Barchester Healthcare Homes Limited

Newton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Newton House is registered to provide accommodation for up to 126 people requiring nursing or personal care, including people living with dementia. The home is purpose built and is divided into four discrete 'communities' or units. The Watergate and Somerby units provide accommodation for people with general nursing and care needs whilst Castlegate and Brownlow are reserved for people living with dementia. There were 108 people living in the home at the time of our inspection.

We carried out a comprehensive inspection of the service on 8 December 2015. At this inspection we found two breaches of legal requirements. This was because the provider had failed to establish and maintain effective systems of governance and to correctly identify the staffing levels required to meet people's needs and deploy staffing resources effectively to keep people safe from harm.

After this inspection, the provider wrote to us to tell us what they would do to address these breaches. We undertook this focused, follow-up inspection on 15 December 2016 to check that they had followed their plan and to ascertain that legal requirements were now being met.

This report only covers our findings in relation to these issues. You can read the report from our comprehensive inspection by entering 'Newton House, Grantham' into the search engine on our website at www.cqc.org.uk.

We found that the provider had not addressed either of the breaches of legal requirements we identified in December 2015.

The provider was still failing to ensure staffing resources were deployed in a way that ensured people received safe, effective care that met their individual needs and preferences.

The provider was also still failing to implement and maintain effective systems of governance to ensure compliance with legal requirements in the provision of people's care and support.

Additionally, we found that the provider was continuing to fail to protect people from the risks of falling and of harm from other people living in the home.

We are currently taking action against the provider to ensure that they make the necessary improvements to become compliant with legal requirements. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 was a continuing failure to ensure staffing resources were deployed in a way that ensured people received safe, effective care that met their individual needs and preferences.

There was a continuing failure to protect people from the risks of falling and of harm from other people living in the home.

This meant that the provider remained in breach of legal requirements.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a continuing failure to implement and maintain effective systems of governance to ensure compliance with legal requirements in the provision of people's care and support.

This meant that the provider remained in breach of legal requirements in this area.

Newton 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 provider was 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.

We undertook a focused, follow-up inspection of Newton House on 15 December 2016. This was to check that the provider had addressed the two breaches of legal requirements we had identified at our comprehensive inspection of 8 December 2015. We inspected the service against two of the five questions we ask about services: 'Is the service safe?' and 'Is the service well-led?'. This is because the service was not meeting legal requirements in relation to each of these questions. The inspection was unannounced.

The inspection team consisted of one inspector, a specialist advisor whose specialism was nursing care and two experts by experience. 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 our inspection we reviewed the information we held about the service. This included the information the provider had sent us following our inspection in April 2016, setting out the action they would take to meet legal requirements. We also considered notifications received (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies.

As part of our inspection we spoke with 16 people who used the service, 19 family members or friends, the registered manager, the provider's regional director and clinical development nurse, seven members of the nursing and care team, one member of the activities team and one local healthcare professional who was visiting the home at the time of our inspection. We looked at a variety of documents and written records including six people's care files, accident and incident records and information relating to the auditing and monitoring of service provision.

Inadequate

Is the service safe?

Our findings

When we conducted our comprehensive inspection of the home on 8 December 2015 we found that the provider had failed to correctly identify the staffing levels required to meet people's needs and deploy staffing resources effectively to protect people from the risks of falling or abuse from other people living in the home. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to this breach, the provider told us that they had made changes to staffing arrangements in the home. These changes included ensuring a qualified nurse was on duty at night in all four units, increasing the number of staff employed in the activities team, introducing a second deputy to the registered manager and the introduction of a new approach towards the allocation of staff at the beginning of every shift.

However, despite these changes, most of the people we spoke with during our inspection visit told us of their concerns about staffing levels in the home and the negative impact this had on their safety and welfare in a number of different ways. For example one person said, "They're always short. They're understaffed all day. There's not enough to watch everyone and we have to wait. I dread nights as there's only a couple on." Another person told us, "I have to wait a long time sometimes to be moved around [in my wheelchair]." One person's relative said, "I don't think there are enough staff and evenings are very thin. The management need to get it sorted out." Another relative said, "Sometimes they really struggle. So rushed. I am also not 100% sure he gets his eye drops all the time. It's supposed to be three times a day. My daughter visited the other day from 3.15 – 8.30pm and she said no one gave him any drops in that time. He should have had two lots [in that time]." Another person's relative told us, "They seem very rushed at lunchtime. I come in and see her left [in her bedroom] with her lunch and knife and fork that she can't manage. Then she gets the meal taken away uneaten. She needs more help with eating."

Reflecting this feedback from people and their relatives, throughout our inspection visit we saw many people lying alone in bed or sitting for long periods in communal lounges with no staff support or supervision. At lunchtime, some people were left unattended for extended periods and we also saw staff remove people's uneaten meals without taking the time to support or encourage them to eat. This created a risk that people did not have enough to eat. Commenting on staffing levels in their unit, one staff member told us, "If we have five staff ... we are fine. [But] we sometimes run short with four … if there is last minute sickness and [they] can't get agency or bank. The nurses help us but it's [still] a bit stretching covering the work of five." Another member of staff said that if cover could not be found, senior staff told them, "Sorry, we can't get anyone and you will just have to get on with it." Discussing the staffing situation in their unit on the day of our inspection, another member of staff said, "It's the afternoon and we still have to get people up and out of bed."

Some family members also expressed their concerns about a lack of staffing continuity and the negative impact this had on their relatives, particularly those living with dementia. For example, one family member told us that staff did not always know their relative if they had been brought from other units in the home to cover at short notice. Some staff members also talked to us about this practice which they said left their

team understaffed when colleagues were moved between units to cover sickness or other staffing shortfalls. Commenting on this approach and the impact it had on people living with dementia, the regional director said, "I can't argue with the lack of continuity." Discussing the use of agency staff, one person told us, "I don't like the agency staff as they don't know us." Another person's relative said, "[Staffing levels] are a bit low at times, particularly when one goes off sick. That's when they use agency staff and they don't know the residents." During our inspection visit, we observed the practice of one agency staff member. We watched them come into one of the dining rooms and go up to one person who had finished their lunch. They were carrying a kitchen cleaning cloth and attempted to use it to wipe the person's hands, without any prior explanation. The person was clearly frightened and pulled away. The agency worker then wiped the table with the same cloth and removed the person's empty plate without saying a word.

When we discussed these concerns with the registered manager she confirmed that agency staff were used regularly to cover shifts, pending the recruitment of permanent staff. However, when we reviewed staffing rosters for the three months preceding our inspection visit, we saw that there had been occasions when shifts had not been covered. The manager also told us that she reviewed staffing levels on a regular basis with a standard tool that the provider used in all of its homes. She told us said that the number of hours deployed on the staffing rota were higher than those indicated by the staffing tool. However, the feedback we received and the observations we made during our inspection visit indicated that the provider was still failing to ensure staffing resources were deployed in a way that ensured people received safe, effective care that met their individual needs and preferences.

This was a continuing breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our previous inspection in December 2015, we found that the provider was failing to consistently protect people from the risk of physical attack from other people living in the home who had challenging behaviour. Therefore, in preparation for our follow up inspection in December 2016, we reviewed the notifications we had received from the provider in the previous 12 months. The events notified to us included 51 abusive incidents between people living in the home. This compared to 36 similar incidents notified to us in the 12 months before our previous inspection visit. Reflecting this rising trend, some people told us they did not feel safe. For example, one person said, "It's not safe. I got attacked about 10 days ago [by another person living in the home]. [They] walked up behind me and punched me on the head. Then [they] went to a [person] in a wheelchair and tipped [them] out. No staff were around when it happened." Another person told us, "I got attacked by [someone] last night." Another person said, "I lock my door now to stop [other people] coming in. And they still bang on it, day or night. [Name of person] is terrible and [name of person] has hit me a couple of times."

Staff told us they deployed a variety of strategies to try to keep people safe from others including organising medicine reviews, trying to ensure certain individuals did not sit next to each other and implementing action plans that had been agreed in consultation with the provider's specialist dementia support team. However, the high number of incidents that were still being notified to CQC indicated that these interventions were not consistently effective in keeping people safe from harm. For example, when we reviewed the incidents of this type recorded between July and December 2016, we saw that one person had been the victim of abuse from other people on eight separate occasions in a three month period. When we looked at this person's care plan we found there was limited information for staff on how to support this person to keep them safe and during our inspection visit we observed the person putting themselves at risk of further abuse from others, with minimal intervention from staff. Staff told us that they had identified another person as being abusive towards one other person in particular. As a result, they told us they ensured the two people were kept apart. However, from our review of recorded incidents, we saw that this person had physically

assaulted four other people during the course of November 2016. This person's care plan had no guidance for staff on actions to take to try to prevent this happening.

When we discussed our concerns in this area with the registered manager she told us that the issue was being monitored in the home's regular 'clinical governance' meetings. However, when we reviewed the records of these meetings given to us by the provider, we saw no reference to the issue other than one short entry in the minutes of the meeting of July 2016 highlighting the need to record and notify each incident separately. When we discussed with the registered manager the fact that there had been no reduction in the number of incidents notified since our last inspection, she acknowledged that further action in this area was needed.

On our previous inspection of the home, we also found that the provider was failing to consistently protect people from the risk of falling. In preparation for this follow up inspection we reviewed the notifications of serious injuries sustained by people living in the home. In the 12 months preceding our inspection, the injuries notified to us included 15 fractures resulting from falls. This included one person who had fallen and sustained fractures on three separate occasions in less than five months. During our inspection visit we reviewed the total number of occasions in the period February to October 2016 when people had fallen (not just those which had resulted in a serious injury) or been 'found on the floor' following an unwitnessed incident. This identified that there had been a total of 401 recorded falls or people found on the floor in this nine month period, over 75% of which had been unwitnessed by staff. The number of incidents recorded each month remained broadly similar throughout the period.

Reflecting this trend, some people's relatives expressed their concern about the high incidence of falls and the risk this presented to their loved ones. For example, one family member told us, "He's supposed to be on 1:1 when I am not here, due to his falls risk. [But] he had a fall and hit the back of his head last week. The hospital glued it for him." Another family said, "[My relative] has told me that the night staff are 'awful' and so she tries to get out of bed herself and often falls." As highlighted earlier in this report, communal areas of the home did not have a continuous staffing presence and during our inspection we saw that this undoubtedly contributed to the very high number of unwitnessed falls. For example, we observed one person sitting in the lounge with their walking frame place in front of them. They called for assistance but no staff were present so they attempted to stand unaided, which they were unable to do. They made several other calls for assistance and attempts to stand unaided before another person sitting in the lounge was able to attract the attention of a passing member of staff. Thankfully, the person did not fall on this occasion but the lack of supervision and support from staff had clearly created an increased risk to their safety.

Staff were able to tell us of a range of actions they had taken to try and address the risk of people falling including medicines reviews, the use of sensor mats and other specialist equipment and the use of one-to-one staffing support. However, the consistently high number of recorded falls (particularly those that were unwitnessed) and the serious injuries sustained as a result indicated that these interventions were not consistently effective in keeping people safe. For example, one person had a history of falls over several months, including one occasion in August 2016 when they had fallen out of bed and sustained an injury. But it was only on the day of our inspection that the person was supplied with an 'ultra-low' bed to reduce the risk of further injury. A staff member told us that the bed had only become available as another person in the home no longer required it. When asked by a member of our inspection team how easy it was to obtain specialist equipment, the same staff member told us requests had to be approved by senior management and that, "It is a long process."

When we reviewed the risk assessments and care plans of people who had been identified as being at risk of falling, we found they often contained contradictory guidance for staff to follow. For example, one person's

mobility care plan stated their movements should be monitored every 30 minutes, whilst their falls care plan stated they were at high risk of falls and required observing at 15 minute intervals. Another person's mobility care plan stated they were at 'moderate' risk of falls and their falls care plan (which had been written at the same time) stated they were at 'very high risk' of falls. We also found it difficult to ascertain from some people's care plans whether alternative or additional preventive measures had been considered or implemented following a fall. For example, one person's care plan stated a referral to the local NHS falls prevention team was required but there was no evidence that the referral had been made or that the person had ever been seen by the falls team. Care files contained a diary of each person's falls but there was no evidence that staff had used these to identify any themes or actions which might have reduced the risk of future falls.

When we discussed our concerns with the registered manager, she told us that a number of initiatives had been taken to try to reduce the number of falls including enhanced auditing by the home's clinical governance group, a review of the home's admissions policy and increased use of one-to-one staffing support. However, the persistently high numbers of recorded falls and serious injuries indicated these actions had not been effective in reducing the ongoing risk to people's safety.

Taken together, the provider's continuing failure to protect people from the risk of harm from other people living in the home and from the risk of falling was a breach of Regulation 12(2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

When we conducted our comprehensive inspection of the home on 8 December 2015 we found that the provider had failed to implement and maintain effective systems of governance to ensure compliance with legal requirements in the provision of people's' care and support. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to this breach, the provider told us they had made a number of changes to management and administrative systems in the home including requiring the registered manager to be 'a presence on the floor observing care practice and ensuring good standards throughout the home', the introduction of 'monthly clinical governance meetings', the use of 'bi-monthly quality first audits' to be conducted by the regional director and 'bi-monthly resident/relative meetings'.

However, as highlighted in the Safe section of this report, these initiatives had not led to any significant reduction in the risks to people's safety and welfare in the 12 months since our previous inspection. The number of recorded falls remained persistently high, resulting in serious injuries to several people, one of whom had sustained three fractures in less than five months. The number of incidents between people living in the home notified to CQC had increased since our last inspection and people told us they still felt frightened and unsafe. As indicated in the Safe section above, the provider remained in breach of legal requirements in relation to staffing and was now also in breach of requirements relating to safe care and treatment.

When we reviewed the provider's auditing and monitoring systems, some of which had been introduced since our previous inspection, we found some of these appeared very superficial and lacking in rigour, with little evidence of any positive impact on people's safety or wellbeing. For example, following our last inspection, the provider had told us that the new clinical governance group would review both falls and abusive incidents between people to 'establish trends and plans to address them'. However, as noted elsewhere in this report, when we reviewed the minutes of the clinical governance group meetings we found that there had been almost no discussion of the issue of abusive interactions between people, despite the continuing high number of incidents of this type. Similarly, the provider had told us that the regional director would review falls and abusive incidents as part of their regular 'quality first' audits. However, when we reviewed the report of the most recent audit conducted in November 2016, we found very little evidence that this had been done in a systematic or robust way. Additionally, although staff were proactive in recording and reporting accidents and incidents that had occurred within the home, when we reviewed completed accident and incident forms, on all the forms we looked at, the section of the form used to record details of preventive measures put in place to reduce the risk of something similar happening again, was blank.

At our last inspection of the home we had identified shortfalls in internal reporting which meant senior staff, including the registered manager, lacked sufficient knowledge to manage the home effectively. Although the provider had sought to address this issue through the introduction of a daily walkabout by the registered manager and other initiatives, on this inspection we found that the shortfalls in audit and monitoring systems meant senior staff still lacked a proper insight into the reality of people's experience of living in

Newton House. For example, despite the clear evidence of consistently high levels of falls and serious injuries, the registered manager told us, "I think people are safer [than at the time of our last inspection]." Similarly, sharing her view on the quality of service provided to the people living in the home, the regional director told us, "I think people are safe. [It's] not in the same place as last December."

The provider's ongoing failure to implement and maintain effective systems of governance to ensure compliance with legal requirements in the provision of people's care and support was a continuing breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.