identifier using a hand-held device to ensure the correct person's drug file is recalled. The system then carries out a number of checks to ensure the following are correct; resident, medicine, time, dose, quantity and in date. If administration is outside any parameter, the system alerts the user immediately.

The PCS medicines management system highlighted six people's drugs to be audited on a daily basis, to check that medicines were being administered safely and appropriately.

Medicines were securely stored in a locked treatment room and only the senior member of care staff on duty held the keys for the treatment room. Medicines were transported to people in a locked trolley when they were needed. The staff member checked people's medicines on the electronic medicines administration record (eMAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines.

Medicines were given from the container they were supplied in and we saw staff explain to people what medicine they were taking and why. Staff gave people the support and time they needed when taking their

medicines. People were offered a drink of water and staff checked that all medicines were taken.

Current refrigerator temperatures were recorded and they were between 2 and 8 degrees Celsius. However, minimum and maximum temperatures relating to refrigeration also need to be recorded daily, to make sure medicines are stored within the recommended temperature ranges. The registered manager told us this would be addressed immediately.

We saw one person received their medicines covertly. The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example mixed with food or drink. We saw the decision making adhered to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had taken place with the relevant people. The best interest meeting involved care home staff, the health professional prescribing the medicine(s) and a family member.

Staff showed us how unwanted or out of date medicines were disposed of and records confirmed this. However, there was only one signature confirming the disposal of medicines. The registered manager told us this would be addressed immediately. This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who lived at Newland House received effective care and support from well trained and well supported staff. Family members told us, "You get whatever you want when you ask for it. We're well looked after. I like it in here. It's all good", "I'm happy with everything" and "I can't think of anything that's really wrong. I don't have any problems, I don't think anyone does". A visiting hairdresser told us the staff were exceptional and "Go the extra mile."

We looked at the training records and the registered provider's training matrix, and saw mandatory training included first aid, health and safety, infection control, moving and handling, food hygiene, safeguarding, mental capacity, equality and diversity, falls, nutrition and fire safety. The training matrix showed the majority of staff were up to date with their training and where there were any gaps, the training was planned. For example, first aid training, moving and handling and health and safety training was all booked for early in the new year with external accredited training providers. Five of the six staff files we looked at contained training certificates, which confirmed the information on the training matrix however the sixth file did not contain up to date certificates. We discussed this with the registered manager who told us this member of staff had completed their mandatory training in 2015 however they were unable to find the staff member's certificates at the time of our inspection visit. Staff we spoke with told us their training was up to date.

We looked at supervision and appraisal records. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We saw supervisions took place regularly and included discussions on time keeping, personal development, competence, managing self and others, training, objectives and philosophy of care. All the records we saw were signed and dated by the supervisor and member of staff. We asked staff about supervisions. They told us, "Two monthly. We discuss issues, bare below the elbow, training, they're more useful than appraisals." We looked at appraisal records and saw some members of staff had not received an annual appraisal in 2015. The registered manager told us as they were new in post, they were waiting until they had got to know staff better before carrying out their appraisals and these would be carried out early in the new year.

We discussed staff induction with the registered manager. They told us all new staff received an induction when commencing employment at the home, which included fire procedures, health and safety, infection control and policies and procedures. The registered manager also told us all new staff will complete the Care Certificate and progress to at least a level two qualification in health and social care. This meant staff were fully supported in their role.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining rooms at meal times when required. People were supported to eat in their own bedrooms if they preferred. The kitchen was clean and spacious and we saw a four week menu was in operation, with people offered choices at meal times. We saw lunch and tea time was 'protected time', which meant relatives and visitors were encouraged to visit the home outside these times. People we spoke with told us the food was good. They told us, "You can ask for anything you want", "Perfect, especially my favourite chicken soup" and "The meals are very good". The hairdresser told us that mid-morning on one day, a person had been sitting

in the dining room and said they would like bacon and eggs. The staff on duty offered to make it for them, which they did, and the person enjoyed eating it.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. Where people were identified as being at risk of poor nutrition staff completed daily 'Food and fluid balance' charts. The food charts used to record the amount of food a person was taking each day, documented the amount of food a person consumed, however portion sizes were not specific. Fluid intake charts recorded the millilitres consumed however fluid intake goals and totals were not recorded. People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health care professionals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw copies of DoLS that had been authorised by the local authority and saw other applications had been made that were awaiting assessment. We discussed DoLS with the registered manager, who was aware of their responsibilities with regard to DoLS, and saw relevant mental capacity assessments had taken place. This meant the registered provider was following the requirements of the MCA and DoLS.

The registered manager told us that they had introduced a new consent document based on the Duty of Candour, with the intention to be open and transparent with people who use their services in relation to care and treatment. The new consent document covered the following areas: consent for staff to access the care plan, consent to take photographs for the use of identification purposes and for medical reasons.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Records showed that the relevant people were involved in decisions about a person's end of life choices. When a person could no longer make the decision themselves, we saw that an emergency health care plan (EHCP) was in place for a person that showed a 'best interest' meeting had taken place with the person's family and the GP, to anticipate any emergency health problems.

Communication care plans were in place and we saw specific detail for staff to follow in relation to how they engaged with people. One person's communication plan stated, "[Name] can indicate their wishes through

non-verbal means, they will shuffle forward on their wheelchair or armchair if they do not wish to be there, [Name] can point to things i.e. bed chair etc. to indicate this is where they wish to be taken." The individualised approach to people's needs meant that staff provided flexible and responsive care, recognising that people living with communication impairment could still live a happy and active life.

People's records showed details of appointments with, and visits by, health and social care professionals and we saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example GPs, district nurse teams, social workers, dietitian, speech and language therapists (SALT), DoLS assessor and chiropodist. Care plans reflected the advice and guidance provided by external health and social care professionals.

We looked at the layout of the building and although the service was limited by the size and shape of the building and narrow first floor corridors, we found it could be more suitably designed for people with a dementia type condition. The bedroom doors were numbered with residents' names and were handwritten. Doors had not been personalised with photographs or colour and there was little signage around the home, which meant it was difficult to navigate. Some of the carpets were patterned and there were no dementia friendly displays on walls. We discussed the design of the home with the registered manager who was aware of improvements required to provide visual stimulation for people with dementia, which included improved contrasting wall and fixture colours, improved signage on doors and walls and the provision of attractive and interesting memorabilia and artwork.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Newland House. They told us, "The girls are very pleasant, very willing. Even the young girls are really good" and staff treated people with "Gentleness".

There was a calm, positive atmosphere throughout our visit and we saw that people's requests for assistance were answered promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful and caring.

We observed that people were asked what they wanted to do and staff listened. In addition, we observed staff explaining what they were doing, for example in relation to medicines. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff were patient, kind and polite with people who used the service and their family members. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. Overall, people looked clean, comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected. We saw interactions between staff and people who used the service included, "Are you putting your make up on, is [Name] coming today?", "You look beautiful, you look really pretty with the hair band on your head, that looks nice, do you want a coffee?", "You're just dosing off darling, there you go, there's your tea you drink it whilst it's nice and warm" and "Your hair's lovely, they've done it beautiful". A family member told us their relative, who is now immobile, liked to lie in the bath and the staff put extra bubbles into the bath and allowed her to enjoy the experience twice a week.

We heard a person living at the home say to the registered manager, "You're lovely we all love [name of Registered Manager]". People told us they were treated with dignity and respect by staff. They told us, "I like the way they knock on the door [of their bedroom]" and "[The registered provider] makes sure that the girls treat you with respect". This meant that staff treated people with dignity and respected their wishes.

Care plans were in place for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs, and were written using the results of the risk assessments. Staff knew the individual care and support needs of people, as they provided the day to day support and this was reflected in people's care plans.

Each person's care plan contained a social profile, where the information had been collected with the person and their family and gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. This was important information and was necessary for when a person could no longer tell staff themselves about their preferences and enabled staff to better respond to the person's needs.

Staff we spoke with told us they knew the individual care and support needs of people, as they provided the day to day support and this was reflected in people's care plans. The care plans gave staff specific information about how the person's care needs were to be met and gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They also detailed what the person was able to do to take part in their care and to maintain some independence.

We saw 'End of life wishes' care plans were in place for people, which meant that healthcare information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

Records confirmed that pre-admission assessments were carried out and people's needs were assessed before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure their safety and comfort.

Following an initial assessment, care plans were developed detailing the care needs and actions and responsibilities required to ensure personalised care was provided to all people. The initial assessment was also signed by the person who used the service. The care plans guided the work of care staff and were used as a basis for quality, continuity of care and risk management. We also saw the care plans were regularly reviewed to ensure people's needs were met and relevant changes added to individual care plans. We saw a note from the registered manager in the handover book which stated, "When completing a monthly evaluation of a care plan no lines must be missed in between each month's evaluation, the only time a blank line is left is on the actual written individual care plan."

We saw risk assessments were in place, which considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to reduce the risks and keep people safe. Standard supporting tools such as the Braden Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments.

The registered manager showed us the dependency assessment tool that they were going to carry out for people. This would ensure there was a summary of the care requirements of people living at the home, to ensure that staff had the capacity and skills to be able to provide appropriate care.

Assessments had been carried out which showed people were at risk of developing pressure ulcers. We found people's care plans were up-to-date to inform staff about people's care and support needs. An example for one person stated, "Staff to check [Name]'s skin integrity on each body wash and are to report and report any problems or concerns". This meant that people's care records contained a detailed care plan to instruct staff what action they should take to maintain skin integrity and showed that people were receiving appropriate care, treatment and specialist support when needed. Continence assessments were completed and care plans detailed the recommended incontinence products that people should use. An example for one person stated "Staff leave [Name]'s en suite light on during the night so [Name] is aware of the whereabouts of the toilet." We also saw elimination records were completed to monitor bladder and bowel movements

Daily notes were kept for each person, they were concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition. Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty, at the beginning and end of each shift. Information about people's health, moods, behaviour, appetites and the activities

they had been engaged in were shared, which meant that staff were aware of the current state of health and well-being of people. We saw staff signed a daily log which acknowledged that they knew and understood people's needs and their responsibilities and actions they should take.

The home employed an activities coordinator, who worked part-time, and activities were also carried out by a student who worked at the home two days per week. When the activities coordinator was not on duty, instructions were left for care staff to carry out the activities. The registered manager told us additional entertainment at the home was paid for by staff raising money from events such as sponsored walks, pie and peas suppers, summer fetes and raffles.

We observed the activities coordinator in one of the lounges using some reminiscence cards to interact with some of the people who used the service. They then spent some time in one of the other lounges singing with some of the other people who used the service. Some people knew the words of the songs but others didn't however there were no song sheets available to help those people who didn't. The activities coordinator told us they had previously been care staff at the home and they had come back to do activities. They told us they sometimes played dominoes with the people who used the service and carried out 'Arm and leg exercises'. They told us they had not received any training in delivering activities for people with dementia but had "Picked it up as I went along."

A family member told us, "There's never enough activity, especially one to one activity" and was concerned there was no pantomime that year. Other people we spoke with told us there were enough activities in the home. One person told us they went out on their own into the town. They also told us they had 300 DVDs in their room, which they brought downstairs to share with residents. We observed this happened during the afternoon on the first day of our visit. Another person told us they sometimes went out with a member of staff in a taxi to buy clothes. They also told us they preferred their own company so stayed in their room, coming down to the dining room for meals.

We looked at a copy of the provider's complaints policy, dated 20 May 2015, which was on display in the home. This described the complaints procedure, responsibilities, verbal and written complaints and investigation process and timescales. We looked at the complaints file and saw the last complaint received by the home was in 2011. People we spoke with were aware of the complaints policy and knew how to make a complaint. None of the people or family members expressed any concerns to us during our visit. One person told us, "I can't complain, no complaints. I couldn't knock it. I like it here. It's beautiful." The registered manager told us the next residents' and family meeting was taking place at the end of January 2016 and complaints would be discussed at this meeting. This meant the provider had an effective complaints process in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. One staff member told us the registered manager was "Efficient" and "They get things straight away". They also told us the service was "Friendly and caring."

We saw staff were regularly consulted and kept up to date with information about the home and the provider. We saw records of staff meetings, which had taken place regularly and agenda items included safeguarding, sickness, key workers, laundry, DoLS, mobile phones, medicines and care plan reviews.

The service had good links with the local community. One person who used the service went to a day centre and another person went to a local club with their social worker. Local singers and artists regularly visited the home and the registered manager told us they were in discussion with a local church group about visiting the home at regular intervals.

We saw copies of the 'Newland House good governance policy' and '2015 annual development plan' and looked at what the provider and registered manager did to check the quality of the service.

We saw medicines audits were carried out regularly and included quizzes to test staff knowledge on the subject. Care records were audited every month by senior care staff however the registered manager was in the process of implementing new care records, including a new quality assurance process. We also saw copies of monthly mattress audits, infection control audits and staff hand hygiene assessments.

The registered manager was new to the home and told us, and showed us, what quality assurance processes they were in the process of implementing. As well as changes to the care plans, these included a new general audit process, and giving the senior care staff more responsibility for audits to aid their professional development. The registered manager told us the registered provider regularly visited the home and talked to people and visitors however these visits were not documented. The registered manager told us they completed a daily walkaround to check the home however this was also not documented. We discussed this with the registered manager who told us they would record these checks in the future.

We saw records of residents' meetings, the most recent was for a meeting in September 2015. The agenda included discussions about the home, activities, meals, Christmas shopping and staffing. The minutes of the meeting recorded that people did not have any concerns about staffing, were happy with the home and made suggestions for future activities.

We saw a 'Customer satisfaction survey' had taken place in 2015 and 18 responses had been received, which were mostly positive about the home.

This meant that the provider gathered information about the quality of their service from a variety of sources.