Barchester Healthcare Homes Limited

Newton House

Inspection report

148 Barrowby Road
Grantham
Lincolnshire
NG31 8AF
Tel: 01476 578072
Website: barchester.com

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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**

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 111 people living in the home at the time of our inspection.

We inspected the home on 8 December 2015. The inspection was unannounced.

The home did not have a registered manager. The registered provider had appointed a new manager in July 2015. At the time of our inspection an application to register this person had been submitted to CQC. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers ('the provider'), 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.

Summary of findings

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection the provider had sought and obtained DoLS authorisation for 29 people living in the home.

During our inspection we identified a number of areas in which improvement was required to ensure people living at Newton House were provided with safe, person-centred care.

The provider had failed to correctly identify the staffing levels required to meet people's needs and to deploy staffing resources effectively to keep people safe from harm. The provider had also failed to implement and maintain effective systems of governance to ensure compliance with legal requirements in the provision of people's care and support. You can see what action we told the provider to take in respect of these two issues at the back of the full version of the report.

Although staff understood the issues involved in supporting people who had lost capacity to make some decisions, some staff did not have the necessary skills and knowledge to meet people's care needs safely and effectively.

People were not provided with sufficient stimulation and some staff did not support people in a caring and person-centred way that promoted their privacy and dignity.

The provider worked closely with local healthcare services to ensure people had prompt access to any specialist support required. However, the management of people's medicines was inconsistent and was not always in line with good practice or national guidance.

The provider met regularly with people and their relatives to discuss any concerns and suggestions. However, formal complaints were not always handled in accordance with the provider's policy.

Food and drink were provided to a good standard and the provider had sound recruitment procedures in place.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

The provider had failed to correctly identify the staffing levels required to meet people's needs and deploy staffing resources effectively to keep people safe from harm.

The management of people's medicines was inconsistent and was not always in line with good practice or national guidance.

Sound recruitment processes were in place.

Requires improvement

Is the service effective?
The service was not consistently effective.

Some staff did not have the necessary skills and knowledge to meet people's care needs safely and effectively.

People had prompt access to any specialist healthcare support they needed.

Food and drink were provided to a good standard.

Requires improvement

Is the service caring?
The service was not consistently caring.

Some staff did not support people in a caring and person-centred way that promoted their privacy and dignity.

The provider made use of personal advocacy services in the local area.

People's personal information was stored confidentially.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People were not provided with sufficient occupation and stimulation.

People and their relatives knew how to raise concerns or make a complaint. However, formal complaints were not always handled in accordance with the provider's policy.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

Requires improvement

Summary of findings

The provider had failed to establish and maintain effective systems of governance to ensure legal requirements in the provision of care and support were met.

The requirements of some of the provider's policies were not applied consistently.

The provider's response to issues highlighted through monitoring and audit processes was not consistently effective.

The provider met regularly with people and their relatives to discuss any concerns and suggestions.

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. The 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 visited Newton House on 8 December 2015. The inspection team consisted of two inspectors, a specialist advisor whose specialism was nursing care of older people 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 the inspection the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with 10 people who lived in the home, nine visiting friends and family members, the manager, the provider's regional director, eight members of the care staff team, two members of the activities team, the head housekeeper and the head chef.

We looked at a range of documents and written records including 15 people's care records, training records and five staff recruitment files. We also looked at information relating to the administration of medicines, staff supervision, managing complaints and the auditing and monitoring of service provision.

We reviewed other information that we held about the service such as notifications (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.

Requires improvement

Is the service safe?

Our findings

Some of the people we spoke with had concerns about staffing levels and the way staff were deployed in Newton House. One person told us, "I feel a bit lonely. I say [to the staff] could they stay and talk with me but there are too many people to look after so they don't. Sometimes I am worried." A relative said, "I do have a slight worry about staffing in the evening. Sometimes when I am here in the evening in the busy period, there doesn't seem to be many staff around. I have occasionally had to go searching for a member of staff to help [my relative]."

Reflecting some of these concerns about staffing levels, throughout our inspection visit, in all four units in the home, we saw many people sitting for extended periods of time with nothing to occupy them. One relative told us, "There is never much going on. I have seen the list of activities but have never seen any in this part of the building. I am sad that there is nothing to stimulate [my relative].

The manager told us she reviewed staffing levels on a weekly basis with a standard staffing tool that the provider used in all of its homes. However, she told us that the provider's staffing tool under-estimated the level and type of staffing required to meet the particular needs of some of the people living at Newton House. For example, in line with the provisions of the tool, there was no dedicated nursing cover in the Brownlow unit after 9pm. This was provided by the night nurse in one of the other units, which the manager and other staff told us was insufficient to provide the necessary leadership in the Brownlow unit at night. As part of our inspection we also noted that, as a result of the lack of a dedicated night nurse in the Brownlow unit, people who had medicines at night were receiving them at 8pm, before the evening nurse went off duty. The medicines administered at this time included sedatives which created an increased risk of falls if people were still up and about.

In preparation for our inspection visit we reviewed the notifications (events which happened in the service that the provider is required to tell us about) we had received from the provider in the previous 12 months. The events notified to us included 36 altercations between people living in the home, including occasions when people had punched or slapped each other. These incidents occurred mainly in one of the specialist units for people living with dementia. The provider had also notified us of nine serious injuries to people in the previous 12 months. In the period June to November 2015 these included four people who had sustained fractures as a result of falls. As part of our inspection we reviewed the record of accidents and incidents on two of the four units in the home. In the three months preceding our inspection, there had been 60 occasions recorded in which people had been 'found on the floor' following an unwitnessed incident.

We discussed these concerns with the manager who told us she was aware of all of the issues we had identified and had made changes to staffing levels to try to ensure people were safe from harm. However, she told us that this had had not achieved any reduction in the number of incidents. The manager said, "It's not about the number of staff but the way they are organised."

Taken together, the provider's failure to correctly identify the staffing levels required to meet people's needs and to deploy staffing resources effectively to protect people from the risks of falling or abuse from other people living in the home was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's care records and saw that other risks to each person's wellbeing had been assessed and preventive measures put in place. For example, where people had been addressed as being at risk of malnutrition, their weight was monitored regularly and detailed records of what they had to eat and drink were maintained. The provider had also assessed the risks to people if there was a fire or the building needed to be evacuated. A 'grab pack' was stored in the office which contained emergency equipment such as torches and key information about each person such as their next of kin.

Staff were clear about to whom they would report any concerns relating to people's welfare and were confident that any allegations would be investigated fully by the provider. Staff said that, where required, they would escalate concerns to external organisations. This included the local authority safeguarding team and the Care Quality Commission (CQC). Staff had received training in this area and policies and procedures were in place to provide additional guidance if necessary. Advice to people and their relatives about how to raise any concerns was provided in the 'Welcome to Newton House' booklet that was given to people when they first moved into the home.

Requires improvement

Is the service safe?

When we reviewed the arrangements for the storage, administration and disposal of medicines we found that these were not managed consistently throughout the home. Although we found sound practice in some units, in others the management of people's medicines was not in line with good practice and national guidance. For example, on one person's medicines form it was stated that they should have their blood sugar monitored on a weekly basis. However, in the period from 3 November to 6 December 2015 there was no record of this having been done. We also saw that there was no record of pre-administration pulse checks being completed for two people who used a medicine where it is important that this is done. One person had been prescribed a sedative to be taken 'as required' but there was no protocol in place to guide staff as to when this should be offered to the person. Although there was no evidence that people had come to any harm, these errors and procedural lapses increased the risk to people's safety.

We saw the provider had safe recruitment processes in place. We examined five staff personnel files and saw that references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the service had employed people who were suitable to work with the people living in the home.

Requires improvement

Is the service effective?

Our findings

People had mixed views about the ability of staff to meet their needs effectively. One family member told us, "[My relative] can't always make their own decisions so relies on the staff. They know what they are doing." However, one person said, "Most of the care I get from staff is good. But there are too many that are not well-trained and don't do things right." Another person told us, "Some staff are not as good as others."

The provider maintained a detailed record of the training needs of each member of staff and employed an in-house trainer to deliver most of the core training required. We saw that over 90% of staff had completed all of the training identified by the provider as being necessary to meet legislative and policy requirements.

New members of staff completed a week-long programme of practical and classroom-based induction to ensure they were familiar with the provider's key policies and procedures. This was followed by a period of shadowing experienced members of staff before they started to work as a full member of the team. The induction programme incorporated the new national Care Certificate which sets out common induction standards for social care staff. Longer-serving members of staff also undertook some of the Care Certificate modules to update and refresh aspects of their training.

However, despite the induction and training arrangements put in place by the provider, we saw that some staff did not always demonstrate that they had skills and knowledge necessary to meet people's needs safely and effectively. For example, we observed two members of the care team support a person move into the lounge in their recliner armchair. One member of staff rolled a blanket under the person's ankles and held them off the ground as the carer manoeuvred the chair. This was not in line with the moving and handling procedures detailed in the person's care plan and put both the person and the staff involved at risk of injury.

We also found that the supervision of staff, particularly front line care staff, was not being delivered consistently in line with the provider's supervision and appraisal policy. One member of the care staff team told us that they had received only, "one or two supervisions" in the previous seventeen months and that they were unaware of the provider's requirement that they should have an annual appraisal. The manager acknowledged that supervision was not being delivered in accordance with the provider's policy. This meant some members of staff had not been given the full amount of support and guidance specified as necessary by the provider to enable them to carry out their role effectively.

Staff showed a good understanding of, the Mental Capacity Act 2005 (MCA). This 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. Staff demonstrated they understood the importance of establishing proper consent before providing care or support. One staff member told us, "Most people do not lose capacity entirely. They can still make choices about what they want to wear that day or what they want to eat."

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). At the time of our inspection the provider had sought and received DoLS authorisation for 29 people living in the home, to ensure that their rights were protected and they could continue to receive the care and support they needed. Further applications were pending.

Staff ensured people had access to local healthcare services whenever they needed them. From talking to people and looking at their care plans, we could see that people's healthcare needs were met through the involvement of a wide range of professionals including GPs, dieticians, continence advisors and speech and language therapists. For example, some people had been assessed as being at risk of choking. A senior staff member told us, "We make a SALT (Speech and Language Therapist) referral but take immediate action such as providing pureed food until they are seen by the SALT." One person told us, "The staff soon get the doctor if anything is wrong. I had the optician here too. Staff came round to ask if I wanted to see them."

Requires improvement

Is the service effective?

People told us they enjoyed the food and drink provided in the home. One person told us, “The food is fantastic. It’s really adventurous too.” One visiting family said, “It’s like hotel quality.” We observed people eating lunch and snacks and saw that they were served food and drink of good quality. The menu provided people with a choice of options for each of the three meals of the day. Morning and afternoon tea were also served every day providing a choice of hot or cold drinks and snacks, including fruit and homemade cakes. The head chef told us that people would always be provided with an alternative if they did not want any of the choices on the menu. On the day of our inspection we saw that one person had cauliflower cheese as an alternative choice for lunch. Another person requested soup with their afternoon tea rather than at lunchtime.

Kitchen staff maintained a detailed list of people’s nutritional needs and preferences and used this information when preparing food and drink for people. For example, the chef told us that one person was following a low sodium diet and kitchen staff had recently attended allergen training provided by the local authority. Staff were aware of the risks of malnutrition and dehydration and maintained detailed records of how much people had to eat and drink.

Requires improvement

Is the service caring?

Our findings

People had a variety of opinions about the way staff interacted with them. One person told us, "You couldn't wish for better staff." But another person said, "Most of the staff are nice, but not all."

During our inspection we saw some examples of staff supporting people with kindness and sensitivity. For instance, we saw two members help someone make their way to the toilet. The staff worked together to support the person in a calm and unhurried way, speaking to them gently throughout. Another member of staff told us, "It's important to give people as much choice and control as possible. I always ask people what they would like to drink, even if I think I know the answer. People can change their mind!" However, we also saw occasions when staff failed to engage with people in a caring and person-centred way. For example, at lunchtime, we saw a member of staff support someone to eat their lunch. The staff member offered the person a spoonful of food but from a position above the person's head which made it difficult for them to eat. The person became distressed and refused to eat. The staff member then stopped assisting the person and walked away without saying anything to them, or to any of the other staff in the dining room at the time.

On another occasion, we saw two members of the care staff team attempt to use a mobile hoist to support a person move from an armchair to their wheelchair. The person's wheelchair had been placed in the wrong position and the hoist battery was out of charge. The failure of the staff to plan the procedure or check the equipment in advance caused a delay whilst a fresh battery was obtained and the wheelchair was repositioned. When the hoisting manoeuvre finally started, the person was uncomfortable with the way the staff had positioned their arms in the hoist and asked staff to stop. The person called out several times, "Please let me down, I don't fancy it. Please, please." Despite their obvious distress, staff carried on with the hoisting manoeuvre.

We saw that some staff supported people in a respectful way that took account of their individual needs. For example, one member of staff told us about a person they supported who liked to use the toilet independently as much as possible. The staff member said, "I help them to get to the toilet and then stand and wait for them at the door." However, we also observed other situations in which people were supported in a way that did not promote their dignity. For example, we saw a member of staff assisting another person to have their lunch. The person had their food pureed to avoid the risk of choking. Kitchen staff had pureed the meat, potatoes and vegetables separately and presented them attractively on the plate. However, the staff member took a large spoon and mixed everything together without asking the person if this is what they wanted. There was too much food on the spoon for the person to eat in one mouthful and we watched as the member of staff used the spoon to wipe food from the person's chin and put into their mouth.

We saw that staff knocked on the doors to private areas before entering and were discreet when supporting people with their personal care needs. However, we also some people lying in bed with their bedroom door open and their bedcoverings on the floor. This meant anyone passing by in the corridor could see their nightwear.

We discussed these concerns with the manager who acknowledged that improvement was needed in the way some staff interacted with the people living in Newton House. She told us, "We need to change the approach of some staff. They need to be more person-centred."

The manger told us that any personal information about people was stored in lockable cabinets or on password protected computers to ensure confidentiality.

The provider made use of personal advocacy services in the local area. Advocacy services are independent of the service and the local authority and can support people to make and communicate their wishes. The manager told us staff had recently found it helpful to work with an advocate to provide to support someone who had lost capacity to make certain decisions relating to their personal finances.

Requires improvement

Is the service responsive?

Our findings

People had mixed views about the communal activities and other forms of occupation and stimulation provided in Newton House. One person said, "I don't always join in but they do things like 'knit and natter', bingo, singalongs and keep fit." Another relative said, "I come in most mornings and I have never seen anything in the mornings."

The provider had established a specialist activities team to take the lead in organising communal activities and supporting people to pursue personal hobbies and interests. There were two activities coordinators employed in the team working a combined total of 54 hours each week, normally Monday to Friday. The two activities coordinators prepared a weekly activities programme for each of the four units in the home. Recent events on the programme included a Christmas craft session, a church service, an exercise class and a visit from a 'Pets as Therapy' (PAT) dog. The team also provided people who could not participate in communal activities with one-to-one activity sessions in their own rooms, including table top games, music and crafts.

However, when we spoke to both team members as part of our inspection it was clear that they were finding it difficult to provide sufficient stimulation and occupation to over 100 people. For example, on the day of our inspection there were no one-to-one or communal activities scheduled on the programme. One of the activities coordinators told us that this was because, "We had to spend the morning on a bit of a catch up exercise after the recent Christmas Fayre. With only two of us it's a bit of a struggle." The only activity listed for the afternoon of our inspection was a minibus trip to a local retail park, led personally by both activities coordinators. However, the number of people who could go on this trip was restricted to three. This meant that, of the 111 people living in the home on the day of our inspection, only three had received any communal or individual support from the activities team. Reflecting this lack of structured stimulation, in each of the four units in the home, we saw many people sitting for extended periods of time with nothing to occupy them. A senior member of the care staff told us, "We need more activities staff because many people are nursed in bed and can't join in [communal activities]. We need more one-to-one activities for these people and the activities staff don't have time."

When someone was thinking of moving to Newton House, a senior member of staff would normally carry out a pre-admission assessment of their care requirements, to make sure the home was able meet their needs. Within 24 hours of someone moving in, staff prepared an initial care plan which recorded key information and any risks relating to that person's care. Over the next seven days, staff developed a comprehensive care plan which detailed each person's full needs and preferences. One member of staff told us, "The care plans are very helpful, although it's also important to talk to people." Another staff member said, "It's nice to chat with people and share their past with them."

Care plans were very detailed and addressed a wide range of needs and preferences which were reviewed by staff on a monthly basis. A full review took place every six months, involving people and their relatives if they wished. One relative told us, "I have been involved with [my relative's] care plan and am very much informed." Another relative said, "They keep me up to date."

Staff used the information in each person's care plan to ensure they received the care required to meet their particular needs. For example, one member of staff told us about someone who had been assessed at risk of developing a pressure ulcer. Specialist help had been obtained and preventive measures had been put in place which had ensured the person's condition improved. Other people had been assessed at risk of weight loss and we saw that where specific concerns had been identified, these had been followed up. For example, some people received specially fortified food to promote weight gain.

People were encouraged to personalise their room and we could see that some people had their own photographs and other souvenirs on display in their bedroom. Most people had their name and a photograph on their bedroom door. These were intended to help people, particularly people living with dementia, to find their way to their own room. However, these were often situated at the top of the door, above eye level, which made them difficult for some people to use. There was also a lack of signs to communal facilities such as lounges and toilets which, again, made it harder for some people to move around the home independently. People had access to a wide variety of communal lounges and a secure garden area. However, the garden was in a poor state of repair and was not a pleasant place for people to spend time in.

Requires improvement

Is the service responsive?

There was a complaints procedure available to people and their relatives who told us they felt comfortable raising concerns if they were unhappy about any aspect of their care. One person said, “If I had to, I’d see [one of the nurses]. She checks each week if all is okay.” A relative told us, “If I had a complaint, I’d go to the main office or one of the nurses.”

From information we had received before our inspection, we were aware that one relative had recently made a formal complaint and was dissatisfied that the provider had not responded within the timescales set out in its complaints policy. We discussed this with the manager who told us, “It took longer to respond than I expected it to.” At the time of our inspection this complaint remained ongoing.

Requires improvement

Is the service well-led?

Our findings

People we spoke to told us that they thought the home was well-led. One person said, "I think it's well-run. It's nice and homely and you can take what you like into your room." Staff told us that the manager had made a positive impact since taking up post in July 2015. One member of staff said, "I didn't really meet the previous manager but the current manager is very supportive."

However, as detailed throughout our report, our inspection identified many concerns and shortfalls against legal requirements in the provision of care and support to the people living at Newton House. These stemmed, in part, from weaknesses in governance, including the leadership of the care staff team which allowed staff to support people in ways that were not consistently safe, effective, caring or responsive. The manager and other senior staff appeared to have limited control over the actions of front line care staff. Although the manager had identified concerns relating to staff attitudes and behaviour, and the impact these had on the quality of care provided to people, the systems used to address and correct these issues were ineffective. For example, when we discussed the incident in which staff supported someone to move unsafely through the home in their recliner chair, the manager told us that, "I told them off recently [for doing the same thing]." When we discussed a situation we had observed during our inspection when we watched a number of staff members sitting in a lounge, talking amongst themselves rather than engaging with people, the manager said, "We told them not to do that."

Shortfalls in internal reporting systems meant senior staff lacked sufficient knowledge to manage the home effectively, also contributed to the lack of good governance. For example, when we raised an incident that occurred five days before our inspection in which a person had sustained a serious injury, the manager told us that she had been unaware of the seriousness of the incident until the day of our inspection. Additionally, as part of our review of medicines management, we saw that on one unit there had been four medicine errors in the period 3 to 15 October 2015. However, a pre-inspection information return submitted by the provider on 28 October 2015 advised us that there had only been two medicine errors in the whole home in the previous 12 months.

We also found that, although the provider maintained a comprehensive programme of audits to monitor the quality of the care provided at Newton House, the action taken in response was not consistently effective. For example, the accident and incident monitoring system had highlighted the number of falls and the altercations between people but the preventive measures taken had not reduced the risk of harm.

Additionally, the provider had failed to ensure that the requirements of some key policies were consistently applied within the home, for example the supervision and complaints policies.

The provider's 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 breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew about the provider's whistle blowing procedure and said they would not hesitate to use it if they had concerns about the running of the home or the company that could not be addressed internally.

The provider held regular meetings for relatives and friends. These were attended by manager and provided people with an opportunity to discuss any issues or concerns. The manager told us that she had recently changed the meetings to a Saturday, at the request of relatives. Meetings with people who lived in the home were also held, although the manager told us she was keen to find ways to encourage more people to attend.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed to correctly identify the staffing levels required to meet people's needs and deploy staffing resources effectively to keep people safe from harm. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to establish and maintain effective systems of governance to ensure legal requirements in the provision of care and support were met.