Newford Ltd

Newford Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 26 April 2016 and breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 12, safe care and treatment and Regulation 17, good governance. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Newford Nursing Home on our website at www.cqc.org.uk.

Newford Nursing Home is registered to provide accommodation with personal care and nursing for up to 41 people. People who use the service may have physical disabilities and/or mental health needs such as dementia. At the time of the inspection the service supported 38 people.

There was a registered manager at the service. 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.

At this inspection we found continued regulatory breaches. You can see what action we told the provider to take at the back of the full version of the report.

Some improvements had been made in the way medicines were managed, but further improvements were needed to ensure that administration and monitoring of people's prescribed dietary supplements was monitored to protect people from potential risks associated with medicines.

People's risks had been assessed, but we found improvements were still needed to ensure these were consistently planned and followed to protect people from the risk of harm.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Improvements were needed to the management structure to enable the registered manager to have dedicated time to act on improvements and monitor the quality of the service effectively.

There were enough suitably qualified staff available to keep people safe and the provider had effective recruitment procedures in place.

People and staff told us the registered manager was approachable and staff felt supported in their role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed to ensure prescribed dietary supplements were managed safely.

Improvements were needed to ensure that people's risks were consistently planned and managed.

People were protected from abuse because staff understood how to recognise and report suspected abuse.

There were enough staff available to meet people's needs in a timely way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and improve the quality of the service were not always effective.

Improvements were needed to ensure that there was a clear management overview of the service

People and their relatives were able to approach the registered manager with any concerns. Staff told us that the registered manager was approachable and supportive.

Newford Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

We undertook an unannounced focused inspection of Newford Nursing Home on 10 October 2016. The inspection was undertaken by two inspectors.

This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 26 April 2016 had been made. The team inspected the service against two of the five questions we ask about services: is the service safe?, is the service well led? This is because the service was not meeting some legal requirements.

Before the inspection we reviewed information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries and safeguarding concerns that had occurred at the service.

We spoke with five people who used the service, two relatives, four staff, the registered manager and the provider. We viewed six records about people's care and eight people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that there were risks to people's safety and welfare because medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some improvements had been made to the way medicines were managed. However, we found that further improvements were required.

We found that the stock levels of nutritional supplements that people had been prescribed did not balance with the amount recorded on the Medicine Administration Records (MARs). We checked four people's nutritional supplements and found that they all had less in stock than the MARs stated. The registered manager told us that they did not know why these were incorrect and told us that they would implement a weekly check of the stock alongside the monthly checks that were in place. This meant that we could not be assured that people had received their supplements as prescribed.

People's risks were not consistently planned or managed. For example; we saw from incident records that one person regularly displayed behaviour that challenged when staff attempted to provide personal care. The care plan's we viewed did not give staff guidance on how to manage this person's behaviour. Staff we spoke with told us that this person often displayed behaviour that challenged but they gave inconsistent accounts on how this person needed to be managed. This meant that this person was at risk of inconsistent and unsafe care because their risks had not been planned for.

We saw from the incident records that another person had fallen from their wheelchair.. The care plan had been updated after this fall to show that this person needed to be mobilised in a specialist chair to ensure their safety and protect them from the risk of further harm. We saw that this person had fallen from a wheelchair again after their care plan had been updated. Staff we spoke with told us that this person used their specialist chair at all times, although one member of staff told us that this person had been supported in a wheelchair on one occasion but did not know why this had happened. We asked the registered manager why this person had been supported in a wheelchair, as this did not follow their plan. They were unable to explain why staff had not followed the plan and stated that this person should not be supported in a wheelchair. The person had not suffered any injuries from this fall, but this person had been put at risk because staff had not followed their assessed plan of care. We saw that the person was being supported in their specialist chair on the day of the inspection. This meant that this person had suffered a fall because their plan of care had not been followed to protect them from harm.

The above evidence showed people were at risk of harm because their risks were not consistently planned and managed. This is a continuing breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the registered manager had implemented protocols for medicines that were prescribed 'as required'. We saw that these protocols gave staff guidance as to when people needed these medicines, dosage and frequency. Staff we spoke with were able to tell us when people needed their 'as required' medicine and this was also detailed in the care plans. We carried out a check of boxed medicines held

within the home against the amount recorded on the MARs and we found that the stock balanced. This showed that some improvements had been made to the safe management of medicines.

People told us they felt safe when being supported by staff. One person said, "I feel very safe here. I move using a hoist and staff talk me through what they are doing so I don't feel frightened". Another person said, "I couldn't manage at home, but I'm safe and looked after in here". We saw that people were happy and appeared comfortable when staff provided support. Staff told us what actions they would take if they were concerned that a person was at risk of harm and the possible signs that people may display if they were unhappy and where abuse may be suspected. We saw records which confirmed that referrals had been made to the local authority to ensure people were protected from the risk of harm.

People told us that there were enough staff available. One person said, "I ring my call bell and staff come straight away, I don't have to wait". A relative said, "There are plenty of staff about and they pop in and out to check if my relative is okay". We saw that there were enough staff available to meet people's needs in a timely way and call bells were answered swiftly by staff. Staff we spoke with felt there were enough staff available and plans were in place to cover shortfalls in staffing numbers. The registered manager had a system in place to assess the staffing levels against the dependency needs of people. We saw changes had been made to staffing levels when needed, which ensured there were enough staff available to keep people safe. We found that the provider had a recruitment policy, which had been followed and ensured people were supported by suitable staff.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we found that the systems in place to monitor and mitigate risks to people were not effective. We also found that improvements were needed to the management of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some improvements had been made but further improvements were needed to meet the requirements of the regulations.

We found that some improvements had been made to the systems in place to monitor the service. For example; the system in place to audit boxed medicines had improved and we found that action had been taken when required. However, further improvements were needed to ensure that all the systems in place were effective in monitoring and mitigating risks to people. For example; we saw that incidents and accidents were monitored and analysed by the registered manager. These contained information about the incidents and the actions taken, but these did not always identify where staff had not followed a person's plan of care to manage them safely. We found errors in the stock of people's nutritional supplements which had not been identified by the registered manager. We found that one person's care plan stated that staff needed to ensure they drank a certain amount each day, but we found that this person did not have a fluid chart in place for staff to record this person's fluids. We asked the registered manager how they checked if fluid charts had been completed and we were told "We do not have a system in place for that". This meant that further improvements were needed to ensure effective systems were in place to monitor the service.

We saw and the provider told us that they had employed a consultant to independently assess the quality of the service provided. However, this had not been completed in a timely manner and had taken four months after our first inspection to recognise that action was needed to identify and make improvements to the quality of the service. We saw a report that the consultant had provided which was detailed and recommended action points to be completed to improve and an improvement plan was now in place. Some of the actions had been completed, but there were still a high number of incomplete actions outstanding. This meant we were unable to assess whether improvements would be completed in a timely manner and sustained.

We saw from the rotas and the registered manager told us they were the nurse on duty for three of their four working days at the service. The registered manager told us that this impacted on their ability to manage the service effectively and make the required improvements. This meant that the registered manager was unable to have a clear overview of the service. We saw that the consultant had also raised concerns regarding the availability of the registered manager as they did not have sufficient time to manage the service effectively. This was included in the improvement plan, but this had not been acted on by the provider at the time of the inspection .We spoke with the provider and relayed our concerns with regards to the management of the service, which was impacting on how the service was monitored which meant people's risks were not always mitigated. The provider told us they would consider the information provided and the possibility of giving the registered manager more time to carry out the management of the service. This meant that improvements were needed to the way the service was managed.

The above evidence shows people were at risk of harm because effective systems and clear leadership was not in place to ensure people's risks were monitored and managed. This is a continuing breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that the provider had not notified us of incidents at the service, which were required by law. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found improvements had been made and the provider was meeting this regulation.

The provider has a duty to notify us (CQC) of any incidents that had happened at the service, which enables us to monitor the service. For example; expected and unexpected deaths, serious injuries, Deprivation of Liberty Safeguards (DoLS) and alleged abuse. We found that the registered manager had notified us of any DoLS that had been authorised for people who used the service. We checked the incident log and safeguarding records against the notifications that we had received since the last inspection and found that these had been reported when required. This showed that the registered manager had a clear understanding of their responsibilities to notify us of incidents at the service.

People and their relatives told us the registered manager was approachable and they felt comfortable raising any concerns with them. One relative said, "I know who the manager is and I can speak to them if I have any concerns". Staff told us the registered manager was supportive and they could approach the registered manager if they needed to. One staff member said, "The manager is very supportive. I can go to them with any concerns I have and they are always really helpful". We saw staff were comfortable approaching the registered manager on the day of the inspection.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not consistently planned and managed to protect people from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor and manage the service to mitigate risks to people was not always effective and their was not clear leadership at the service.