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 provides the regulated activity accommodation for persons who require personal care to up to 13 people. The service provides support to older people, people living with dementia or a sensory impairment and people with a physical disability. At the time of our inspection there were six people using the service. The service is a large, converted property. Accommodation is arranged over two floors and there is a stair lift to assist people to get to the upper floor.

People's experience of using this service and what we found
There was a lack of strong leadership at the service and despite a reduced number of people living at the service and the support of a manager, the provider had failed to make the required improvements to the service in the six months since our last inspection. Shortfalls at the service continued to place people at risk of harm.

The provider did not have a clear vision for the service or set of values for staff to work to. Checks had not been completed on some high risk areas of the service, such as diabetes care. Audits of the quality of other parts of the service had not identified the shortfalls we found. Robust systems were not in operation to gather and act on the views of people, relatives staff and other stakeholders. Where people had shared their views, these had not been used to improve the service. The provider did not have a detailed action plan in place to drive improvements and had relied on visiting professionals to identity shortfalls and guide them in how to address these.

People continued to be at risk because hazards to them had not been assessed and mitigated. Where risks had been identified action had not been consistently planned to protect them from harm. There was a lack of guidance of staff about how to keep people as safe and well as possible.

The management of medicines had improved, however further improvements were required. Medicines were not always returned safely and some medicines had not been returned. Again, we found medicines were not always stored at a safe temperature and there was a risk they would not be effective. Guidance was not in place around how to administer some when required medicines.

Effective systems were not in place to learn lessons when things went wrong. Accidents had been recorded and analysed. However, action had not been taken to reduce the risk of accidents happening again and they continued.

Staff deployment was not based on people's needs and there were times when only one staff member was available to support people. Some staff had not completed practical training in core skills such as first aid and moving and handling and the provider had not assured themselves staff had the skills, they needed to keep people safe. Staff recruitment had improved, and the required checks of staff conduct and character had been completed.

Action had been taken to reduce the risk to people of the spread of infections including Covid-19. We observed staff were wearing masks correctly. People were supported to see visitors when and where they wanted. Staff knew how to identify safeguarding risks and the provider had reported any concerns to the local authority safeguarding team for their consideration.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Following our inspection the provider closed the service.

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 inadequate (published 13 January 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 14 October 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve medicines management, safe care and treatment, staff recruitment, learning lessons, infection prevention and control, records, checks and audits and obtaining and acting on feedback.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has not changed. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Newlyn Residential Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, medicines management, learning lessons, staff deployment, checks and audits, records and acting on feedback 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, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 Health and Social Care Act 2008.

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.

Inspection team
This inspection was completed by one inspector.

Service and service type
The Newlyn Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Newlyn Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is not required to have a registered manager. This means 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 local authority professionals who work with the service. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. Please see the well-led section of the full inspection report for further details. We used all this information to plan our inspection.

During the inspection
We spoke with three people and one relative about their experiences of the service. We spoke with five staff including the provider and three care staff. We reviewed a range of records. This included four people's care records, multiple medication records and two staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to assess the risks to service users' health and safety and take action to mitigate risks. This was a breach of regulation 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 in relation to the assessment and mitigation of risks. People's care had not been planned and delivered to keep them as safe as possible and they continued to be at risk of harm.

- Following our last inspection, the provider obtained information for people's GP about their diabetes care. This included their recommended blood glucose range and testing. This information had not been used to plan people's care. One person's care plan stated their blood glucose was tested each year, but staff told us they tested it when the person was unwell. Their blood glucose record said it should be checked weekly, but this had not happened. The care the person received when their blood glucose levels were too high was not consistently recorded and no checks had been completed to make sure action taken was effective. This left the person at risk of becoming unwell.
- People were at risk of harm because care had not been planned to manage risks associated with their medicines. Some people were prescribed medicines to thin their blood, this increased their risk of bleeding and bruising. Following our inspection, the provider told us they had put guidance in place for staff. However, this was generalised, did not identify risks to each person or provide inform to staff about how to mitigate the risks.
- Effective action had not been planned and taken following our last inspection to stop people losing weight. When people were at risk of losing weight, their meals and drinks had not been fortified with extra calories despite instruction in care plans to do this. Food items, such as milk powder which are used to increase the calories in foods were not in stock and the provider relied on prescribed food supplements to increase people's calorie intake. This is against national guidance which states to always support people at risk of losing weight to eat a high calorie diet.
- No action had been taken since our last inspection to manage the risk of people choking. One person was assessed as being at risk of choking and required the texture of their food to be modified. However, no guidance had been provided to staff about the person's sitting position whilst eating or what to do if they choked. The provider put this in place after our inspection.

The provider had failed to assess the risks to service user's health and safety and take action to mitigate risks. The placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) 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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely
At our last two inspections the provider had failed to ensure medicines were safely managed. This was a continued breach of regulation 12(1) 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 in relation to medicines. People continued to be put at risk by poor medicines management processes.

● Medicines continued to be stored in an unsafe manner. The provider had failed to take effective action, in line with their policy, to ensure medicines were always stored below the manufacturer's maximum recommended temperature of 25°C. In March 2022 the temperature in the medicines room had reached 25°C on 11 occasions and exceeded 25°C on five occasions. There was a continued risk people's medicines would not be as effective because they had become too warm.
● The provider did not have an effective process in place to dispose of unwanted medicines. The name and strength of some medicines no longer required was not recorded along with the quantity and person they were prescribed to. This was not in line with national guidelines. We also found seven medicines at risk of misappropriation were awaiting return. The provider told us they had returned all unwanted medicines the day before our inspection but was unaware of these medicines. The stock levels of medicines could not be checked to ensure they were accurate, and medicines had not been misappropriated.
● Some guidance had been provided to staff about how to administer people's 'when required' medicines. However, we found there was no guidance in place for four when required medicines. This included laxatives and pain relief. There was a continued risk people would not receive their medicines when they needed them.

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.

● Some improvements had been made in the way medicines were managed. All out of date medicines had been returned to the pharmacy for destruction. The opening date of medicines with a short shelf life such as eye drops, had been recorded. Prescribed creams were now stored in locked cupboards in people's bedrooms. The application site of pain relief patches was rotated over four areas of the body to reduce the risk of skin damage. Staff checked the patches were in place daily and had not come off.

Learning lessons when things go wrong
At our last inspection 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.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17 in relation to monitoring and mitigating risks. People continued to be put at risk because effective systems were not in operation to review accidents and prevent them reoccurring.

● A system had been put into place since our last inspection to review accidents and incidents. However, this was not effective, and people continued to be at risk because patterns and trends had not been identified. One person had sustained at least five skin tears on their legs between January and March 2022. The cause for the skin tears was not known and had not been investigated.
● The accident review had noted the accident time had not been recorded for two of the nine accidents which occurred between January and March 2022. No action had been taken to ensure accidents records were complete so patterns and trends could be identified.

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

● Action was taken following a medicines administration error to reduce the risk of the error occurring again. More robust systems were put in place to tell staff when the medicine needed to be administered and additional checks were put in place.

Staffing and recruitment
● Staff deployment was not planned around people's needs. The provider told us, "I have just carried on with the rota as it was when I first came here". Care staff covered household and domestic duties including preparing breakfast and doing laundry. They also cleaned the house at the weekend when no cleaner was deployed. Night staff had a two-hour sleep break during their shift. All of this took care staff away from people and meant at times only one staff member was available to support people, including the two people who needed assistance from two staff.
● Staff vacancies continued and vacancies for a cook and activities co-ordinator had not been filled. The provider told us one staff member had requested additional hours and been asked to do some activities with people. This was not the staff member's substantive role and they had no skills or experience in this role. The provider could not be assured the staff member had the skills they needed to fulfil this role.
● The provider had not assured themself staff had the practical skills they needed to fulfil their roles safely. Staff had not completed any practical training, such as moving and handling or first aid since the COVID-19 pandemic began at the beginning of March 2020. The provider told us this was because of COVID-19 restrictions. There were no restrictions in place at the time of our inspection.
● The provider told us they believed some staff had completed practical first aid training but was unable to demonstrate this with training certificates. New staff had not completed practical moving and handling training. Their competence had been assessed by the manager, however they were not a trained moving and handling assessor. There was a risk some staff did not have the skills to move people safely or respond in an emergency.

The provider had failed to deploy sufficient and suitably skilled and competent staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

At our last two inspections 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19. People were protected by safe recruitment processes.

● The provider had completed checks to ensure staff were of good character and had the skills required to fulfil their role before they were employed. Any gaps in staff's employment history had been identified and explained. Other checks included Disclosure and Barring Service (DBS) checks and obtaining references. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
At our last inspection the provider had failed to manage the risk of preventing and controlling the spread of infections. This was a breach of 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to infection prevention and control.

● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 using PPE effectively and safely.
● 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 was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
● People received visitors when they wanted in their bedroom or communal areas. Visitors had chosen to show evidence of a negative Covid-19 test before they entered the service.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risks of abuse. People told us they felt happy and safe living at the service. 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 provider 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.
● The provider had shared any safeguarding concerns they had with the local authority safeguarding team so they could be investigated. They also notified us so we could check they had acted to keep everyone as safe as possible.

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 our last inspection we rated this key question Inadequate. The rating for this key question has remained 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.

Continuous learning and improving care
At our last two inspection 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.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17 in relation to checks and audits. People were not protected by effective processes to identify and address shortfalls in quality and safety of their care.

● Following our last inspection, we took enforcement action against the provider and required them to send us monthly reports detailing any actions identified by their audits of ten high risk areas, with timescales for completion. The provider sent us reports each month, however these did not clearly detail any shortfalls they found, or the action taken to address them. Despite us contacting the provider to support them to submit the correct information, we did not receive the information required by the condition on their registration.
● Checks and audits were not completed on all of areas of the service and shortfalls in quality and safety had not been identified. Key areas, such as the management of choking risks and the accuracy and completeness of records, had not been reviewed. Checks had not been completed to ensure staff had all the guidance they needed to provide effective care and treatment and any shortfalls in practice were identified and addressed. This left people at a continued risk of harm.
● No checks had been completed on people's diabetes care. We found people living with diabetes were offered a diet high in sugar. Low sugar alternatives such as sugar free jelly and ice-cream were not held in stock. Staff did not support people to have a low sugar diet in line with their care plan. One staff member told us, "They can have what they like". Records showed people had eaten high sugar foods several times a day including cakes, biscuits and buns and their blood glucose levels were above their usual range. The provider told us they were not aware of this.
● Effective medicines audits were not in operation. A check of medicines at risk of misappropriation on 14 April 2022 found no medicines awaiting return to the pharmacy. We found five were awaiting return when the check was completed. A check on 13 April 2022 noted the room temperature was 'slightly raised on two occasions'. We found it was above the manufacturer's recommended temperature on five occasions. The provider's action plan stated the extractor fan was to be used 'if needed'. The extractor fan was noisy, and the provider told us this was why staff were not using it. No alternative action had been taken to ensure medicines were always stored at a safe temperature.

● Effective audits had not been completed to ensure people at risk of losing weight were offered a fortified diet. Audits checked the amount eaten was recorded accurately but not what had been offered and consumed. The provider was unaware foods and drinks offered were not fortified with extra calories, or that high calorie foods such as milk powder were out of stock.
● Weight audits looked at the last three weights recorded. However, the dates the weights were taken was not recorded. This made it difficult to identify any trends or evaluate if actions had been effective.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last two inspections the provider had failed to maintain accurate and complete records about each service user. This was a continued breach of regulation 17 (Good governance) 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 17 in relation to records. Records continued not to be complete.

● Records in relation to people's care had improved since our last inspection however, further improvements were required. Staff had not consistently recorded if they had taken people's blood glucose readings before or after they had their medication and ate a meal. This made it difficult for health care professionals to identify any changes in the person's health and plan their care and treatment.
● Staff had not recorded how much medicine had been administered to people prescribed a variable dose of medicine. For example, one medicine was prescribed 'one or two'. Staff had not recorded how many had been administered. This made is difficult for their health care professionals to review if the medicine was effective or changes needed to be made to the prescribed dose.
● Decisions made, why and by whom, had not been consistently recorded. We found an instruction to staff requesting one person's blood glucose levels were checked for 3 consecutive days in April 2022. This was not in line with guidance from their GP. There were no records around this decision, including who made it and why. A member of care staff told us they had made the decision without consultation with the person's GP or provider. There was a risk the decision had subjected the person to unnecessary blood glucose testing.

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

● In March 2022 we asked the provider to complete a Provider Information Return (PIR) and return it to us by 19 April 2022. We did not receive the provider's response. The PIR is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We asked the provider for an explanation as to why they did not complete the PIR. We did not receive a response from them.

The provider had failed to send their provider information return when requested. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There continued to be a lack of effective leadership and oversight and again this had impacted on all areas of the service. The provider had been supported by a manager and they worked together to manage the service with the provider being in overall control. However, the provider had failed to develop a culture of good care. They and staff did not recognise improvements were required to deliver care to nationally recognised standards. One staff member told us, "I don't think there is anything wrong with the home".
● Leadership at the service was weak. The provider had not developed a clear set of visions and values for the service and shared these with people, their relatives and staff. These are important to support everyone to understand the expected quality of the service and challenge the provider where they fell short.
● Staff told us enjoyed working at the service and the provider was approachable and supportive. They told us how the provider had supported them with personals issues and was "flexible" when they were unable to work. One staff member told us, "[The provider] has been so good to me, very supportive". Staff used a communication book to keep up to date with changes in people's needs and felt informed about any changes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At our last inspection the provider had failed to seek and act on feedback from service users and other key stakeholders on the service for the purposes of continually evaluating and improving the service. This was a breach of regulation 17 (Good governance) 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 17 in relation to seeking and acting on feedback. Key stakeholders had not been asked for their views of the service. The views of people had not been used to improve the service they received.

● People and their relatives had not been asked for their feedback on the service since our last inspection. The provider had reviewed feedback they received in September 2021 and found the majority was positive, however some concerns had been raised. One relative had commented their loved one had dirty nails at times. The provider was unable to tell us how this had been addressed and if the relative had been informed of any action taken to resolve their concern.
● Other people had commented on a lack of activities. The provider had informed them a singer would be visiting every fortnight and a staff member would be offering activities. However, the singer was no longer visiting because the cost was prohibitive. Care staff offered activities when they had time, but no time had been planned to support people to take part in activities they enjoyed.
● Staff were asked for their views of the service in December 2021 and four staff responded. Feedback was mostly positive. However, staff had commented about issues between two staff members. The provider was unable to tell us what they had done to address these issues and could not tell us if they were resolved.

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

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
● The provider had met with people and staff following our last inspection and informed them of some of the shortfalls we found. They were not clear about the reduction in their rating from requires improvement to inadequate or how they planned to improve the service.

● Relatives told us they had been kept informed about changes in their loved one's health. They had also been made aware we did not find significant improvements at our last inspection and enforcement action was a possible consequence. Again, they had not been informed of the action the provider planned to take to address the shortfalls and improve the quality of the service.
● Following our inspection, the provider made the decision to serve notice on people and close the service. They met with people, their relatives and staff and informed them of their decision. They were supported by the local authority commissioner to deliver this message and answer any questions people had.

Working in partnership with others
● The provider was not working in partnership with visiting professionals to improve the quality of the service. They relied on visiting professionals, such as local authority commissioners and fire and rescue officers, to identify shortfalls at the service and instruction from them on how to put things right. It remains the provider's responsibility, at all times, to identify and address shortfalls at the service and ensure they follow the latest guidance and regulations.