Highcliffe Nursing Services Limited

Newtown House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 21 January 2019 and was announced. It continued on the 22 and 23 January 2019 and was announced. The inspection was carried out by one adult social care inspector. When we last inspected in October 2018 we found a breach of regulation as people were not having their risks monitored and reviewed and people were not having their medicine administered safely. At this inspection we found improvements had not been made and there was a continued breach of regulation.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question 'Safe' to good.

Newtown House 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. Newtown House is registered to provide care and accommodation for a maximum of 26 people. Accommodation is provided over two floors and all rooms are single occupancy. A passenger lift provides access to the first floor. People have the use of a communal lounge and dining room and there is a level, secure outside garden.

At the time of our inspection there was not a registered manager in post. 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.

Risks to people had not always been assessed, monitored or reviewed. This included the use of bed rails, using equipment to restrain a person, falls, accidents and incidents. Medicines were not always administered safely. A person had received an incorrect dose and the persons GP and the local safeguarding team had not been informed. That meant any associated safety risks had not been considered by the appropriate professionals. One person had complex symptoms and had medicine prescribed for 'as and when'. There was no protocol in place to ensure the persons symptoms were managed effectively.

No audits or monitoring of the service had taken place since our last inspection in October 2018. Accurate records of the care and treatment people received had not been maintained. Examples included people's mobility needs and managing people's risks. Lessons had not always been learnt when things went wrong. Accident and incidents had been recorded but not reviewed which meant lessons had not always been learned when things went wrong. A complaints process was in place but had not been followed. A complaint had been received but not responded to in a timely manner. Records did not include an acknowledgement to the complainant, details of an investigation or the outcome.

Changes in the management structure of the home had led to reduced nursing hours which impacted on the length of medicine rounds and keeping records up to date. People were supported by staff that had been recruited safely including checks for their suitability to work with vulnerable adults.

Staff had an induction and ongoing training which enabled them to carry out their roles. Since the last inspection staff had not received any supervision and no staff meetings had been held which had left staff feeling unsupported. Staff morale was low and they lacked confidence in the management and organisation.

Pre admission assessments had taken place and captured people's needs and choices. This information had been used to create an initial care and support plan. Care and support plans were not always reflective of the care people were receiving. People had access to healthcare when needed including dentists, opticians and dieticians. People had their eating and drinking needs understood and met.

The principles of the Mental Capacity Act were not always followed as assessments had not always been completed and there were not always records to demonstrate decisions were made in a person's best interest and in the least restrictive way.

People did not have comprehensive end of life care plans that included the management of symptoms. Legal reporting responsibilities for reporting an unexpected death had not been followed and was at the time of our inspection being investigated by the police.

People spoke positively about the care they received and felt involved in day to day decisions about their care. People told us staff were respectful of their dignity and privacy.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Risks to people were not always assessed, monitored and reviewed.

People did not always have their medicines administered safely.

When things went wrong lessons were not always learnt.

A reduction in available nursing hours was impacting on the management of risk. Staff had been recruited safely.

People were protected from avoidable infection.

People felt safe and were supported by staff who understood their role in identifying and reporting suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not always followed which meant people were at risk of their freedoms and choices not being respected.

Staff had an induction and ongoing training that provided them with the skills needed to carry out their roles.

Pre admission assessments gathered information about people's needs, choices and any specialist equipment needed.

People had their eating and drinking needs met.

People had access to healthcare whenever needed.

Is the service caring?

Good

The service was caring.

People had positive and caring relationships with the staff team.

People were involved in decisions about their day to day care.

People had their dignity, privacy and independence respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care and support plans but they were not always reflective of people's care needs.

A complaints process was in place but not being followed.

Unexpected death reporting processes had not been followed and were under police investigation.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance processes were not being carried out.

Statutory notifications had not always been reported to CQC.

Records relating to people's treatment, health and wellbeing were not always accurate.

Opportunities for engagement and involvement of people, relatives and the staff team were limited as meetings had not taken place.

Staff lacked confidence in the management of the home and the organisation which had led to low staff morale.

Newtown House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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'

The inspection was prompted in part by notification of two incidents. One was concerned with the safe management of medicines and the second related to an unexpected death. These incidents are subject to a police investigation and as a result this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC about the incident indicated potential concerns about the management of medicines and end of life care. This inspection examined those risks.

The inspection began on the 21 January 2019 and was unannounced and the inspection team consisted of an adult social care inspector. It continued on the 22 and 23 January 2019 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We gathered this information during our inspection.

During our inspection we spoke with four people who used the service and three relatives. We spoke with the manager, a nurse and two agency nurses, six of the care staff, the chef and two housekeepers.

We reviewed seven peoples care files and discussed with them and care workers their accuracy. We checked two staff files, care records and medication records and the complaints log. We walked around the building

observing the safety and suitability of the environment and observing staff practice.

After our inspection we asked the manager for a copy of the staff training matrix and details of agencies that commissioned care. This information was provided on the 29 January 2019.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service in October 2018 we found breaches in regulation in relation to safe care and treatment. People's risks were not monitored or reviewed. Medicines had not always been administered safely. Following our last inspection, we asked the provider to tell us how they would make the required improvements. At this inspection we found that improvements had not been made.

Risks to people had not always been assessed, monitored or reviewed. One person was at risk of falling. Equipment had been used as a restraint to prevent them from standing up. No risk assessment had been completed to determine if this was appropriate and the least restrictive action. One person had bed rails to prevent them falling out of bed. This person had been found on their bedroom floor. The risk of using bed rails was not reviewed following this accident. A care worker told us "(Name) still has bed rails as they try to get out of bed". Another person had fallen and the accident form stated '(Name) must have climbed over their bed rails'. No review of the risk of serious injury was completed after this accident and bed rails had continued to be used.

Lessons had not always been learnt when things went wrong. Accident and incidents had not been used as an opportunity to reflect on practice and improve people's safety. Two people had fallen from wheelchairs. Neither incident had been reviewed so that risk could be assessed and actions considered that would prevent further accidents and reduce the risk of avoidable harm. Another person had 10 recorded unwitnessed falls over six weeks. Their falls risk assessment had not been reviewed following any of the accidents.

One person had presented with behaviour that may have placed themselves or others at risk of harm. Their care plan stated that any such incidents needed to be recorded on a behaviour monitoring chart for review of triggers and trends. There was no chart in place and a care worker told us "We've not really been doing the charts, been a bit sporadic". This meant the risks to the person and others could not be appropriately assessed.

One person had a recorded unplanned weight loss of 6kg in one month. Staff had been recording their food and drink intake on charts each day. Charts for three out of seven days showed their last recorded drink was at 3pm. One day recorded the person had declined all meals. The charts had not been monitored or reviewed so that actions could be considered to reduce the risk of further weight loss.

People were not always protected from environmental risks as they had not always been assessed. We observed in one person's bedroom a freestanding radiator which was hot to the touch. A risk assessment had not been completed to consider any risk of avoidable harm such as burns to vulnerable people.

People were not always having their medicines administered safely. One person had four medicines prescribed for as and when required (PRN) to manage a range of complex symptoms associated with their clinical condition. No PRN protocols, pain management charts or a medicine care plan were in place to ensure the person received their medicines when needed or to monitor and review their effectiveness.

One person had received an incorrect dose of medicine. The medicine administration chart was not amended until four days after the error was identified. The medicine error procedure had not been followed. The person's GP and the local safeguarding team had not been notified which meant that any associated safety risks had not been reviewed by the appropriate professionals.

People were not always receiving their medicines at the prescribed times. A nurse told us "When only one nurse it means the morning medicine round finishes at 11am".

The manager told us processes and systems had not kept people safe. .

Risks identified for people had not been assessed, monitored and reviewed in order to minimise the risks of avoidable harm. People were at risk as medicine administration was not always carried out in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Changes to the management structure of the home had increased pressure on the nursing team and their work load. There had not been a deputy manager in post since November 2018 and they had provided additional clinical support to the nursing team. A nurse told us the impact had been lengthy medicine rounds and no time to review care and support plans. The manager explained that last minute staff absence had impacted on staffing levels as care agencies were not always able to provide cover. The manager had been providing clinical support to cover nurse shifts and told us this had impacted on time spent overseeing the management of the service. People told us staff were able to meet their needs. One person said, "Staff have the time to help me; I never feel rushed". We observed call bells being answered promptly and people receiving their care in a timely way. People were supported by staff that had been recruited safely. This had included reference and criminal record checks to ensure they were suitable to work with vulnerable people.

People told us they felt safe. One person said, "I do feel safe; that was the one reason I came here as I didn't feel safe on my own". Staff had completed safeguarding training and understood how to recognise signs of abuse and the actions they needed to take if they suspected harm. Safeguarding information was on display in the foyer providing contact numbers for reporting concerns. People were protected from discrimination as staff had completed equality and diversity training and understood the need to respect people's lifestyle choices.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand cleansing facilities were available around the building. All areas of the home were clean and odour free.

Requires Improvement

Is the service effective?

Our findings

The principles of the Mental Capacity Act 2005 were not always followed. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Mental capacity assessments had not always been completed and when people lacked capacity the process for making decisions in a person's best interest had not been followed. This included the use of restrictions on a person's freedom such as the use of bed rails. After the inspection we notified the local authority safeguarding team of our findings. DoLs applications had been made to the local authority and were awaiting assessment. At the time of our inspection there were no authorised DoLs in place. Files contained copies of power of attorney legal arrangements for people. We observed care staff offering people choices and respecting decisions people made. Examples included offering people opportunities to go into the garden, join people for lunch in the dining room and where they spent time in the day.

Staff had completed an induction and had on-going training which provided them with the necessary skills to carry out their roles. We spoke with an agency nurse who told us their induction had included a handover about each of the people living at Newtown, fire procedures and the treatment rooms. Staff consistently told us they did not feel supported as supervisions had stopped since the change of management. We discussed this with the manager who told us that this was due to management pressures due to a shortage of senior staff and would be reviewed.

People and their families had been involved in a pre-admission assessment which had been used to gather information about their care needs and lifestyle choices. The assessment gathered information about a person's medical history, how they would like to be supported and any specialist equipment needed such as pressure-relieving mattresses. The information had been used to create an initial care plan.

People had their eating and drinking preferences met. One person liked a late breakfast and we observed staff providing this. Another person enjoyed a vegetarian diet and the chef provided examples of meal choices. One person told us, "The food is good here and there is a choice of something different; it's never a problem". We observed people with specialist beakers which were easier to hold and provided more independence for people. People were able to choose whether they shared their meal with others or in their own room. Since our last inspection a room had been converted into dining space and this provided an option for people to sit at a table for meals rather than have a chair tray. A care worker told us "The table was laid up beautifully for Christmas dinner".

People had access to private and communal areas in the home and a secure garden. Repairs had not always been carried out in a timely way. The home had a bathroom on the first and ground floor. The bath seat upstairs had not been working which meant people had to be taken downstairs for a bath. Care workers told us it had been out of action for some months. The manager was aware but unable to tell us the plans for repair. Staff told us this was not impacting on meeting people's personal care needs.

People had been supported to access healthcare both in planned and emergency situations. Records showed us people had access to a range of health professionals including chiropodists, opticians and dentists. The service worked with other organisation to ensure people had effective care. This included community mental health teams when people needed support with their dementia. When people moved between services, such as a hospital admission, key information went with them. This included a medicine record, communication needs and contact numbers of families. We found that some of this information was out of date and required reviewing.

Good

Is the service caring?

Our findings

People and their families spoke positively about the care they received. One person told us "It's the nicest place I've been in for poorly people; they are kind in spirit". A relative told us "They are so kind to (name). Nothing is too much trouble, they even baked a cake for (name) birthday". Another relative told us "(Relative) had built up a good rapport with the care staff and nurses. (Relative) likes a laugh and the staff have a bit of banter with (relative)".

We observed a relaxed and friendly atmosphere between people, their families and staff. Staff spent time talking and listening to people demonstrating patience and kindness. We observed one person shouting out and appearing distressed. A care worker went and knelt beside them and provided reassurance. The person immediately stopped shouting and smiled appearing more relaxed. Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them.

People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything.

Staff understood people's communication needs. A care worker explained how a person was blind, "We leave everything in the same place such as furniture and the commode. We describe food on their plate and explain where it is". One person had difficulty finding the right words and used hand signs to express themselves and how they were feeling. We observed staff effectively interpreting what the person was communicating and involving them in decisions.

People told us they felt involved in decisions about their day to day lives. One person told us "If I have wanted bed rest I can. They (staff) are relaxed about me getting up and dressed". Another explained how staff respected their wishes for not getting dressed until later in the morning. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. People's clothes and personal space reflected a person's individuality.

People had their privacy, dignity and independence respected. People were addressed by their chosen name. We observed people being supported at their own pace with staff encouraging them patiently both with their meals and mobility.

Information about people and staff was stored securely to ensure their right to confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People had care plans but the information did not always reflect the care they were receiving. One stated a person was unable to sit independently and were cared for in bed We observed them sitting in a chair in the lounge. Another person's care plan stated they transferred with a stand aid but the manager told us they transferred independently. Another person was having their food and drinks recorded daily but this had not been recorded in their care plan. A care worker told us "The care and support plans are not up to date; it's embarrassing".

A quick reference summary sheet was used for handover between each shift that detailed information about each person's health, how they take their medicines and care needs. One care worker told us "I haven't had time to read the care plans. I ask staff what's what. The handover is great at keeping us up to date with changes". We found the handover sheet was out of date. It included one person who had died. Information had not been updated about people's changing mobility needs. A nurse told us "We are not having the time to complete the care and support plan reviews". Both days of our inspection the nurse managing the shift was from a care agency and not familiar with people but reliant on written care plans. Staff knew people well and were able to describe how people's needs were met. However inaccurate records meant people were at risk of inconsistent or inappropriate care.

People had an opportunity to be involved in end of life care planning which included any spiritual or cultural needs. There had been an unexpected death at the service and the correct processes had not been followed which included notifying the police. At the time of our inspection the police were investigating the circumstances.

The service met the requirements of the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People had their communication needs assessed and the information was used to create a communication care plan.

People had an opportunity to join in with planned activities. An activity timetable was displayed in the foyer. One person told us "There used to be a magazine and you could plan and I do miss that". The activity co-ordinator was not available during our inspection which meant that limited activities were taking place. One person told us "(Activity Co-ordinator) comes to see me as I'm not keen to go downstairs". Another person was bed bound and had limited communication, their activity record read 'Sang 'You are my Sunshine' to (name); one of (name) favourites". We observed people reading the daily newspapers, watching TV and reading in their rooms.

A complaints policy was in place which people and their families were aware of and felt able to use if needed. A written complaint had been received in November 2018 and records showed us this had not been dealt with in line with the services policy. At the time of our inspection there were no records of an acknowledgement of the complaint, details of any investigation or a reply sent to the complainant.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service in October 2018 we found that systems and processes had not been effective in monitoring and reducing risks to people including the administration of medicines. Following our last inspection, we asked the provider to tell us how they would make the required improvements. At this inspection we found that improvements had not been made.

There had been no audits or monitoring of the service since our last inspection in October 2018. This meant that there was no governance in place to assess, monitor and mitigate risks to people's health and wellbeing. The provider's action plan had included a review of the medicine audit tool to include topical creams and 'as and when' medicines and this had not been completed.

Accurate records of people's care and treatment had not been maintained. Examples included incorrect information about people's mobility needs, dietary needs and actions needed to manage risks to people.

Systems and processes were not operating to assess, monitor and mitigate risks to the health and wellbeing of people. Accurate, complete and contemporaneous records were not kept about their care and treatment of people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management structure of the home had significant changes in November 2018 when the registered manager and deputy manager left the service. At the time of our inspection a manager had been appointed in November 2018 and was overseeing the management of Newtown House.
Three statutory notifications had not been submitted to CQC. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. One was a reportable pressure ulcer and two were to report a police incident. This meant that CQC had not received information to support their monitoring of the service.

Staff described morale as low and communication as poor. A care worker told us "We haven't got next week's rota yet and it starts on Monday; we used to get them four to six weeks in advance. We should have had a staff meeting but it didn't happen". Another member of staff told us "There has been no meetings (since October); I don't feel I have any support at all".

There had been no opportunities for staff, people and their families to be engaged and involved in the development of the service since our last inspection in October 2018. A care worker told us "We had nothing official about the registered manager and the deputy leaving; they just slipped out". Another care worker told us "Feel there is nobody to speak with if we're unhappy. We haven't even been introduced to the person who replaced (registered individual)". The manager told us that they would look at rescheduling a staff meeting.

Staff told us they understood what was expected from them and that there was good teamwork between the nursing and care staff teams. A care worker said, "The nurses get stuck in and help us; the teamwork is

pretty good".

The staff team were aware of where to access up to date information on best practice such as health and care national guidance. Information had been shared appropriately with other agencies such as safeguarding teams and social care commissioners.

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 Risks identified for people had not been assessed, monitored and reviewed in order to minimise the risks of avoidable harm. People were at risk as medicine administration was not always carried out in a safe way.

The enforcement action we took:

Warning Notice - 28 days to meet the regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operating to assess, monitor and mitigate risks to the health and wellbeing of people. Accurate, complete and contemporaneous records were not kept about their care and treatment of people.

The enforcement action we took:

Warning Notice - 28 days to meet regulation