Angel Care plc

Newlands Care Home

Inspection report

18 Tetlow Lane
Manchester
Greater Manchester
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Tel: 01617920993

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

This unannounced inspection took place on 11 September 2017. At our previous inspection in April 2015 we found that the service was not always responsive and there was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection although we found that the provider was no longer in breach of this regulation we had further concerns that the service was not consistently safe, effective, caring, responsive or well led. We found three further breaches of regulations. You can see what action we have taken at the end of the report.

Newlands Care home provides accommodation, nursing and personal care to up to 30 people. At the time of the inspection there were 30 people using the service. The service is designed to meet the religious and cultural needs of the Jewish community.

There was a registered manager in post who supported us throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission 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.

There were insufficient numbers of suitably trained staff to keep people safe and meet their needs in a timely manner. The provider had not responded to the registered manager's request to increase the staffing levels to ensure people's needs were met.

Risks of harm to people were reduced, however some action taken to reduce the risks may not have been the least restrictive.

The principles of The Mental Capacity Act 2005 (MCA) was not consistently followed to ensure that people who lacked the mental capacity to agree to their care and support were supported by the legal representatives to agree in their best interests.

Staff were trained to fulfil their roles, however further supervision was required to ensure that staff practice was safe and appropriate.

People did not always receive care that met their assessed needs or individual preferences and their independence was not always promoted.

The registered manager and staff knew what to do if they suspected abuse and followed the local safeguarding procedures.

People's nutritional needs were met and if their needs changed or they became unwell health care advice and support was gained.

People's medicines were managed, stored and administered safely by staff who had been trained. Staff were employed using safe recruitment procedures to ensure they were of good character and fit to work.

People were supported to engage in hobbies and activities and their religious and cultural needs were met. Staff were kind and compassionate with their interactions with people.

There was a complaints procedure and people were regularly asked their views on the service. Action was taken when people raised concerns.

The registered manager was well liked and respected by people, relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were insufficient numbers of staff to safely meet the needs of people in a timely manner.

Risks of harm were not always managed appropriately to keep people safe.

People were safeguarded from abuse and the provider followed safe recruitment procedures to ensure that staff were of good character and fit to work.

People's medicines were stored, managed and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the MCA and DoLS were not always being followed to ensure that people who lack mental capacity were being supported in their best interests.

Staff received training to fulfil their role, however their performance was not always supervised.

People's nutritional needs were met and if they became unwell or their needs changed, health care support was gained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported to be as independent as they were able.

People were not always offered choices about their care.

People's right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their individual assessed needs.

People's religious and cultural needs were met and most people were offered opportunities to engage in activities.

There was a complaints procedure and we saw action was taken to resolve the complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not responded to the registered managers request for adequate staffing levels.

The registered manager responded and acted upon the feedback they received.

The audits in place were effective in maintaining a safe environment.

People and staff liked and respected the registered manager.

Newlands Care 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 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 11 September 2017 and was unannounced. It was undertaken by one inspector and an expert 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information that we held about the provider and the service which included notifications that we had received from the provider about events that had happened at the service. For example, serious injuries and safeguarding concerns.

We spoke with 10 people who used the service and five visiting relatives. We spoke with the registered manager, two care staff, a team leader, the cook, the activity coordinator and a visiting Rabbi.

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 looked at four people's care records, three staff recruitment files, staff rosters and training records. We looked at the way in which medicines were managed and at the systems the provider had in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2015 we found no concerns about the staffing levels within the service. At this inspection we saw that there had been a reduction in staff numbers and there were insufficient staff to meet the needs of people in a safe and timely manner. There were four carer's, one senior carer and a qualified nurse on the day of the inspection. The registered manager told us that this was the usual staffing for the morning and afternoon and that they had identified that they needed more staff during the afternoon and evening as some people who were living with dementia were experiencing periods of heightened anxiety at these times and required more staff support. The registered manager told us that they had requested an increase in staff from the provider but this had not been agreed.

A person who used the service told us: "There used to be more carers. There has been deterioration in some of the people that live here over the years and they need more support. We have to wait longer now". A relative told us: "Weekends are bad for staff, with residents getting more demanding and restless, the home could do with more staff". Another relative told us: "For some reason, some weekends there is a shortage of staff and there is more people in bed and people waiting for ages to be changed".

We observed that several people remained sitting in wheelchairs in the lounge during the morning rather than being transferred into the more comfortable lounge chairs. These people would have required the support of two staff to transfer them into the chairs and we saw that there were not two staff available to support these people as staff were supporting other people to get up. We discussed this with the registered manager who informed us that the staff had probably felt that transferring people into the comfortable chairs would have taken too long as they would then be transferring them back for lunch in the dining room. We observed that these people remained in their wheelchairs for up to an hour and a half before lunchtime as there were insufficient staff to support them into their lounge chairs.

We looked at two people's care records and saw that their mobility assessments stated that they were able to walk with a walking frame and supervised by staff. We observed that these two people were in wheelchairs during the day. We discussed this with the registered manager and they told us that there were insufficient staff to be able to support these people to walk when they needed to so they were being transported in wheelchairs. The lack of sufficient staff meant that these people's assessed needs were not being met and their right to independence was not being promoted.

Three people were being cared for in their bed on the first floor. These people had been assessed as requiring hourly checks. We saw that two of these people had not been checked on the hour and there had been an hour and a half delay. During the afternoon, one person who was living with dementia became anxious and was asking to leave. A member of staff was allocated to spend time with the person and this lasted up to three hours. This person had not been assessed as requiring one to one support and this meant that this staff member was unable to support other people's needs. Another person who was anxious was spending time sitting in the office with the registered manager. The registered manager told us that this was because they would otherwise disrupt other people in the lounge and there were not enough staff to be able to distract them.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks of harm to people were assessed and action was taken to minimise the risk. If people experienced falls, sensor mats and mattresses were put in place to alert staff to them falling. We saw signs around the service next to call points which alerted people to use the call bell when requiring assistance. The signs stated 'Call don't fall', however not all people would have been able to read these signs due to their dementia. We found that not all the action being taken to keep people safe was the least restrictive. For example we saw that one person was being restricted to their wheelchair with the use of a lap strap. This person was able to walk with the support of staff, however because there was not always enough staff to be able to support them at the times they required it, a lap strap had been put in place to reduce the risk of them falling.

We saw records that confirmed the provider used safe recruitment procedures when employing new staff. Pre-employment checks would include references and the completion of disclosure and barring service (DBS) checks. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that provider could be sure that staff were of good character and fit to work with people who used the service.

A person who used the service told us: "I am safe here, we are all friendly with each other, if you are not happy you can tell any one of the staff members". Staff we spoke with knew what constituted abuse and knew what to do if they suspected someone had been abused. A member of staff told us: "I would speak to the manager if I suspected anything. If they didn't do anything I would go higher". The provider's whistleblowing procedure was clearly visible on the wall and the registered manager had recognised and responded by referring any safeguarding concerns to the local authority for further investigation. This meant that people were being protected from the risk of abuse.

People's medicines were being stored, managed and administered safely. A person who used the service told us: "If you need something for pain or you've got any discomfort, the nurse is always there giving you everything you need". The nurse administered medicines and we saw there were daily checks of the medicine room and fridge temperatures. There was photograph identification of each person and a clear list of any allergies people may have. We saw that the balances of medicines were regularly checked to ensure that people had their medicines at the prescribed times.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had no concerns in the effectiveness of the service. At this inspection we found that the principles of the Mental Capacity Act 2005 (MCA) were not being consistently followed.

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that some people who had been assessed as not having the mental capacity to agree to their care at the service had not had a DOLS authorisation submitted. We observed one person who was living with dementia asking to leave and stating that the staff 'could and should not keep them there'. We also observed that this person was removed from the lounge when they were anxious and taken upstairs, we heard them say they did not want to go upstairs. A member of staff told us that when the person became unsettled they needed 'time out'. We discussed this with the registered manager who explained that the person was being offered time and reassurance to allow them to become calm. Neither of these restrictions had been agreed through the principles of the MCA and no DoLS authorisation had been requested from the local authority.

We saw another person was being cared for in bed with bed rails in place. We were told that the staff were unable to get the person out of bed safely due to issues with the moving and handling of the person and them requiring a specialist chair. The registered manager and the person's relative confirmed that action had been taken to look for a suitable chair for the person to sit out in, however the person lacked the mental capacity to agree to be at the service and restricted to their bed. A DoLS authorisation had not been requested for this person and these actions had not been legally agreed as the least restrictive action to take to keep the person safe.

Another person was being restricted with the use of a lap belt when they were sitting in their wheelchair or lounge chair. We were told by the person's physiotherapist that the person lacked the mental capacity to keep themselves safe and would attempt to walk alone. The person's mobility plan stated that the person could walk with a walking frame as long as they were supported by staff. During our inspection we did not see this person's walking frame and they were not given the opportunity to walk. This meant that this person was being restricted by the use of a lap strap on their chair. A DoLS authorisation had not been requested for the person in relation to them residing at the service or the restrictions in place.

These issues constitute a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they felt that staff were effective in their roles. One person told us: "Staff

are very good and well trained people, I have no concerns". Staff we spoke with told us that they felt supported to fulfil their roles and we saw that staff were undertaking regular training to enhance their skills. However, staff did not always put their training into practise as they did not always recognise and understand the principles of the MCA. For example, removing one person from the lounge against their wishes. We also observed one member of staff move two people in a way that was potentially unsafe and we reported this to the registered manager. The member of staff had undertaken moving and handling training however their practise was not always safe. This meant that staff performance was not always being monitored and supervision of staff was not always effective to ensure that staff carried out their roles competently.

People told us they liked the food. One person told us: "I like my food, they always provide me with home cooked meals with different options". A relative told us: "There is always enough food and my mum is a fussy eater, but staff always do their best". The service served kosher food and people who used the service were aware of this at their admission. The kitchen itself was segregated between areas where meat was cooked from where dairy produce was handled. There was specific cutlery used to ensure that meat and other products did not come into contact with other diets such as non-kosher. We observed that people who required a special diet or assistance with eating and drinking received it. A relative told us: "It takes at least 90 minutes for my relative to eat, staff are always caring and patient, I can't do what they do, they do it well". Some people had been assessed as requiring a soft diet and their drinks thickening due to being at risk of choking. We saw that staff offered people soft foods and their drinks were thickened as the instructions stated. People's weight was monitored and people were referred to their GP and dietician if significant weight loss was noted. This meant that people's nutritional needs were being met.

When people became unwell or their health care needs changed, staff sought advice from the appropriate health care professionals. One person told us: "When I need a doctor's attention, staff ask me if I would like them to arrange a visit for me". People had access to their GP, dentist, podiatrist as well as other health care agencies. We saw that some people's mental health had deteriorated and a referral for support from the mental health care teams had been made. This meant that people were being supported to access health care when they needed it.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had no concerns in the way that people were treated. At this inspection we observed that staff supported and spoke to people in a kind and caring manner; however we saw that some people were left to sit in wheelchairs rather than being transferred into more comfortable chairs. We were informed that this was due to a lack of staff and the time it would take to move people. The registered manager told us that they had informed the provider that they required more staff but this had not been agreed. This did not demonstrate a caring attitude as people did not benefit from sitting in a more comfortable chair even be it for a short amount of time.

People were not always encouraged to be as independent as they were able to be as we saw two people who were able to walk were not being supported to walk and were using wheelchairs. We noticed that one person was sitting in a wheelchair that did not belong to them. We were informed that this was due to a lack of available staff. This did not demonstrate a caring provider as they had not agreed to increase the staffing levels to meet the needs of people who used the service.

People and their relative told us that staff were kind and caring in their approach. One relative told us: "The atmosphere is good and relaxed. I could have taken my relative anywhere else bigger and perhaps more modern but here it is like family, the staff are brilliant". Another relative told us: "I think this is one of the best homes around, staff have got my relative's best interest at heart, they are very well looked, I could not wish for a better place".

People were mostly offered choices about their day to day care and were involved in decisions about their care. A relative told us: "Even though my relative sometimes lacks capacity, staff always offer them a choice and treat them with respect". Another relative told us: "To answer your question if I am being involved in care plans, the answer is yes, we have done a needs checklist with staff and have done an advance directive, we discussed it with my children". A person who used the service told us: "Staff do everything for me and still encourage me to make choices and do something's for myself".

People and their relatives told us that their privacy was respected. One person told us: "The staff are caring and polite, they always knock at my door if they need anything". Another person told us: "If you are in your room and you want to be left alone, staff don't bother you". This meant that people's right to privacy was being upheld.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had concerns that people's risk assessments were not always being up dated to ensure that people's assessed needs were being met and they were safe. There was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made however further improvements were required. There was no longer a breach of this regulation.

People's needs had been assessed and we saw there were care plans and risk assessments. People and their families had been involved in the planning of their care. However we saw that people's risk assessments were not always being followed, for example, people who were able to walk were not being supported to walk. People's care plans in relation to their anxiety and behaviour did not inform staff how to support people at the times they became anxious. This meant that staff did not know what to do at these times and although they offered reassurance this was not always done in an appropriate manner, for example, moving a person from the lounge against their wishes from the lounge to upstairs. Comprehensive care plans would have supported staff to meet people's needs and offer reassurance in way that meant people would have their needs individually responded to.

There was a range of activities available to people if they chose or were able to join. One person who used the service told us: "We do what we like, we talk to each other, sing-along, we love music and singers coming in to offer some entertainment". However some people spent long periods of time alone in their room due to not being able to come downstairs. It was unclear what activity and stimulation these people were offered throughout the day. A member of staff told us: "The domestic staff are really good as they go around they have a chat and keep an eye on people". We spoke with the relative of one person who told us that they wanted their relative to be able to get out of bed for a better quality of life and that they were looking into having the person's needs assessed for a suitable chair.

The service met the religious and cultural needs of the Jewish community. The registered manager told us that not all people who used the service were Jewish but they were made aware that the service provided kosher foods and there would be Jewish celebrations at the point of pre assessment and admission. There were visiting Rabbi's who offered people spiritual care and support. We were told that people did not have to join in the celebrations if they chose not to and that if people had another cultural or religious need that they would be supported to meet those needs.

We saw that staff had personalised people's bedroom doors with subtle signs which would help staff know the needs of people at a glance. There were signs which identified whether people had a DNAR in place or not. There was also a colour coded sign which highlighted the level of support the person would need in the event of an emergency such as a fire. These signs meant that staff would be able to respond in a timely manner if a person became unwell or there was an emergency such as a fire.

There was a complaints procedure and this was clearly visible in the corridor. People told us that they knew how to complain and that they were confident that their complaint would be handled. One person who

used the service told us: "We are always involved, the manager keeps us in the loop with everything". A relative told us: "We are always invited to meetings, she asks us about our concerns, tells us of improvements and asks for suggestions". We saw that relatives had complained that they were not always offered a drink when visiting. We saw that a drinks station had been put in place and we observed that visitors were helping themselves to drinks during the day.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had remained in post since the previous inspection. Prior to the inspection the provider submitted a PIR which stated 'when staffing the home we use the Isaac and Neville Dependency tool to ascertain the needs of our clients. Therefore our staffing levels change when our clients needs change. Our staffing levels are client lead not business lead'. However the registered manager informed us that since the last inspection the staffing levels had been reduced at the instructions of the provider even though the dependency levels of some people had increased. They had asked the provider to increase the staffing due to the changing needs of people who used the service and they had been informed they could not. This meant that the provider was not ensuring that the quality of care people received was of a good standard.

The registered manager had not recognised that people were potentially being unlawfully restricted of their liberty and some staff practise was not being supervised to ensure that it was appropriate.

The provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager immediately made DoLS referrals for three people we identified as being at risk of having their liberty restricted unlawfully prior to us leaving the site. This showed that they were responsive and acting upon our feedback.

The registered manager undertook several regular audits in relation to the building maintenance, kitchen and medicines. We saw that the home was well maintained and medicines were being managed safely.

There were regular meetings with people who used the service, staff and heads of departments. People were asked their views of the service through quality surveys and the feedback from these surveys was available for people to view. A relative told us: "No one really needs a meeting as the manager's door is always open, I get a survey about the care here almost every six months, I have completed one about a month ago". Feedback had been mainly positive and when issues had been identified action had been taken, for example the drinks station for visitors had been implemented.

We saw that the registered manager had identified through analysis of records that there were several people who were experiencing urinary tract infections (UTI'S). UTI's are often connected to not having enough to drink. We saw the registered manager had discussed this with staff and asked them to ensure that people were offered and encouraged to drink plenty. During our inspection we observed that people were offered lots of drinks and there were drinks available for people to be able to help themselves.

People, their relatives and the staff told us they liked the registered manager. One staff member told us: "[Manager's name] has the people who live here at the heart of what she does. I wouldn't have stayed so long if it wasn't the case". A relative told us: "The manager is excellent, she is responsible for many improvements, staff are much more attentive with residents, more interaction and the laundry situation,

which was a problem before, has improved greatly, every piece of clothing is now labelled".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded from improper care and treatment as the principles of The MCA 2005 were not consistently followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not responded to the registered manager's request for more staff to improve the quality of care for people.