HC-One Limited

# Newlands Nursing & Residential Home

## Inspection report

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04 August 2016

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## Ratings

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| Overall rating for this service | Inadequate |

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| Is the service safe? | Requires Improvement |
| Is the service effective? | Inadequate |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Inadequate |

# Summary of findings

## Overall summary

This inspection took place on 02 and 04 August 2016 and was unannounced.

Newlands Nursing and Residential Home is located in the residential area of Heaton Moor, Stockport. The home is registered to accommodate a maximum of 72 people for residential and nursing care, although as double rooms were not in frequent use HC-One Limited who own the home advertise it as providing care for up to 68 people. Care is provided over four floors, with residential care being provided on the basement level, nursing care on the ground and first floors, and intermediate nursing care on the top floor. There is parking on site and in streets nearby. At the time of our inspection there were 65 people living at the home.

We inspected Newlands Nursing and Residential Home on 27 January 2016 when we found the service was not meeting the requirements of the regulations in relation to providing supervision and support and requirements relating to information required to ensure staff were fit and proper to work at the home. Our last inspection of the service took place on 03 July 2014 when we found the service had made improvements and was meeting the requirements of all the regulations inspected at that time.

At this inspection we identified nine breaches of five of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe management of medicines, assessing and mitigating risks, staffing levels, checks relating to employment of fit and proper persons, providing safe care and treatment, records, training, equipment and good governance. You can see what actions we have told the provider to take at the back of this report. We are currently considering our response in relation to enforcement for some of the breaches of regulations and we will update the section at the end of this report once any such action has concluded.

There was no registered manager in post at the time of our inspection. The registered manager had resigned and had left the service the week prior to our inspection, and a new 'turnaround' manager had been appointed as the interim acting manager.

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.

We brought this inspection forward from its planned date due to concerns we had received from relatives and a Whistleblower. Whistleblowing is when a worker reports concerns they have around practices or wrongdoing. Concerns relating to various issues at the service had also been raised with us by the local authority following one of their monitoring visits.

We identified concerns with the way the service was assessing and managing risks to people's care. Whilst risk assessments had been completed, these were not always reviewed as frequently as they should have

been. Actions identified in risk assessments, such as monitoring people's weights on a weekly basis were not always undertaken. We found that records did not consistently evidence that people had received the support they required with repositioning to help reduce the risk of pressure sores.

We reviewed records for one person who required support with a percutaneous endoscopic gastrostomy (PEG). A PEG is a tube that is inserted into the stomach and often used to supply food and medicines to people who are unable to take them orally. We found directions for care staff lacked detail and the provider was unable to show us evidence that all tasks relating to care required in relation to the PEG had been completed. This meant this person may be put at risk of a detrimental impact on their health and wellbeing.

We found issues in relation to the safe management of medicines. For example, we found medicines records were not always updated in a timely manner following advice from a health care professional. This meant there was a risk people would not receive the correct medicines or dosages. Clinic rooms were warm and we saw the temperature had risen above recommended limits. If medicines are not kept at the correct temperature their efficacy can be affected.

During the day we saw there were sufficient numbers of staff to respond to and meet people's needs. However, night staff raised concerns about staffing levels on night shifts. The provider was not able to demonstrate that staffing levels had been reviewed at a local level in consideration of the dependency of people living at the home. The night prior to our inspection we found support funded for one to one support over-night for one person had not been provided.

Staff received training in a range of subject areas including safeguarding, moving and handling and dementia. However, staff had not received regular supervision from a manager. The provider was also unable to provide evidence that agency staff working at the home had received an induction, or that nursing staff had received training or competency assessments in relation to tasks they were undertaking such as taking blood samples. This meant the provider could not be certain that staff were competent to provide safe and effective care to people.

People told us they found staff had a kind and caring approach. We observed positive interactions between staff and people living at the home and regular staff knew people well. For instance, we observed staff talking with people about shared interests and calling people by their preferred names. People told us staff respected their privacy and dignity and staff we spoke with had a positive approach to supporting people's independence.

People told us their family members could visit without restrictions and we saw evidence that family members had been involved in helping plan their relative's care where this was appropriate. Care plans contained information in relation to people's preferences, likes and dislikes.

We saw people received the support they required to eat and drink. Staff we spoke with were aware of people's dietary requirements as was recorded in their care plans. However, we found people's food and fluid intake was not always recorded when there had been a need for this to be done.

Care plans had been regularly reviewed but in some cases had not been re-written for some time, which meant the most relevant information was not always easily accessible. This would increase the risk of care being provided that was not in accordance with a person's current needs or preferences.

There had been three registered managers in post at Newlands over the previous three years. Staff told us they felt the home needed a stable management team.

There were systems in place to review and monitor the quality and safety of the service. However, these had not been effective at addressing the issues we had identified. We also found actions were not always identified or signed off from audits, and there had been a gap in some of the monitoring following the previous manager's departure. We found that issues we had identified as concerns in 2014, such as lack of regular staff supervision were also found to be an issue at this inspection. This showed systems had not been effective at maintaining standards at the home.

People told us they were able to make day to day decisions and choices, such as when they got up and when they were supported with bathing. People told us staff listened to them and acted on any concerns they might raise.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If sufficient improvement is not made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## 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.

Medicines were not managed safely. Records were not always updated in a timely manner and we found thickening agents were not stored securely on our arrival. Records did not evidence that people had had cream medicines applied as directed.

Risk assessments were carried out in relation to potential risks such as malnutrition and pressure sores. However, measures in place to reduce risk, such as regular weighing and recording repositioning were not always completed as required.

Staffing was adequate during the day. However staff and a relative raised concerns about staffing levels at night. We found staff absences were not always covered. Staff told us they could find it difficult and rushed to meet people's needs when staffing levels dropped below expected levels.

### Is the service effective?

**Inadequate**

The service was not effective.

We found instructions for care to be provided in relation to one person's percutaneous endoscopic gastrostomy (PEG) were inadequate. Records did not evidence that they had received the care and support they required to maintain the PEG and keep them healthy. A PEG is a tube that is inserted into the stomach and often used to supply food and medicines to people who are unable to take them orally.

Records did not evidence that people who were at risk of pressure sores were receiving the support they required to reduce the risk of them developing. One person's records in relation to wound care were incomplete.

Staff had not received regular supervision and felt support could be better. The provider was unable to provide evidence of training or competency assessment for two nurses who were undertaking specific procedures. There was no record of induction for agency staff.

## Is the service caring?

Good

The service was caring.

People and relatives spoke positively about the caring approach of staff. We observed positive interactions between staff and people using the service, such as staff talking with people about their interests.

Staff communicated clearly with people and gave people time to respond and make choices.

People told us their family members were able to visit them without restrictions. Records showed family members had been involved in reviewing people's care where this was appropriate.

## Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were complete and had been regularly reviewed. However, in some instances the person's needs had changed substantially since the original care plan had been written, meaning the most relevant information was not always easily accessible.

We found one person had been supported back to bed due to feeling unwell. Staff had not ensured that their call bell was accessible and this was located on the opposite side of the room.

People told us that staff listened to them and their feedback. They told us they were able to make choices on a day to day basis such as the time they got up, and when they were supported with bathing.

## Is the service well-led?

Inadequate

The service was not consistently well-led.

The registered manager had left the service shortly prior to our inspection and there was no deputy manager in post at the time of the inspection..

There were systems in place to monitor the quality and safety of the service provided. However, these had not been effective in ensuring issues found at our inspection had been addressed. We found some repeated issues that had been highlighted at previous inspections.

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| The provider was responsive to our feedback and provided a response detailing immediate and planned actions to address the concerns we raised | |

# Newlands Nursing & Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 02 and 04 August 2016 and was unannounced. The inspection team consisted of three adult social care inspectors 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.

Prior to the inspection we reviewed information we held about the service. This included notifications that the service is required to send us about safeguarding, serious injuries and other significant events. We reviewed other information we had received, including any information shared with us by relatives of people using the service and staff members. We spoke with the local authority quality assurance team about their experience of the service, and they shared the findings of a recent quality monitoring visit they had conducted at the home. We also viewed the findings of a recent external infection control audit carried out at the home. We contacted Healthwatch Stockport who told us they had not received any feedback in relation to the service.

During the inspection we spoke with 12 people who were living at Newlands Nursing and Residential Home and seven relatives who were visiting at the time of the inspection. Following the inspection we spoke with one additional relative by phone. We spoke with 18 members of staff. This included eight care assistants; four regular and one agency nurse; the cook; the assistant operations director; the 'turnaround manager'; the activities co-ordinator and a training manager.
We observed care and support delivered in communal areas throughout the course of our inspection and visited areas of the home including the kitchen, communal areas and clinic rooms. 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 records relating to people's care and support. This included 11 care files and eight people's medication administration records (MARs). We also reviewed records relating to the running of a care home, including four staff personnel files, records of servicing and maintenance of the building and equipment, and records of audits and checks carried out around the home.

Requires Improvement

# Is the service safe?

## Our findings

We identified concerns in relation to the safe management of medicines. Medicines were stored in clinic rooms in locked trolleys on each floor of the home. Two of the medicines fridges were out of order, which meant medicines requiring refrigeration had to be stored in the two remaining fridges on two floors of the home. Staff told us new fridges were on order. We found the clinic rooms were warm, and records of temperatures indicated there had been times when they had exceeded the recommended 25°C. On the first floor of the home, staff had not completed the record of the clinic room temperature for over two months. If medicines are not stored at an appropriate temperature they may become less effective. The assistant operations director told us new clinic rooms were being created as part of a planned refurbishment, which would help address the issues with temperature control. We saw a project plan that indicated the scheduled date for completion of the refurbishment was February 2017.

Records in relation to medicines did not always provide complete information that would support staff to ensure people received their medicines safely and as prescribed. For example, we saw that one person's medication administration record (MAR) showed they should have been administered a certain medicine and that this had not been done. We queried this with the agency nurse on duty who informed us the medicine had not been received from the pharmacy and they showed us an entry in the communication book requesting that they contacted the GP to obtain the prescription. However, when we looked at this person's care records we saw it had been recorded that this medicine had been discontinued the previous month. A member of regular nursing staff had updated the MAR by the second day of our inspection, however due to the record being inaccurate, there was a risk this person may have been administered the medicine inappropriately.

We found other issues with records relating to medicines. On the top floor we found three people's records did not include their photograph or when required (PRN) protocols that were required. Staff told us this was because these people had only recently moved in. However, this would increase the risk of people not receiving their medicines when they required them or of medicines being administered to the wrong person. PRN protocols provide information to staff such as detailing when they should administer medicines that are not required on a routine basis. We also found there was no record of application for one person's cream medicine, and other records of the application of creams showed inconsistent application. We saw instructions provided by a diabetic nurse, that detailed the correct insulin dose for one person were not understood correctly by the nurse administering one person's insulin on the second day of the inspection. The nurse had followed the old rather than the new instruction and the MAR did not reflect the correct current dosage. We raised this with the manager and asked the nurse to seek advice regarding this. The nurse spoke with the GP who they informed us was happy with the actions taken by the care home nurse.

On the first day of the inspection, we saw thickening agents were stored insecurely in the dining areas on each floor. Although we did not see any person left unsupervised in these areas, there was a risk presented due to their unsafe storage. NHS England issued a patient safety alert in February 2015 in relation to risk of asphyxiation through accidental ingestion of thickening agents. We raised this issue with the assistant operations director and turnaround manager who took immediate actions to address this with staff, and the

thickeners were moved to safe storage.

The issues outlined above were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medicines.

We saw risk assessments had been completed to assess potential risks to people's health, safety and wellbeing. For example, we saw risk assessments had been completed in relation to use of equipment such as bedrails, risks of malnutrition, choking, moving and handling and pressure sores. On the first day of the inspection staff were unable to locate any risk assessments for one person's care file we reviewed. We raised this with the managers at the service who instructed staff to complete new risk assessments. On the second day of our inspection we saw the original records had been located, and we were told night staff had removed the risk assessments to update them. This meant the agency member of nursing staff working the day shift on the first day of our inspection may not have been aware of risks identified in relation to this person's care.

We also found measures identified to reduce risks were not always effectively implemented or monitored. One person's care plan and risk assessment indicated they required assistance with two hourly repositioning due to being at very high risk of developing pressure ulcers. There was no record of repositioning in place and staff told us this person was resistant to repositioning. However, this was not detailed in the care plan. This person did not have a pressure sore, however they would be at increased risk of pressure sores developing if they were not supported to reposition as required. Due to our concerns we raised this issue with the local authority safeguarding team who took no further action. The provider told us they would review the care plan and put the appropriate charts in place. We also saw two instances where people's weights were not being monitored as frequently as their care plans indicated was required, and one person's risk assessment in relation to malnutrition had not been reviewed since April 2016, despite the assessment stating monthly review was required. This meant there was a risk that changes in these people's health might not be identified and acted upon in a timely manner. We also saw records that indicated a second person was at risk of developing pressure sores and was primarily cared for in bed. However, there was no record of repositioning in place. We raised this issue with the provider following the inspection, and asked them to make a safeguarding referral if required.

These issues were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to assessing and mitigating risk.

We asked people living at Newlands and their relatives whether they thought there were sufficient staff available to meet people's needs and received a mixed response. Two people we spoke with responded positively, with one person telling us; "They respond to buzzers very quickly. We never have to wait long." However, one person and one relative raised some concerns in relation to staffing levels. One person said; ""The staff do their best but they sometimes need more help. They are very busy." A relative we spoke with also told us that on two occasions staff had not responded to their relative in a timely manner when they had required assistance to use the toilet.

During the inspection we saw that staff were able to meet people's needs in a timely manner. However, all three night staff we spoke with told us they felt there were not sufficient staff on shift at night due to the high level of need of the people they were providing care to. They told us they this meant they would have to rush to complete all tasks required. One member of care staff told us; "I don't think two carers and one nurse is enough on this floor as all bar two people need assistance with bathing and eating. We try our best, but it is bad as you have to rush to keep up." The provider told us staffing levels were calculated centrally, but were flexible and were informed by the use of dependency assessments, which should be reviewed by the home

manager. However, some of the dependency assessments we saw had not been reviewed in the past month, and the provider was unable to locate any evidence that dependency assessments had been considered by the former registered manager.

One staff member we spoke with raised concerns that the floor they worked on had been short by one member of staff the night prior to the first day of our inspection. They told us the shift had been hard to manage due to one person who required close supervision who 'wandered' at night, and because there had been a new admission in the evening of the day prior to our first day of inspection. We found that the person requiring close supervision had been funded to receive one to one support, which was due to start the night prior to the first day of our inspection. However, due to staff sickness, which had not been covered, this support had not been provided. One family member also raised concerns with us in relation to the impact this person had on their family member due to behaviours that could be disruptive to other people living on that floor. We referred the concerns in relation to the lack of one to one staff cover to the local authority safeguarding team. Rotas also showed that on 26 July 2016 there had been one staff member on duty on the floor providing residential care. The assistant operations director told us this was an exception due to staff sickness and that the staff member was supported as required by staff on the other floors. They told us this situation had been assessed as being safe.

These issues in relation to providing sufficient numbers of staff were a breach of Regulation 18(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Due to safeguarding concerns reported to CQC we had brought this inspection forward from its planned date. CQC had referred the concerns reported to the local authority safeguarding team who were in the process of making further enquiries at the time of the inspection. The service kept a log of safeguarding incidents, as well as a copy of any internal investigations they had been asked by safeguarding to carry out. We discussed some of the safeguarding cases that had been raised within the previous year with the assistant operations director. They acknowledged that there had been some shortcomings with how thoroughly some of these concerns had been followed-up. This was something that the provider had noticed, and appropriate actions were being taken by the provider in response to this.

Staff we spoke with had an adequate understanding of safeguarding procedures at the home and were able to explain what signs they would look for that might indicate potential abuse or neglect. For example, one staff member told us that they would report unexplained bruising or changes in behaviour to their manager. We saw the safeguarding policy was clearly displayed in the reception area, which would ensure staff were able to refer to this if required. Staff we spoke with were aware of the whistleblowing procedures and how they could escalate any concerns they may have if this was required.

Staff files contained relevant information about that person's recruitment. For example we saw staff had completed an application form and had been interviewed. Staff had their identification checked and references were obtained from previous employers to help the provider assess whether the applicant was of suitable character for the job. On the first day of inspection, the Disclosure and Barring Service (DBS) reference numbers for current staff members were unavailable. We asked the assistant operations director about this who told us their system had failed as they were supposed to record them on paper in the office but this had not happened. They assured us the information was on the computer system, and we were shown evidence of this on the second day of our inspection. DBS checks inform the employer if a staff member has any convictions or is barred from working with vulnerable people, and help employers make safer recruitment decisions. We saw records that demonstrated checks of nurses registrations (PINs) had been carried out on a regular basis. However, we found the PIN check for one member of nursing staff was missing. This had been rectified by the second day of our inspection. However, the same issue had

previously been identified at the home during a CQC inspection in January 2014. This shows systems for checking nurse registration were not effective.

This was a breach of Regulation 19(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection we found some issues in relation to practices to prevent and control the spread of infection. For example, we observed clean towels and bedding on a chair in a communal area and one of the bathroom bins was overflowing. The clean laundry was moved shortly after our arrival, however when we checked the bin later in the day it was still overflowing. The environment was free from any malodours but was in need of some updating. For example, we saw torn wallpaper in one of the dining areas, some carpets looked worn and faded and paintwork around the home was scuffed and chipped. This would make it harder to maintain a clean environment. The assistant operations director informed us these issues would be addressed during the planned refurbishment. We saw signs providing guidance to staff on good handwashing techniques and gel hand cleaner was available from dispensers around the home. We observed staff used personal protective equipment (PPE) such as gloves and aprons when required.

We saw staff had completed accident forms to report such incidents appropriately. We saw there was a record of any immediate actions taken to reduce potential risks to people. Staff we spoke with were aware of procedures to follow in the event of someone sustaining a fall. One staff member told us they would make sure the person was comfortable, call a nurse and call an ambulance if required. We also saw evidence of post-accident observations having been carried out in cases where people had fallen, but not required a hospital admission.

Regular checks were undertaken to make sure the premises were safe. For example, checks were carried out to ensure the gas and heating systems were safe and checks relating to fire safety were completed. However, we found there had been a gap in the monitoring of fridge temperatures in the kitchen when the regular cook had been on leave. The agency worker had not completed these checks. We raised this with the assistant operations director who told us they would address this with the agency. This meant there was a risk that food were not being kept at a safe temperature during this period . We found the certificate of testing for the fixed wiring installation identified a number of issues that required non-urgent work to ensure the system was safe. We requested evidence of this work having been undertaken, but had not been provided with this at the time of producing this report. We will follow-this up and take further action if required. We found the building was secure, and on our arrival we had to wait for staff to come to the front door to let us in.

Equipment used to support people's care, for example hoists, were clean and had been serviced in line with recommendations. We found staff had not consistently maintained records of water temperatures before they supported people with bathing or showering. However, staff told us they would always check water temperatures prior to supporting people, and we were told water outlets were thermostatically controlled, which should prevent water temperatures exceeding recommended levels. The service had a business continuity plan, which directed staff what to do in the event of an emergency such as a gas leak or flood. This would help ensure staff were able to respond appropriately in emergency situations to keep people safe.

Inadequate

# Is the service effective?

## Our findings

We looked at how the home provided care to meet and support people's health care needs. Records showed a range of health professionals including GPs, podiatrists, speech and language therapists and tissue viability nurses had been involved in people's care. We were told two people living at the home had pressure sores. We saw that people who were at risk of, or who had pressure sores had appropriate equipment in place such as pressure relieving mattresses, which were checked on a regular basis. Shortly before the inspection we also contacted a tissue viability nurse who visited the home. They did not raise any concerns in relation to the service's management of pressure sores or wounds.

However, we found the service was not able to evidence they had consistently provided people with the care and support they required to meet their health care needs. For example, we found repeated gaps in records of repositioning for one person and records of repositioning were missing for part of July 2016. This meant the service was not able to evidence this person had received pressure relief as directed, which could put this person at risk of developing pressure sores. There was however, no evidence of a detrimental impact on this person.

We looked at records in relation to wound care for two individuals. We saw that records for one of these people did not consistently evidence that the wound was checked and dressings changed as frequently as directed. The records were also limited in detail, in that an adequate description of the wound had not been completed on a regular basis. We did not find any evidence of a negative impact on this person, the wound was described as improving and the person was also under the care of a visiting tissue viability nurse. However, two nurses we spoke with suggested that agency nurses did not always complete dressing changes as required, and the lack of a consistent record meant we could not be certain this care had been provided. We referred both of these concerns to the local authority safeguarding team who concluded no further action was required from safeguarding at that time.

We looked at records of care provided to a person who had a percutaneous endoscopic gastrostomy (PEG) in place. A PEG is a tube that is inserted into the stomach, often to provide food, fluids or medicines to people who are not able to take them orally. The care plan lacked detail; for example, it did not indicate requirements in relation to cleaning or rotating the PEG. There was no record of the PEG being rotated, which is a task that should in most cases be undertaken daily. The provider updated the care plan and showed us a record of PEG cleaning. They told us rotation of the PEG would be undertaken at the same time as the PEG was cleaned, and a regular member of nursing staff we spoke with confirmed this. However, the records of cleaning of the PEG also contained gaps and did not show this task had been completed daily on a consistent basis. The last record of cleaning for the PEG was 10 days prior to our inspection. However, the provider sent us a record following the inspection that indicated the PEG had been cleaned since this date. Due to our concerns that this person had not received appropriate care, we referred this concern to the local authority safeguarding team. We were subsequently made aware that this person had been admitted to hospital and the hospital had also raised a safeguarding alert in relation to the PEG. We are currently making further enquiries into this concern and will consider what further actions may be required based on review of any additional evidence.

The provider was unable to provide evidence that appropriate and safe care had been provided to people to manage risks to their health appropriately. This was a breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received positive comments from people living at Newlands about the food and meal-times, and people told us they received sufficient amounts to eat and drink. Comments we received included; "We are encouraged to eat healthy foods and keep up our fluid intake. If we do not want what is on the menu they will get us what we ask for," and; "We have fun at mealtimes – the staff help us if we need it." One relative told us; "The staff make sure that those who cannot feed themselves are fed and have enough fluids…" We saw drinks dispensers were placed around the home, which would allow those who were able to help themselves to drinks as they wished. There were also regular drinks rounds and staff told us they would support people to have a drink when they carried out their regular checks for people who were in bed.

Care plans detailed people's dietary preferences and requirements and we saw these aligned with any recommendations made by specialists such as dieticians or speech and language therapists (SALTs). We saw people with diabetes had specific care plans in place that provided details in relation to their dietary requirements, monitoring blood sugars and meeting related health care needs, such as foot care. We spoke with the cook who was aware of how to prepare meals to meet people's dietary requirements, such as how to fortify foods to increase people's calorie intake. We observed the support provided over meal-times and saw people were assisted to eat and drink as required and following any guidance in their care plans. We saw staff made records of people's food and fluid intake. However, we found records of intake had not been maintained for one person since May 2016. Staff were unclear whether this person's intake should be recorded and were unable to locate any more recent records. Records of intake would be required for this person due to concerns around weight loss and a risk of choking. We saw that staff were providing this person with support with their nutrition and hydration as directed in their care plan, however records were not being maintained.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed, and staff confirmed that they had received training, including the provider's mandatory training, fire safety, safeguarding, moving and handling. The operations director told us newly recruited staff were given opportunity to 'shadow' a more experienced member of staff for several shifts. Staff spoken with verified this and stated that it was important as it meant staff only supported people when they felt they were competent and safe to do so. The home's administrator was responsible for checking the training records each month to ensure staff were accessing training as required. This ensured that people were being cared for by staff that were suitably trained. All staff spoken with felt that the home offered a variety of training in different formats that supported their role which helped with confidence and competency. Staff also said the home had supported members of staff who wanted to, to undertake a National Vocational Qualification (NVQ).

The assistant operations director informed us the service had 45 hours of vacancies for care staff and 121 hours of vacancies for nursing staff at the time of our inspection. This meant the service was using regular agency staff to cover gaps in the rotas. We asked the assistant operations director what induction agency staff were provided with to ensure they understood their duties and responsibilities. We were told all agency staff received an induction, however, no records of this could be located. This meant we could not be certain that agency staff had received a sufficient induction to enable them to carry out their role effectively. The turnaround manager set up a new induction folder and told us they would ensure all agency staff completed the induction. We also found that on the second day of our inspection there was not a good skill mix of staff

across the home. On the first floor we found there was one permanent member of care staff working with an agency nurse and two agency care staff. The turnaround manager had recognised this shortcoming and we heard them discussing the need to move staff between the floors to ensure there were strong staff teams who knew the people they were providing care too.

Staff files contained little evidence of supervisions and appraisals having taken place. The provider's policy indicated all staff should have supervisions at least six times per year. We found the majority of staff had received either one or no supervision in 2016. Staff we spoke with told us they could be better supported by management, and they had not had supervisions in over 12 months. Staff also told us that they had never received an appraisal. During our inspection we saw evidence that only three staff had received an appraisal in the past 12 months. Supervision is important to ensure staff are adequately supported and competent to undertake their role. We had also found issues in relation to supervision at our inspection in January 2014, and the lack of regular supervision had also been raised with the home following a local authority audit in July 2016.

During the inspection we became aware that nursing staff had undertaken tasks including changing a PEG tube and taking a blood sample. We requested evidence that nursing staff were trained and competent to undertake these tasks, but the provider was not able to locate any such record at the time of our inspection. This meant the provider could not be certain that staff were competent to safely undertake these tasks.

The issues outlined above in relation to the supervision, training and competency assessment of staff were a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can 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 the provider kept a record of DoLS applications and authorisations. Where people had an authorised DoLS in place, we saw this was reflected in their care plan. Sixty-seven percent of staff had received some training in the MCA/DoLS, and staff told us they were aware of MCA. Staff understood they should ask people for consent before they delivered care. We observed staff offered people choices so they could make decisions at the time they needed to be made. For example, we heard people being offered choices at mealtimes, and saw staff asked for a person's consent and explained what they were doing when supporting them using a hoist. However, we also observed clothes protectors were put on two people without them first being asked if this is what they wanted. Clothes protections can be an effective way of helping people maintain their dignity, however it is good practice to check that people are happy to wear them.

Care records contained mental capacity assessments related to specific decisions. Staff understood how people's ability to make informed decisions could change or fluctuate. This meant that people's ability to make some decisions was assed to help ensure people were supported to make decisions themselves whenever possible, and to demonstrate why decisions taken on a person's behalf were in their best interests.

Newlands Nursing and Residential Home did not specialise in providing care to people living with dementia. However, from our review of care records we were aware that there were people living at the home with a diagnosis of dementia. Seventy-four percent of staff had completed some training in dementia, with over half of staff having completed additional modules of HC-one's dementia training course. There were few adaptations to the environment to help make it more accessible to people living with dementia. The assistant operations director told us they were not aware that any specific consideration had been given to making the environment more dementia friendly at the planned refurbishment, but that this suggestion could be taken forward. We saw a board in the lounge on the basement floor, which was used to display the day, date and weather. On the second day of our inspection this board was displaying the previous day/date at 11:15am the following day. Rather than supporting people, this could cause confusion, particularly for people living with dementia.

We found some areas of the home were cluttered, with items being stored in inappropriate areas. For example, we  saw two hoists and a wheelchair were being stored in one of the bathrooms, and items including hoists, wheelchairs, commodes and a ladder were being stored in a stairwell in an area where a sign had been put up stating 'Do not use as a storage area'. These issues had also been raised in the local authority's July 2016 audit.

Good

# Is the service caring?

## Our findings

People we spoke with talked positively about the caring approach of staff, and they told us they had good relationships with members of the staff team. One person said; "All the care staff here are wonderful. They treat you as a person and they get things done." Another person told us; "We helped our carer [care staff] to plan her wedding and she brought pictures in. We have a really close relationship." One relative we spoke with said; "The care assistants are brilliant."
We asked two staff members whether they would be happy for a friend or family member to receive care and support at Newlands. Both staff members responded positively. One staff member said; "Yes definitely. I like the home. It doesn't smell, the staff are friendly."

Our observations of staff interactions with people demonstrated that regular staff knew the people they provided support to well. For example, we observed staff talking with people about their interests and holidays they had been on. Staff were able to tell us about people's life histories and things that they were interested in. We saw people smiling and talking comfortably with staff, which showed people were comfortable received support from the staff at the home. Staff told us they got to know people well and we observed staff calling people by their preferred names.

People told us staff supported them to retain as much independence as possible. For example, one person told us; "My mobility is not very good but they keep me active and walking with a frame to make sure I retain as much independence as I can." Staff told us they would try and encourage people to get up and mobilise if they were able to, and one staff member told us one person they supported would, through choice, use their fingers to eat. They told us this was a positive action that helped this person retain independence rather than having to rely on staff to assist them with eating.

Care plans provided details on ways in which staff should help uphold people's privacy and dignity whilst providing them with care and support. For example, one care plan for a person who had a catheter in place provided clear detail and guidance for staff when providing catheter care. The plan included guidance and instruction about how to maintain the person's dignity and talked about what the person could do for themselves. Staff told us they would always knock on peoples' room doors before entering and would close the doors and curtains if providing support with personal care. We observed staff spoke discreetly to people when offering support to use the toilet. One relative told us; "They look after our mum really well. She is always clean, dressed and colour co-ordinated. They maintain her pride and dignity."

We observed staff communicated clearly with people and gave people time to respond and make choices, such as when they had been provided with a choice of meal. People had care plans in place that provided details about their communication support needs, including the need for any specific equipment such as hearing aids. We saw staff providing one person with support to replace the batteries in their hearing aid to enable them to continue to join in with a conversation.

Records in people's care plans showed there had been regular contact with families, and where appropriate, both people and family member's had been involved in care planning. One relative told us; "The staff know

my mum. They listen to her and to us and make her care plans about her as an individual." Another relative said; "I am involved and informed about my mum's care. I am asked my opinion and they listen to me." People told us there were no restrictions on when their family members could visit.

We saw that there were posters in communal areas advertising the availability of advocacy services, including independent mental capacity advocates (IMCAs). An IMCA supports people who have no appropriate friends or family to represent their views and wishes, and who lack the capacity to make decisions for themselves. We saw evidence in care plans where advocates had been involved in people's care. This helped ensure that there was always someone identified who could be involved in making important decisions who would represent that person's wishes and best-interests.

Requires Improvement

# Is the service responsive?

## Our findings

Before people moved to Newlands, the manager or a senior member of staff met with people in order to carry out a comprehensive assessment to make sure their needs could be met. If the assessment indicated that they would not be able to give the support that they needed then people and their relatives were guided and supported to look at other options. Visits were offered to people who wanted to move in to help people make an informed decision about whether they wanted to move to Newlands. During the assessment process, extensive information was gathered so staff knew as much as possible about the person, their life and background to ensure a smooth transition into the service. This information was recorded in people's care records and included information about people's lives, preferences and choices as well as their likes and dislikes. This would help staff provide care that was person-centred.

Other than the instances referenced in the 'safe' and 'effective' sections of this report, we found care plans contained the guidance and information staff would need to allow them to meet people's needs in accordance with their preferences. Specific details for individuals and what was important to them was also documented. We saw care plans had been reviewed on a monthly basis. However, we found in some instances, people's needs had changed significantly since the original care plan had been written, which in some cases was around 2 years previously. Although the person's current support needs were detailed in the monthly reviews, this would increase the risk that staff, and in particular agency staff who were not familiar with people's needs would not be aware of the care that should be provided.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff told us they read the care plans and found they provided the information they required to understand how to meet people's needs. However, one staff member told us they rarely had time to review care plans. Staff also told us they were kept up to date with peoples' current needs at the handovers they attended when they came on shift. One member of staff said, "I read the plans and we also get good handovers if anything changes." However, another member of staff told us that they had not been updated in relation to a change in one person's needs following them being off work on leave. They told us this could have resulted in the person being given fluids of the incorrect consistency if other staff had not noticed.

During our inspection we were informed by staff that a person had been supported back to bed due to them feeling unwell. When we passed this person's room we noticed that the call bell was located out of their reach on the opposite side of the room. We raised this issue with staff who told us this person had not been back in bed long. They also confirmed this person could use a call bell, and that they could press it repeatedly. Following us raising this issue, the call bell was put back in place. We also raised this concern with the local authority safeguarding team.

This was a  breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the proper use and location of equipment.

The home employed one full-time activities co-ordinator at the time of the inspection. We were told there were additional hours available, which should help with the provision of activities over seven days per week. During the inspection we saw people attending the hairdressers within the home, where the activities co-ordinator was also providing 'pamper' sessions and engaging people in conversation. On the second day of our inspection we observed a small group taking part in a cake decorating activity. We reviewed records of activities provided, which indicated a range of activities had been provided, including entertainers, a garden party, music and one to one's. Due to the size of the home, the activities co-ordinator was only able to engage a limited number of people in activities throughout the day, and we saw few attempts by staff to arrange or support activities. We asked one staff member if staff supported any activities. They told us; "We try to get people singing, but I don't think there's enough to occupy people as it's a large home." There was evidence that the home was supporting people to maintain relationships with family and friends. For example, one person told us they were always supported to another floor in the home at meal times to enable them to eat with their family member who also lived at the home.

Due to concerns raised with CQC about possible early rising by staff with people, the inspection on the first day commenced at 4:15am. On our arrival, we did not find that anyone was out of bed or that staff were waking people up early out of convenience or routine. People we spoke with told us they were able to make day to day decisions such as when they got up and went to bed, and what they ate at meal times. Staff told us there were no set times to get people up and confirmed people could lie-in or get up early as they wished. Staff said people were also able to choose the time's they would prefer support with washing or bathing and told us there were no issues with staffing pressures meaning people had to be supported with this care early in the morning. We noted that there were few spaces available in the dining rooms on each floor and there was not sufficient room to accommodate all people in the dining areas at the same time should they have wished to eat there. Staff told us some ate in their rooms and that this was through choice. No-one we spoke with indicated they were not able to eat where they wished.

We asked people and relatives whether they received an appropriate response if they ever raised a concern or complaint. One person and one relative told us they had been satisfied with the response provided to concerns they had raised. The relative told us; "If we raise a concern they immediately try to solve it." A second relative we spoke with said the former manager had not seemed to do much in response to a concern they had raised. However, they told us they had spoken with the new manager and that they now felt satisfied with the actions being taken. The manager said they had an "open door" policy for people, their relatives and staff to discuss any issues of concern or to make suggestions about improvements in the home. We saw the service kept a record of complaints and this provided evidence that complaints had been investigated, responses provided to the complainant and actions identified if required to address the issue of concern appropriately.

We saw resident and relatives meetings were held on a regular basis. People told us they were aware of these meetings, but did not always attend as they felt able to discuss any issues they may have with staff on a day to day basis. One person said; "The staff ask if we are happy, and if there is anything bothering us we are encouraged to discuss it." Another person told us; "They [the staff] do listen to us and we can go to the resident meetings. But we are usually happy so do not have anything to say." We saw people living at Newlands and their families had been sent surveys seeking their feedback on the service in April and May 2016. The findings from the surveys had been analysed, which would help the manager to better understand potential areas for improvement and where action may be required. The provider told us people living at Newlands and family members had been consulted in relation to the planned refurbishment. We requested, but did not receive any evidence of this consultation so we were unable to verify this.

Inadequate

# Is the service well-led?

## Our findings

There was no registered manager in post at the time of our inspection. The former registered manager had registered with CQC in October 2015 and had left the service on 29 July 2016, shortly before our inspection. There was no deputy in place at the time of the inspection and they had also left the service within the past six months. The provider told us they were actively recruiting to these vacant posts. There was also one 'unit manager' in place who was a nurse who worked 'on rota' and had additional management responsibilities.

A new 'turnaround manager' was in place at the time of our inspection who was also in the process of undergoing their HC-One induction having been recently recruited. An assistant operations director who was responsible for a group of homes in the local area was also available to provide support to the new turnaround manager. The assistant operations director informed us turnaround managers were experienced managers and that Newlands had been identified as requiring a turnaround manager due to the current lack of leadership and internal systems that were flagging potential concerns.

Our records showed there had been three registered managers at Newlands in the past three years. Staff we spoke with felt the frequent management changes had a negative effect on the staff team. One staff member told us; "We are concerned there is no manager. I think we need unit managers and a permanent manager so we have someone to go to [for advice and support]." Another staff member said; "It's a good home to work in, but managers come and go. Nothing is stable. I think it's too big a home for one manager."

We found 'nursing stations' on each floor were situated in the main corridors. We saw that documents containing confidential personal information were being kept insecurely at each of the nursing stations. For example, we found food and fluid intake records, the communication book and faxes with prescription requests loose on the desk at one nursing station. Care plans were also kept in unlocked filing cabinets next to the nursing stations. The assistant operations director told us this issue would be addressed at the planned refurbishment and told us they had taken actions to ensure documents were stored securely. However, this issue had also been raised at the local authority's audit and was an on-going issue at the time of our visit. Whilst we found no evidence of confidential information having been inappropriately accessed, there was a risk that this could happen.

Records of care provided were in many cases poorly organised, hard to follow and in some cases incomplete. As referenced in the 'safe' and 'effective' sections of this report, we found gaps in records of repositioning and wound care and could not be certain whether people had received this care. There were also records of care that were missing, such as the record of food and fluid intake for one person and some records of repositioning for another person. Issues in relation to record keeping had also been raised as a concern and area for action following a safeguarding meeting that was referenced in the local authority's audit. We found on-going issues in relation to keeping accurate records.

The issues of secure storage and keeping an accurate record of care provided were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had comprehensive systems in place for monitoring the quality and safety of the service. The manager completed monthly audits to review health and safety practices, equipment, medicines, care plans and incidents such as falls in order to try to help identify any trends and prevent them re-occurring. We saw that the manager had also carried out checks 'out of hours' to maintain an awareness of how the service was running when they were absent. Records showed any incidents were investigated, and an action plan or additional support put in place where needed. For example, a person was continually falling whilst trying to get out of bed, so this person now used a crash mat to reduce the risk of injury should they sustain a future fall.

The manager also carried out a daily walk around of the service making observations and speaking with staff and people using the service. The provider had completed a 'care home self-assessment tool' which had been created around the CQC's key lines of enquiry. This document was very detailed and identified areas of concern in relation to regulation. All areas of concern were then entered onto an action plan that documented what could change to address the concern, identified who was responsible and when the action was to be completed by. We looked at some of the identified areas of concern and found they had been responded to.

Despite these comprehensive reviews, we found that some identified areas of concern highlighted in the medicines audits did not have an associated action to address the concern. For example, audits undertaken in July 2016 indicated two discrepancies in relation to stock, that opening dates of liquid medicines weren't recorded and issues with the temperature of the clinic rooms. The assistant operations director checked the on-line care management system where actions should have been created, but was unable to find the associated records. There had also been a slight lapse in the completion of audits during the period of transition from the old to the current management. For example, the monthly falls and weights review meetings had not taken place in July 2016. The audit and quality assurance systems had also not been effective in identifying and addressing the issues we have reported in this report, such as issues with records of care and care plans. Systems in relation to the supervision of staff had lapsed and the system for checking nurses' registration had also been ineffective. Both of these issues had been identified as areas of concern at CQC's inspection in January 2014. Whilst the provider had made improvements and had met all requirements at the subsequent inspection in July 2014, this indicated systems were not adequate to maintain the improvements. The monitoring of kitchen fridge temperature had not been completed when the regular cook had been on leave.

These issues were a breach of Regulation 17(1) in relation to the requirement for effective systems to assess, monitor and improve the quality and safety of the service provided.

We gave feedback to the provider as to our initial findings at the end of the inspection site visit. The assistant operations director was pro-active in responding to the concerns we had raised and sent us a response to our feedback four days following the inspection that detailed immediate and further planned actions to address the concerns raised. The assistant operations director told us they would produce an action plan that would incorporate our feedback as well as the concerns raised from the recent local authority audit. This showed the provider was listening and responding to feedback from relevant parties.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care plans did not always contain a clear assessment of people's current needs.<br><br>Regulation 9(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>It had not been ensured that a call bell had been made available to a person in bed. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Systems for checking nurses registration had not been operated effectively. The provider had not ensured that nursing staff continued to have the required professional registration.<br><br>Regulation 19(1) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Confidential records were not kept securely.<br><br>Regulation 17(2)<br><br>Records of care provided had not been completed consistently or were missing,<br><br>Regulation 17(2)<br><br>Systems in place to monitor and improve the quality and safety of the service had not been operated effectively.<br><br>Regulation 17(1)(2) |

**The enforcement action we took:**

We issued a warning notice against the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not ensured sufficient numbers of staff were on duty to meet people's needs.<br><br>Regulation 18(1)<br><br>Staff had not received regular supervision. The provider was unable to demonstrate that agency staff had received an adequate induction to the service. The provider was unable to provide evidence that all staff were competent to carry out the duties they were performing.<br><br>Regulation 18(2) |

**The enforcement action we took:**

We issued a warning notice against the provider.