Ms Lynda Martin

The Newlyn Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Newlyn Residential Home was providing personal care to 11 people aged 65 and over at the time of the inspection. The service can support up to 13 people in one adapted building.

People's experience of using this service and what we found
People told us they felt happy and safe living at The Newlyn Residential Home. However, we found the service was not well led and people were at risk of harm. The provider was working shifts at times this had taken them away from leadership tasks. They did not have a good oversight of the service, checks and audits had not been completed and shortfalls had gone unnoticed. A manager had been appointed shortly before our inspection to support the provider.

People's medicines were not managed safely. Medicines had not always been stored, administered or disposed of safely. Care had not been planned to keep people as safe as possible. Some risks had not been identified and guidance had not been provided to staff about other risks. Accidents and incidents had not been kept under review to identify any patterns or trends. Records of people's care were not always complete.

Staff had not been recruited safely. Some important checks had not been completed and the provider was unaware of staff's practice in some previous social care roles. There were enough staff on duty to meet people's needs but frequent staff absences put pressure on other staff and the provider who were busy and tired.

People were not always protected from the risk of the spread of infection. We found staff were not following national guidance around the correct wearing of face masks and this increased risks to people.

People, their relatives and staff were not fully involved in what happened at the service. Views obtained through surveys had not been analysed and used to improve the service. Staff meetings were not held often to keep staff informed of any changes and gather their feedback. However, people and their relatives told us they were confident to raise any concerns with the provider and these had been addressed. People's relatives told us they were kept informed about any changes in their loved ones health and wellbeing.

People were protected from the risk of abuse. Staff knew how to recognise the signs of abuse and were confident to raise concerns with the provider or blow the whistle outside of the home. Staff felt supported and appreciated by the provider. They had a shared goal of providing dignified and respectful care to people while maintaining their independence.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 25 December 2020) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to infection control procedures, recruitment processes, staff deployment and care planning. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of risks to people, safe medicines management, staff recruitment, infection control, obtaining and acting on people's views and ineffective checks and audits and incomplete records at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Newlyn Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services. Systems were not in operation to review accidents and incidents and take action to prevent them form happening again.

Inspection team
This inspection was completed by one inspector.

Service and service type
The Newlyn Residential Home Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with three members of staff including the provider, manager and health care assistant. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service. We spoke with three relatives about their experience of the service and five members of staff.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to ensure medicines were recorded accurately. This was a continued breach of 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12. People continued to be put at risk by poor medicines management processes.

- People were not protected by safe medicine management processes. Two medicines prescribed to ensure a person was comfortable at the end of their life were out of date and could not be used. The opening date of other medicines, such as eye drops, had not been recorded. This is important as some medicines need to be discarded shortly after opening.
- People's medicines were not always stored safely. Some medicines were at risk of being misappropriated were not stored in line with legal requirements. This increased the risk of them being misappropriated and not being available when people needed them. At times medicines had been stored above 25°C, the maximum temperature recommended by the manufacturer. There was a risk people's medicines would not be as effective because they had become too warm. Prescribed creams were stored in unlocked cupboards in people's bedrooms. Any risks associated with this had not been assessed.
- Pain relief patches were not applied and managed safely, leaving people at risk. On occasions staff had applied a patch to the same site within three or four weeks. This was against the manufacturers recommendations and risked damaging people's skin. One patch had fallen off but action had not been taken to find it and dispose of it safely. Another patch which had fallen off had not been returned to the pharmacy for safe disposal. Staff did not check the patches were in place each day and did not know when they had come off. There was a risk people would be in pain because they were not getting their pain relief as prescribed.
- Guidance had not been provided to staff about when to administer some people's 'when required' medicines. For example, medicines used to treat chest pain. Other guidance did not contain all the information staff needed to administer the medicine consistently. For example, the signs people were anxious and required medicine to help them remain calm. One person told us staff offered them pain relief and gave them one or two tablets depending on how much pain they had. However, other people were not able to tell staff when they needed they medicine and there was a risk they would not receive it when it was needed.

The provider had failed to ensure medicines were safely managed. This placed people at risk of harm. This

was a continued breach of 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to complete robust checks of staff's character and experience before they began working at the service. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 19. People continued to be put at risk by poor staff recruitment processes.

● People continued not to be protected by robust recruitment checks. Staff had not been asked for their full employment history with satisfactory explanations of any gaps in employment. The provider's application form asked for start dates of employment but not leaving dates. Any gaps in employment could not be unedified and the reasons explained.
● Where staff had previously worked in care roles, checks on their conduct had not been fully completed. References had not always been obtained from the staff members last employer. The provider was unaware of their responsibility to obtain satisfactory evidence of staff's conduct in previous health and social care roles.

The provider had failed to complete robust checks of staff's character and experience before they began working at the service. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other important recruitment checks had been completed. Action had been taken to ensure criminal record checks with the DBS had been received before staff began working with people. Copies of staffs training certificates had been obtained to confirm they had the skills they required to fulfil their roles.
● There were enough staff to meet people's needs on each shift. One person told us, "The staff are always there if I need them". However, staff were often off at short notice. These shifts were covered by other staff, agency staff or the provider. This took the provider away from managerial tasks. Staff and the provider told us they were very tired at times because of the extra shifts they were covering. There were vacancies for two care staff and one cook which the provider was trying to recruit to.

Assessing risk, safety monitoring and management
● People's care was not consistently planned to keep them as safe as possible. At our last inspection the provider had acted on our previous recommendation and made sure risk assessments and care plans included guidance related to the person and their needs. This improvement had not been maintained and risks to people had not been assessed and mitigated. This left people at risk of harm.
● Some people were living with diabetes and their care plans instructed staff to monitor their blood sugar levels. Guidance had not been provided to staff about the signs people's blood sugar levels were becoming too high or too low and the action to take. People's usual or recommended blood sugar levels were not known and staff had not been trained by a health care professional to undertake blood sugar checks. There was a risk changes in people's diabetes would not be recognised and action taken to keep them as well as possible.
● Risks of people losing weight had not been assessed and mitigated. One person had lost 10kg since January 2021. They had been referred to the dietician shortly before our inspection. However, no action had been taken to reduce the risk of them losing more weight. We would have expected the person to be offered foods fortified with extra calories. Food intake records stated the person often ate 100% of their meal, but

the size of the meal was not recorded so staff knew how much they had eaten. No process was in place to review food and fluid records to identify changes in people's appetite and encourage them to eat and drink more.
● The risk of people choking had not been assessed. Some people had their meals pureed but the reason for this was not known. Staff had noted another person was coughing when they ate or drank and they were referred to a Speech and Language therapist (SALT). SALT guidelines were implemented and had been followed, however, no guidance had been provided to staff about what to do if the person choked.
● Some people enjoyed an alcoholic drink on occasions. The risk of people consuming too much alcohol had not been assessed and action had not been planned to keep them and others as safe as possible. People told us they were supported to go out without staff support if they wished. One person told us, "I have quite a bit of freedom". Again, the risk of people purchasing or consuming alcohol when away from the service had not been assessed, despite people putting themselves at risk at times.

The provider had failed to assess the risks to service users health and safety and take action to mitigate risks. The placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Systems were not in operation to review accidents and incidents to look for any pattern or trends. The provider told us they had a process in place but had not had time to complete this. They had failed to recognise that not reviewing accidents and incidents to identify patterns and trends left people at risk of harm. One person's relative told us their loved one fell on occasions and they were unaware of the action staff had taken to manage the risk. Records showed they person had fallen several times but care had not been robustly planned to support them.
● Accident records contained little detail about what had happened to the person. This information is important when looking for the causes of accidents and deciding on the action to take to minimise the risk of it happening again.

The provider had failed to operate systems to assess, monitor and mitigate health and safety risks to service users. This was a breach of 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Before our inspection we received concerns from local authority commissioners that staff were not always wearing face masks in line with national guidance. We observed staff were not wearing face masks correctly.

The staff member who answered the door to us was seen to be putting a face mask on before opening the door. Other staff wore their facemasks below their nose, which increased the risk of the spread of infections such as COVID 19. The provider told us they had a stock of visors for use in the event of a COVID 19 outbreak at the service. They told us they were not easily accessible because other items were stored on top of them and they were unsure if they were in a usable condition. Records of cleaning completed were incomplete and we were not assured all areas of the service had been cleaned regularly.

The provider had failed to manage the risk of preventing and controlling the spread of infections. This placed people at risk of harm. This was a breach of 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risks of abuse. People told us they felt safe and happy living at The Newlyn. We observed people were relaxed in the company of each other and staff. When people became anxious staff offered them reassurance and spent time with them.
- People and their relatives felt comfortable to speak to the staff about any concerns they had. Staff had completed safeguarding training and were confident to share any concerns with the manager or provider. Staff knew how to blow the whistle outside of the service.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service was not well-led and there was a lack of effective leadership and oversight. This had impacted on all areas of the service. The provider had been completing all the management and business tasks since the previous manager left in April 2021. They told us they were "burnt out" and "struggling" to manage the service. The provider had been unable to complete all the required management tasks to ensure people were safe. They told us, "It's too much for one person, I have been concentrating on keeping people as safe as possible".
- The provider had employed a new manager shortly before our inspection and planned to delegate some management tasks to them. The lack of a manager to support the provider over the past five months, and share the workload, had impacted on the provider and the quality of the service.
- Staff shared the provider's values of care and treated people with dignity and respect. People were supported to maintain their independence and their individual backgrounds, preferences and wishes were respected. Staff felt supported by the provider and manager. They told us the provider was approachable and always available to offer support. They felt appreciated by the provider and were treated with respect.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to ensure records about people's care were accurate. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No improvement had been made at this inspection and the provider remained in breach of regulation 17. People's records continued to be inaccurate and incomplete.

- Records relating to people's medicines were not always accurate and complete. There were gaps in the medicine administration records and the provider could not be assured people had received their medicines as prescribed. The stock balance recorded for one high risk medicine did not match the stock levels held. Four medicines at risk of misappropriation were not recorded on the medicines register. Records of the administration of creams and pain relief patches had been put in place since our last inspection. However, these were not fully completed.

The provider had failed to maintain accurate and complete records about each service users. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Effective systems were not in place to manage staff practice and hold staff accountable. The provider did not hold regular staff meetings to share important messages with staff and understand any challenges they were facing. Staff did not always follow the provider's guidance and fulfil their roles as required. We observed that despite signs on display and reminders from the provider staff did not follow instructions to wear face masks correctly.
● The provider told us constantly chasing the staff team to fulfil their roles took them away from other important tasks, such as monitoring the quality of the service. The provider's action plan had not been reviewed since May 2021 and there were no plans in operation to address shortfalls the provider was aware of.
● Services that provide health and social care to people are required to promptly inform us of important events that happen in the service. This is so we can check appropriate action had been taken. The provider had notified CQC of significant events that had happened at the service.

Continuous learning and improving care
At our last inspection the provider had not ensured all quality assurance checks were effective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No improvement had been made at this inspection and the provider remained in breach of regulation 17. Checks and audits completed by the provider did not protect people from the risk of harm.

● Action the provider told us they would take to improve the service following our last inspection had not been completed. Following our last inspection the provider sent us an action plan detailing the action they would take to improve medicines management, staff recruitment and checks and audits. The improvements had not been achieved and shortfalls at the service had continued unchallenged.
● The provider had a system in place to check some areas of the service, however, no processes were in place to check risk assessments, medicines management and staff recruitment processes. We found high risk shortfalls in all of these areas. The provider's failure to review these areas of the service and identify and address the shortfalls, had left people at risk of harm. Staff administering medicines in the morning told us they were tired after a long night shift. The provider had not considered staff being tired as a possible contributing factor to the number of mistakes they were making.
● Systems to audit other high risks areas of the service including falls, weight loss and care records were in place, but had not been completed. This was another missed opportunity to check people were receiving safe care and were not at risk of harm.

The provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not asked for their views of the service to drive improvement. Action taken to improve engagement with people since our inspection in October 2019 had not been maintained.
● The provider told us people had been supported to complete surveys to share their views of the service.

They could not find the surveys and were unable to tell us what they had done in response to any comments people made. Meetings were not held with people to discuss any changes or ask them for their suggestions. The provider told us they chatted to people to get their views but again there were no records of these chats and the provider was not able to tell us what changes had been made following people's feedback.

● People's relatives and staff had been asked to share their views of the service in April and May 2021. Some staff had shared that staff did not always work as a team, something the provider agreed with. However, responses had not been analysed so the provider could understand what they were doing well and act on any suggested improvements.

The provider had failed to seek and act on feedback service users and other key stakeholder on the service for the purposes of continually evaluating and improving the services. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The provider was working with local authority commissioners to improve the service. They had agreed an action plan and were meeting regularly to review progress. However, at the time of our inspection improvements to the recruitment and infection control processes had not been fully implemented and the provider was in breach of regulations.

● Staff worked well with visiting health care professionals. They had worked together to support people to make advanced decisions about their care and treatment and these were followed by staff.

● The provider was part of a local managers and providers virtual group and used this to obtain advice and guidance.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines were safely managed. This placed people at risk of harm. The provider had failed to assess the risks to service users health and safety and take action to mitigate risks. The placed people at risk of harm. The provider had failed to manage the risk of preventing and controlling the spread of infections. This placed people at risk of harm. 12(1)(2)(a)(b)(g)(h)

The enforcement action we took:

We imposed a condition on the provider's registration.

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 operate systems to assess, monitor and mitigate health and safety risks to service users. The provider had failed to maintain accurate and complete records about each service users. The provider had failed to seek and act on feedback service users and other key stakeholder on the service for the purposes of continually evaluating and improving the services. 17(1)(2)(a)(c)(e)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to complete robust checks of staff's character and experience before they began working at the service. 19(1)(a)

The enforcement action we took:

We imposed a condition on the provider's registration.