

Regency Healthcare Limited

Newlands Hall

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Requires Improvement 

Is the service effective?

Inadequate 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection of Newlands Hall took place on 16 and 17 January 2019. We previously inspected the service in January 2018; at that time, we found the registered provider was not meeting the regulations relating to the requirements of the Mental Capacity Act 2005, safe care and treatment and good governance. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Newlands Hall is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Newlands Hall provides accommodation for up to 30 older people, some of whom are living with dementia. The home has communal living areas on the ground floor and bedrooms are located on the ground and first floor. There were 29 people were living at the home on both days of the inspection.

The service had a registered manager in place. 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.

People told us they felt safe but we found some aspects of the service needed to be improved to ensure people were safe.

The manager was in the process of reviewing and updating peoples care records. However, we found many of the records we looked at were not reflective of people's current care needs. Care plans for end of life care wishes were not always completed. Where people needed staffs support with moving and handling, records were not always an accurate reflection of current need and did not always provide a sufficient level of detail.

Records of people's food and fluid intake were not always completed and did not evidence they were provided with the appropriate consistency of diet and fluids people had been assessed as needing. However, feedback about the meals at the home was positive.

There were sufficient numbers of staff on duty but safe recruitment procedures needed to be followed. New staff received induction. There was a programme of supervision in place for all staff but not all staff training was up to date.

Medicines were stored safely and administered in a caring manner. Where people were prescribed creams and "as required" medicines, improvements were needed to ensure they were administered in a safe and consistent way.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible. However, records did not evidence the service was compliant with the Mental Capacity Act 2005.

People were enabled to access other health care professionals as their needs changed.
People were protected from the risk of infection.

People were treated with kindness. Staff respected people's right to privacy and maintained their dignity.
People spoke positively about the activities provided for them to engage in.

There were systems in place to gather feedback about the service people received. Feedback from people who lived at the home and visitors was without exception, positive. Where a complaint was raised, this was dealt with, although we did not see information on how to complain visible within the home.

The registered provider had a range of audits which the manager and senior care worker completed at regular intervals. However, these had not been effective in identifying where improvements need to be made or action to be taken. Where matters were identified, there was not always evidence the issues had been addressed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During this inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014, related with safe care and treatment, nutrition and hydration, staff training and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

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.

Risk assessments were not always accurate or sufficiently robust.

Recruitment procedures were not always thorough.

Improvements were needed to the records relating to "as required" medicines and topical creams. □

Is the service effective?

Inadequate ●

The service was not effective.

The requirements of the Mental Capacity Act 2005 were not consistently met.

Where people had lost weight, records did not evidence people were supported with high calorie meals and drinks. .

Staff training was not up to date. □

Is the service caring?

Good ●

The service was caring.

People told us staff were caring and kind.

Staff maintained people's dignity and respected their right to privacy.

Confidential information was stored securely. □

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Peoples care records were not always an accurate or up to date.

There was a regular programme of activities in place for people to participate in.

Where a complaint was raised, the manager addressed this. ☐

Is the service well-led?

Inadequate 

The service was not well led.

Systems of governance had not been operated effectively to continually improve the quality of the service.

The home had a manager but they had not yet completed their registration application.

Feedback about the registered provider and the manager was positive.

Newlands Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection commenced on 16 January 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and an assistant inspector. One of the inspectors also visited the home again on 17 January 2019. This visit was announced and was to ensure the manager would be available to meet with us.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority contracts department, safeguarding, infection control, the fire service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with seven people who were living in the home and one visiting relative. We also spoke with the manager, deputy manager, senior carer and two care assistants, the activity organiser, two laundry staff and a member of the catering team. We reviewed five staff recruitment files, we looked at six people's care plans in detail and a further four care plans for specific information. We looked also looked at seven people's medication administration records and a variety of documents which related to the management and governance of the home.

Is the service safe?

Our findings

At our previous inspection we rated this key question as requirements improvement. We identified an ongoing breach of regulation relating to safe care and treatment. People's risk assessments did not provide sufficient detail to protect them from the risk of harm.

At this inspection we still found risk assessments lacked sufficient detail and were not always reflective of people's current needs. For example, the mobility care plan and risk assessment for one person noted they may be able to stand with the aid of staff and a handling belt, although they sometimes need staff to use a stand aid. We noticed a hoist sling located in their bedroom. We spoke with a care worker who told us the persons mobility was variable and sometimes they needed to use a hoist to transfer them. There was no information recorded in their records regarding the use of a hoist, which sling was to be used or how it was to be fitted.

On the first day of the inspection we observed staff supporting a person to transfer using a hoist. We reviewed their care records, they had a risk assessment which referred to them requiring a hoist although there was no detail recorded as to which hoist or sling. We also noted other care records in their file, one noted "uses the stairs" another recorded "uses lift or stair lift."

We also reviewed the care records and risk assessments for three people in relation to the support they needed to access the bath or shower. There was insufficient information detail recorded in each record. Information about how bathing and showering equipment should be used is important as it reduces the risk of falls and slips when staff support people with this activity.

Some people required the use of pressure relieving airflow mattresses. We saw the mattress for one person was set at 80kg. Their most recently recorded weight was 38.8kg. It is important the mattress is set correctly to ensure they work effectively. We brought this to the attention of a member of staff at the time of the inspection, they reset the mattress correctly.

These examples demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to robustly assess the risks to the health and safety of people and doing all that is reasonably practicable to mitigate any such risks.

At our previous inspection we found people's personal emergency evacuation plans were not always reflective of their current needs. At this inspection we saw people's PEEP's were stored centrally. We reviewed a random sample and saw they reflected people's needs. However, in two of the care records we reviewed we found both people had two different PEEP's in each of their files.

The premises and equipment were regularly serviced and maintained by external contractors to ensure they were safe. Regular checks were also completed internally, for example, water temperatures, fire detection and bed safety rails. This ensured any concerns were detected enabling prompt remedial action to be taken.

Records kept in the fire file evidenced regular fire drills were held. We were not able to evidence all staff had participated in a recent drill as no dates had been added to the registered providers training matrix. Participating in regular fire drills helps to ensure staff are confident in their role in the event the fire alarm is activated.

There were sufficient staff on duty to meet people's needs. One person told us, "There's enough staff. If I want help during the day I ask one of them when they are passing and they'll always help me out. There is a buzzer for me to use if I need staff at night." We observed staff were visible and responded to requests for support in a timely manner.

Recruitment procedures were not always thorough. We reviewed five staff personnel records. Application forms had been completed, interview notes were retained and references had been obtained to reduce the risk of employing people who may not be suitable to work with vulnerable adults. We reviewed the work history for a member of staff whose employment had commenced since the previous inspection. They had listed their previous employment year to year. We saw the years ran consecutively but as the months were not recorded, we could not evidence there were no gaps in their employment.

We saw evidence a Disclosure and Barring Service (DBS) check had been completed in four of the five files we reviewed. These checks identify if a candidate has had any criminal convictions or cautions. One staff member had very recently commenced employment at the home. We saw evidence a DBS check had been applied for but the results had not yet been received. The staff member was shadowing a more experienced member of staff but there was no risk assessment in place to evidence the steps being taken to protect people from the risk of harm in the interim period. We brought this to the attention of the manager who implemented a risk assessment immediately.

Some people were prescribed medicines which were to be administered 'as required.' We saw protocols were in place for some, but not all of these medicines. For example, one person was prescribed an 'as required' analgesic medicine. There was a protocol in place for this. Another person was prescribed two 'as required' medicines but there was no protocol in place for either. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

Where people were prescribed topical creams, body maps were not always in place. These are important as they provide clear direction for staff as to where individual creams should be applied.

Medicines were stored safely and securely. We observed a member of staff administering people's medicines. This was done in a kind and caring manner. One person told us, "I don't take many tablets, but they give them to me alright. I'd only have to call out to the staff if they were late and they would bring them straight to me."

We reviewed a random selection of people's medicines. We found the stocks tallied with the number of recorded as administered and there were no unexplained gaps on people's medicines administration records (MAR's).

Staff who were responsible for the administration of medicines had received training an annual assessment of their competency had been completed.

The home was visibly clean and odour free. Staff had access to personal protective equipment, for example, gloves and aprons. We saw staff had scored 100% on a hand hygiene audit and 84% on a "bare below the elbow" audit. Both completed in December 2018.

Accidents and incidents were reviewed to enable action to be taken to reduce future risk. A record was retained of accidents and the manager completed a monthly analysis. We saw the analysis document had changed in September 2018 as the manager had implemented a new document. The document recorded where action had been taken, for example, when a referral had been made to the falls team.

People told us they felt safe. The manager and the staff we spoke with were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

Is the service effective?

Our findings

At our previous two inspections we have rated this key question as requirements improvement. At the last inspection we identified an ongoing breach of regulation as the requirements of the Mental Capacity Act 2005 were not being met. This remained a concern at this inspection.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

The registered manager had a DoLS tracker in place. This recorded nine people currently had a DoLS in place, further applications had been submitted to the local authority and were still awaiting assessment. There were no conditions attached to the authorised DoLS.

Peoples records still did not evidence the requirements of the MCA were being met. For example, one person had a DoLS in place but there was no capacity assessment or evidence of best interest's decision making regarding them living at the Newlands Hall. Staff held responsibility for managing this person's medicines. But we did not see evidence of an assessment of their capacity assessment or best interest's decision making regarding this matter.

The care plan for one person noted they had capacity to make decisions. We saw their consent form had had been signed, but not by them. Only people who have specific legal powers can sign consent forms, for example, health and welfare lasting powers of attorney.

It was clear from observing staffs practice, they understood people's right to make their own decisions and the need to gain consent prior to any intervention. One of the staff told us, "It's about asking people and only doing what they say we can do. Never doing anything they don't want done." Throughout the day we consistently heard staff involving people in making decisions and asking their permission to assist them.

However, we were concerned staff did not fully understand some people may lack capacity to assess risks to their safety. The care records for one person recorded they had been assessed as requiring a soft diet. An entry in their daily notes, dated 10 January 2019 recorded they had eaten sausage and chips. On both days of the inspection we heard staff ask request food for them which was not conducive to a soft diet and

therefore increased their risk of choking. A member of staff told us the person had capacity and could make their own choices. We brought this to the attention of the manager at the time of the inspection. We also made a referral to the local authority safeguarding team.

These examples evidence a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure compliance with the requirements of the Mental Capacity Act 2005.

People were happy with the meals they received at Newlands Hall. People told us, "The food is good. There's always a choice. It's cooked just nice and they bring it to me in my room at lunchtime." Another person said, "The food here is good, very good indeed," and "The food is perfect, absolutely lovely. They give you some choices, but will get you whatever you want. My favourite meal, supper. I look forward to having that in my room while I listen to music. A couple of hot buttered crumpets, perfect."

We observed breakfast and both the lunch and tea time meal being served to people. In the morning we saw people were enjoying breakfast. Meals were served either in the dining room, lounge or individual bedrooms depending upon personal preference. People's individual requests were provided for and each meal time was relaxed and unhurried. Staff assisted people to cut up food where required. Some people had a plate guard in place. This enables people to retain their independence while eating. We heard staff asking people if they had eaten sufficient before removing plates and giving discreet prompts to eat where people may have become distracted.

At our previous two inspections we found staffs' recording of people's food and fluid intake was not accurate and needed to be improved. This remained a concern at this inspection. We reviewed the food records for one person between 2 and 16 January 2019. On five of the days there were gaps in the records and we could not find any record for either 12 or 13 January 2019. We also reviewed their fluid intake records for the same period. On 4 January 2019 there was no record they had drunk any fluid until nearly midnight. There was only one drink recorded between 2pm on 6 January 2019 and 10am on 7 January 2019. On six of the thirteen days we reviewed their total fluid intake was less than 1000mls. This meant we could not be assured this person had received adequate nutrition and hydration in order to maintain their health and well-being.

We identified three people who had unexplained weight loss. One person, had lost 10 kg between July and December 2018. There was no eating and drinking care plan in place. We also noted they had been assessed as needing thickened fluids and pre-mashable diet, to reduce the risk of choking. Their food and fluid records did not consistently evidence this advice was being followed. We reviewed the food and fluid records for each of the three people who had lost weight. The records did not evidence they were being provided with or offered high calorie meals, snacks or drinks to boost their nutritional intake and reduce the risk of further weight loss. The care plan for one person, dated 7 September 2018, instructed staff to weigh them weekly. We saw they had only been weighed once in November and December 2018 and once, at the date of the inspection, in January 2019. This meant staff were not following the direction in the care plan and close monitoring of this person's weight was not undertaken. We discussed our findings with the manager at the time of the inspection. We also referred each person to the local authority safeguarding team.

The care record for this person also instructed staff to monitor their fluid output. Staff recorded their urine output but there was no daily total recorded or analysis as to whether their output was sufficient or if further action was required.

We reviewed the eating and drinking care plans for one person who we had identified with weight loss. Their

care plan, dated September 2018 had not been updated to reflect their weight loss.

These examples demonstrate a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure peoples nutrition hydration needs were met.

Information was readily available within the home regarding current legislation and good practice guidance. For example, we saw information on display regarding the MCA and infection prevention and control. The registered providers policies also referred to relevant laws and guidance. However, as is evidenced throughout this report, the registered provider had not ensured these principles were always applied.

People told us staff had the knowledge and skills to meet their needs. One person told us, "They must have the training they need, because they know their stuff alright. They really are very good."

New staff were supported. A member of staff told us, "The induction was really good, I did all the online training before I started and I did some shadowing." We saw a record of their completed induction when we reviewed their personnel file.

We reviewed the training matrix. This had many gaps indicating not all staff were up to date with their training needs. For example, of the 27 staff listed, seven staff had not completed fire training, eight staff had not completed safeguarding training and seven staff had not completed infection prevention training. Up to date training ensures staff have the appropriate knowledge and skills to perform their job roles.

The training matrix did not evidence if the moving and handling training was relevant to the theory or practical element. We asked the manager but they were not able to clarify this. The matrix recorded eight staff had not completed moving and handling training. The manager told us they had provided the practical moving and handling training for a recently employed member of staff. They had also assessed them as competent. The manager was not a certified trainer or assessor, therefore not qualified to do this. Although when we observed the staff member supporting a person to transfer using a hoist, this was done safely. We also saw a notice on the managers wall confirming practical moving and handling training was scheduled for the week following the inspection.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure all staff have received appropriate training.

One of the staff we spoke with told us they felt E-Learning was not a suitable method of training for them. They told us they had raised this with the management team, but no support or alternative method of learning had been provided for them. It is important staff receive training in a format which meets their needs to ensure they learn the skills and knowledge to meet the demands of their role.

Staff received regular supervision. This was confirmed when we spoke with staff and from records of completed supervision in personnel files.

People told us they had access to other healthcare professionals. One person commented, "If I don't feel special, they'll get the doctor out to me." Another person told us they were very happy as the staff had contacted a local dentist to arrange some treatment for them. A relative said, "They always tell me how [person] is."

We spoke briefly to a visiting health care professional, they told they had staff communicated effectively with them and, if they prescribed any treatment, these instructions were followed.

In the event a person needed to be admitted to hospital the home operated a 'grab bag' system. Staff were to place information about the persons health and well-being, existing medical conditions and medication they are taking in the red bag. The bag remains with the person during their time away from the home. This means that ambulance and hospital staff can determine the treatment a person needs more effectively.

Newlands Hall is a converted property. Bedrooms are situated on both the ground and first floor. There is a communal dining room as well as two lounges and a seating area in the reception. Communal toilets and bathrooms had signs on them, although we noted there was no directional signage on any of the corridors. There was a patio area at the rear of the home, accessed from the dining room.

Is the service caring?

Our findings

People told us staff were caring and kind. Comments included; "It's ok here. The staff are all nice," "The staff are all very good, very good indeed," and "The home is perfect. Everything about it, the staff they are wonderful."

Staff spoke with us about the people they cared for in a professional and empathetic manner. We asked staff what they thought good care was, they told us, "Them that live here are like my gran... It's like a family here... We do our best to care for people," and "Understanding and patience. It is about what they [people] want not what we [staff] want."

People looked clean, appropriately dressed and well cared for. A relative we spoke with said, "[Name of relative] always looks clean and nicely dressed." This indicated that staff had taken the time to support people with their personal care.

Staff spoke with people in a respectful manner, consistently offering people choices and respecting their decisions. During the morning we observed a member of staff serving drinks to people. The staff member offered each person a range of drinks, where a hot drink was chosen, they asked the person if they wanted sugar. People were offered fruit, the member of staff told them what fruit was available and ensured the fruit was presented so the person could easily eat it.

During the day we heard two people speaking with each other. The tone of their voices changed as they disagreed. We heard a member of staff promptly intervene and de-escalate the situation with out causing any distress to either person.

Staff respected people's privacy and dignity. A member of staff said, "We [staff] close doors and we cover them [people] up when we provide care." We witnessed staff knocking on doors prior to entering bedrooms, speaking discreetly with people and taking care to ensure people's hands and faces were clean after they had eaten.

Staff were aware of the need to ensure personal information was kept confidential, "We chat in private. If the GP or nurse comes to see them [people], we [staff] go to their rooms. All the paperwork is kept locked up." All care related records were stored securely and the managers computer was password protected.

Each of the care records provided some basic information about people's life history. This provides information for staff which can enable meaningful conversations and provide insight for staff into people's character and behaviours.

Staff we spoke with demonstrated a good knowledge of people's personalities and individual needs and what was important to them. Through talking to staff and the manager we were satisfied care and support was delivered in a non-discriminatory way and people's rights were respected. Although we noted from the training matrix only three of the 27 listed staff had completed equality and diversity training. This training

promotes staff awareness and helps to reduce the risk of discriminatory practices.

Is the service responsive?

Our findings

The manager told us they were in the process of reviewing and updating everyone's care records. The care records we reviewed included both the old and new care plans formats. However, the care records were not always an accurate or up to date reflection of people's current care needs.

For example, the eating and drinking care plan for one person recorded they needed a soft diet, thickened fluids and were nursed on an airwave bed. However, they no longer required thickened fluids and were not nursed on an airwave bed.

Another person had a very detailed social care plan in place but this was no longer reflective of their current abilities following a deterioration in their health. We also found their care record was disorganised. The social care plan for a further person made no reference to the regular input from their family and their daily trips out of the home with them.

We noted in one care plan a document, 'This is Me' noted they had previously had a possible reaction to nuts and seafood. This information was not recorded anywhere else in their care records and was not included on the 'menu choices' document used by staff to record people's daily meal choices. Although when we spoke with the cook, they were aware and knew which foods the person needed to avoid.

We also identified a number of concerns, as detailed in the safe and effective section of this report, regarding the quality and accuracy of moving and handling information in people's care records and eating and drinking records.

These examples demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure a complete, accurate and contemporaneous record is maintained for all individuals.

Some people living at Newlands Hall had a do not attempt resuscitation (DNACPR) instruction in their care records. These were kept at the back of people's care records and therefore may not be easily located in the event of an emergency. We noted the DNACPR for one person had not been updated to their current address. We brought this to the attention of the manager at the time of the inspection.

People's care records included an advance care plan. This was blank in one of the files we reviewed and was only partially completed in another person's file. Advance Care planning is key means of improving care for people nearing the end of life. It enables people to discuss and record their future health and care wishes thus making the likelihood of these wishes being known and respected at the end of life.

Everyone we spoke with was positive about the provision of activities at the home. One person said, "There is enough to do, I do as much as I want. Some days I'll join in with dominos or whatever, other days I'll read the paper and watch TV. They [staff] get me my paper, and I read every one of them cover to cover." Another person told us, "[Name of activity organiser] is brilliant with activities. I look forward to doing whatever they

are doing with us every day. I'm usually the first one down. [Name of activity organiser] works us hard with keep fit."

It was clear from our conversation with the activity organiser, they were committed and passionate in their desire to ensure people living at the home had fun, laughter and enjoyment in their lives. They had also completed a number of courses to enhance their knowledge and skills. They showed us their most recent newsletters which they produced for people, visitors and staff. The newsletters included information changes to staff, resident meetings, events and outings.

None of the people we spoke with had any complaints about the service they received at Newlands Hall. One person said, "I have nothing ever to complain about. I'd certainly complain if there was. I could tell [name of activities organiser] and the manager. I am sure they would put it right." Another person said, "If I really did want to grumble, then there is the manager I would ask to see. I'm sure she'd come and see me, but things are fine here."

We reviewed four complaints which were logged in the complaints file. We saw a record was maintained of the concern and the action taken to address the matter. This showed, where a complaint was raised, matters were investigated and action taken.

The registered provider had a complaint policy although we did not see information on how to complain on display within the home.

Is the service well-led?

Our findings

At our previous inspection we have rated this key question as requirements improvement. At the previous three inspections we have identified an ongoing breach of regulation as the systems of governance were neither sufficiently robust or effective. At this inspection as already highlighted throughout this report, we found evidence of a number of regulatory failings.

The registered provider is required to have a registered manager as a condition of their registration. The new manager had been in post since September 2018 and told us they had commenced their application to register. Staff were positive about the new manager. They felt they listened and were approachable. Staff were confident they could raise concerns with them and action would be taken.

We observed the manager was visible and easily accessible for people, visitors and staff. They were professional and open in their approach to the inspection and in their interactions with the inspection team. It was clear from talking with people and staff, the culture of the home was to ensure people received a high standard of care. However, the evidence provided in this report evidences the registered providers systems of governance have been ineffective in ensuring regulatory compliance and in ensuring people who live at Newlands Hall receive safe, effective and responsive care.

A number of audits were completed each month. These included, care records, medicines, infection prevention and control, weights, skin integrity and complaints. Although these audits had been completed on a regular basis, they had failed to identify or address the shortfalls we have found. Where an action was identified, there was a lack of evidence to show it had been addressed. For example, a monthly weight audit was completed. One of the people we identified as having lost weight began to lose weight around May and June 2018 but they were not identified on the weight action plan until November 2018. At which point they had lost 6kg, there was no information recorded as to the action staff were to take.

There was no evidence from the information we looked at that governance systems the provider deployed had worked effectively to monitor the quality of peoples care at the home. We reviewed a random sample of care plan audits. One of the audits, dated September 2018 had been completed on the care records for a person whose file we had reviewed. The audit did not highlight any of the concerns we had identified for that person.

There was a lack of oversight to ensure daily care information was accurate and of sufficient quality. For example, people's food and fluid records were not routinely reviewed. This increases the possibility that a change in a person's needs or well-being is identified early, thus enabling prompt action to be taken.

A compliance manager visited the home on a regular basis. One of the staff we spoke with told us they were approachable, visited the home regularly and spent time chatting with people, visitors and staff. The manager told us they also felt supported by the compliance manager. However, we found systems for capturing and managing risk had not been effective. We reviewed the compliance managers visit reports dated May, August and November 2018. Their reports evidenced they looked at a number of aspects of the

service. However, where a shortfall was identified, there was no evidence to suggest the matter had been addressed effectively. For example, the report dated May 2018 reported there were gaps in staffs training, this was again highlighted in the August 2018 report but no follow up was recorded in the November 2018 report.

The registered provider had a range of policies in place, these were reviewed and updated at regular intervals. However, it was clear from our findings during this inspection, these policies were not always followed. For example, the recruitment policy noted that a candidate should not be offered a post until the had assurance the DBS was satisfactory. A medicines policy noted a specific plan must be in place where people were prescribed 'as required' medicines. We found plans were not always in place.

The evidence provided in this report evidences the registered providers systems of governance have been ineffective in ensuring regulatory compliance and in ensuring people who live at Newlands Hall receive safe, effective and responsive care. The evidence also supports the registered providers failure to ensure procedures, practices and standards were embedded and consistently maintained.

These examples demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the systems of governance were not sufficiently robust to ensure regulatory compliance.

Following the inspection, the manager emailed us an action plan. This noted the points we had raised at inspection, actions to be taken, time frames for completion and who was responsible for ensuring the actions were completed.

There was a system in place to ensure regular feedback was obtained. The activities organiser had recently issued questionnaires to people and their families. These were in the process of being completed at the time of the inspection.

Resident meetings were held every couple of months. They were organised and chaired by the activities organiser. We topics discussed included updates on staff and forthcoming events and activities. At each meeting people were asked for their feedback regarding their care, the activities and meals. Responses were consistently positive.

Staff meetings were held, most recently October 2018 and January 2019, the week prior to our inspection. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people living at the home.

The manager and staff service worked in partnership with other agencies. This included GP's, pharmacist, the district nurses and local authority commissioning team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to ensure compliance with the requirements of the Mental Capacity Act 2005.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to robustly assess the risks to the health and safety of people and doing all that is reasonably practicable to mitigate any such risks.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure all staff have received appropriate training.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to ensure peoples nutrition hydration needs were met.

The enforcement action we took:

A warning notice was served on the registered provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider has failed to ensure a complete, accurate and contemporaneous record is maintained for all individuals. The registered provider has failed to ensure systems of governance are sufficiently robust to ensure regulatory compliance.

The enforcement action we took:

A warning notice was served on the registered provider.