

Bupa Care Homes (AKW) Limited

# Newton Court Care Home

## 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?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This inspection took place on 18 and 20 September 2017 and was unannounced. Prior to this on 30 August 2017, a medicines inspector and a shadowing medicines support officer undertook an inspection and looked at supply, storage, administration and audit records for medicines used in the home. The previous comprehensive inspection took place on the 19 July 2016 and the service was compliant with the regulations at that time.

Newton Court Care Home is a purpose built care home located close to Middlewich town centre and is part of the Bupa Care Homes group. All bedrooms are single with en-suite toilet and washbasins. The home is registered to provide care for up to 60 people, at the time of the inspection there were 56 people in receipt of a service.

There was a registered manager in place, who had been registered with The Care Quality Commission since October 2010. 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.

We identified three breaches of the relevant legislation, in respect of safe care and treatment, the need for consent and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Overall, the people and relatives we spoke with were positive about the care and support they received at Newton Court.

We found shortfalls in the safe management of medicines. There were a number of issues relating to the storage, administration and recording of medicines. The registered manager immediately implemented an action plan to address the issues raised.

We reviewed how risks to individuals were managed and found that potential risks had not always been fully assessed, acted upon and recorded within people's care records. We found two examples where staff had not taken appropriate action to mitigate against identified risks.

We saw that accidents and incidents, along with any pressure ulcers and weight loss or gain were monitored. However, we found that the system to monitor and analyse accidents and incidents was not robust because some incidents had not been reported to the registered manager.

We found in some cases that staff had not acted in accordance with the Mental Capacity Act (2005). One person's liberty had been restricted without the person's consent and another person's wishes were not respected because a member of staff believed they were acting in the person's best interests but had not

followed procedures correctly.

Staff understood their responsibility to protect people from abuse and harm. The provider had policies in place for safeguarding vulnerable adults and whistleblowing. Staff we spoke with had an understanding of the signs of abuse and told us that they knew how to report any safeguarding concerns.

We found there were enough staff available to meet the needs of people living at the home. We saw that there were processes in place to ensure the registered manager regularly assessed and monitored staffing levels and ensure sufficient staff were available to provide the appropriate levels of support. The registered manager told us there were some staff vacancies and the home was actively recruiting staff, and that if necessary agency staff were used to maintain staffing levels.

The environment was very clean, well decorated and maintained to a good standard. The home was also free from odours. We observed domestic staff cleaning areas around the building throughout the inspection.

Staff received a thorough induction and ongoing training. Staff said that they felt supported by the management team to carry out their roles effectively.

We found that people's nutritional needs were met. Most people preferred to have their meals in their rooms, but knew they could go to the dining room if they wanted to. The people we spoke with were happy with the quality and frequency of meals, and relatives found them to be good nutritious meals, they told us that overall options were good.

We observed that staff had developed caring relationships and treated people in a kind and compassionate manner. People told us that they were treated with dignity and respect. The service was working with the End of Life partnership to improve people's care and experience at the end of life.

People told us that they were given choices and their preferences were respected about the way they would like their care to be provided.

The registered manager explained that the provider had already identified the need to make improvements to people's care records to ensure they were up to date and reflected people's individual needs. During the inspection we found examples where care plans had not been updated to reflect changes to people's needs. There were occasional gaps in the recording on daily charts, such as charts to record that people had been supported with personal care or oral hygiene.

People and staff were positive about the management team. We found that the registered manager was keen to make any necessary improvements. The registered provider had some quality assurance systems and a home improvement plan in place. However, we found some shortfalls in the effectiveness of these. We found that the registered provider had failed to have robust systems in place to recognise and address the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found as part of our inspection.

## 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.

Medicines were not always managed safely in accordance with best-practice.

Potential risks to people had not always been fully assessed, acted upon and recorded within people's care records.

Staff understood their responsibility to protect people from abuse and harm.

There were enough staff available to meet the needs of people living at the home.

### Is the service effective?

**Requires Improvement** 

The service was not consistently effective

Staff had not always acted in accordance with the MCA.

Staff undertook a comprehensive induction and regular training was provided.

People were happy with the quality and frequency of their meals and their nutritional needs were supported.

People were supported to maintain good health and receive health care support.

### Is the service caring?

**Good** 

The service was caring.

Staff were kind and caring in the way that they approached people and observed some very positive and friendly interactions.

We found that staff were knowledgeable about people's needs and had developed caring relationships with them.

People told us that they were treated with dignity and respect.

### Is the service responsive?

Good ●

The service was responsive.

People told us that their preferences and choices were respected by staff.

People and their relatives told us that they contributed to the planning of their care.

The provider had already identified the need to make improvements to people's care records to ensure they were up to date and reflected people's individual needs.

People were supported to follow their interests and we saw that information about people's interests and lifestyle preferences were recorded within their care plans.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

The registered provider had some quality assurance systems in place. However we found some shortfalls in their effectiveness.

The service had already developed a home improvement plan to make some improvements

People and staff told us that the registered manager was approachable. Staff said that they felt able to raise any concerns and that these would be acted upon.

There was a system in place to gain views from people and relatives on their experience of the care provided.

# Newton Court Care 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 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.

This inspection took place on 18 and 20 September 2017 and was unannounced. Two adult social care inspectors and an expert by experience attended on the first day and one adult social care inspector carried out the inspection on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was aware of our visit to conclude the inspection on the second day. Prior to this on 30 August 2017, a medicines inspector and a shadowing medicines support officer undertook an inspection and looked at supply, storage, administration and audit records for medicines used in the home. This inspection was carried out in response to concerns that had been raised from members of the public regarding medicines and staffing at the home.

Before the inspection, we looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law.

We contacted the local authority before the inspection and they shared their current knowledge about the home. We checked to see whether a Health Watch visit had taken place. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. A recent visit had not taken place but we read the latest report available.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with 19 people who lived at the home and seven relatives/visitors, to seek their views. We spoke with 14 members of staff including one nurse, four care staff, the registered manager, deputy manager, regional manager, quality support manager, regional trainer, chef, activities coordinator, hostess and the maintenance person. We also spoke with a GP, who regularly visited the home.

As some people living at Newton Court were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of five people who lived at the home and inspected other documentation related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people.

# Is the service safe?

## Our findings

We asked people and their relatives whether the support provided at Newton Court made them feel safe. The people we spoke with told us that they did feel safe living at the home and one relative commented, "I do feel reassured that (name) is safe here."

We found shortfalls in the safe management of medicines. We watched some people receiving their morning medicines. Staff gave medicines in a kind and patient way and signed the records after the person had taken their medicine. However, the nurse was disturbed several times during this time, which caused delays and increased the risk of mistakes being made. The morning medicines round took over three hours for one section of the home and records showed that this happened regularly. This meant that there was a risk that some pain relieving medicines could not be spaced equally throughout the day. We found that medicines that should be given 30-60 minutes before food were given during the morning medicines round that took place after people had eaten. This means the medicine may not be as effective.

Most medicines were stored securely in locked cupboards and fridges in the treatment room on each floor. However, we found the door to the upstairs treatment room open on our arrival and a medicine not locked away. Fridge temperature records were not accurate and did not reflect the actual temperature we saw. We asked staff to reset the fridge temperature, as it should be done daily, and this was not done properly. Records showed one fridge to be out of range, with the same fridge operating at a higher than acceptable temperature for 24 days, but this had not been reported to the manager. We discussed the issue with the registered manager and she said she would address this and provide some additional staff training.

Controlled drugs were stored safely in suitable locked cabinets and we checked a number of medicines and found the stock to be correct. Controlled drugs are medicines that have additional control measures in place because of the potential for misuse. Regular checks were done by staff each week. A number of people were prescribed a powder to thicken their drinks because they had difficulty swallowing. We observed a carer making a thickened drink in the dining room. Instructions were followed properly. A record was made each time the powder was used and protocols were in place for each person stating the required consistency for liquids, minimising the risk of choking. However, we noted staff did not always complete these records at the time the drink had been taken. Records should be completed contemporaneously so that staff do not rely on their memory and are as accurate as possible.

The records about medicines on the nursing unit were not well maintained. We found there were gaps and missing signatures on the medicines administration record (MAR) charts so it was not possible to tell if medicines had been given properly. When the stock and the records were compared, with some medicines we found more medication in the home than was expected. One medicine had been signed as given when it was not needed, the nurse told us she had signed in error and a duplicated record for another medicine had been signed twice. This meant we could not be sure if residents had received their medicines correctly and stock balances were not always recorded, so it was not possible to check.

The records about the application of creams were inaccurate or incomplete. They did not show that creams



were applied as prescribed. For example, one person's cream was prescribed twice a day on the prescription but stated 'when required' on their application record. When medicines are prescribed to be taken 'when required', additional instructions are needed to guide staff how and when it should be given. There were a number of people that did not have individualised instructions for their medicines, such as painkillers and laxatives. Some medicines that had a variable dose, one or two tablets for example, did not have clear guidance how many to give for safe administration.

These issues were a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection visit on 20 September the registered manager told us that work had been undertaken around medicines and that an action plan was in place and a number of the actions identified had already been addressed.

We reviewed how risks to individuals were managed and found that potential risks had not always been fully assessed, acted upon and recorded within people's care records. For example, we saw that one person had a sensor mat in their bedroom to alert staff when they attempted to walk. However, during the inspection we saw that staff had placed this away from the person and a carer confirmed that the mat was in the wrong position. We were concerned that the sensor mat itself was a potential trip hazard due to the person's mobility needs. The person explained that they had recently fallen over the lead of the sensor mat. The person had experienced a number of falls and whilst we saw that advice had been sought from the GP and a physiotherapist, records recommended that a full risk assessment should be carried out which had not been completed. A specialist nurse had also recommended that the person's blood pressure should be checked which had not been done. Therefore, staff had not effectively assessed the risk of a person falling and the action taken to manage the risk was inappropriate.

In another example, staff were concerned about a person's safety because they occasionally liked to go out alone. Although the person had always found his way back to the home they were concerned that he could lose his way in future. The person had been out several times and staff told us that they did not always know when he had left the building. We looked at the person's records and found that there was no risk assessment or management plan in place about this issue. We noted on several occasions during the inspection that the main door to the building was left open with no staff presence in the reception area. The person had been advised by staff not to go out alone, which is discussed further in the effective section of this report because we were concerned that this decision had not been made following the principles of the MCA. We raised this with the registered manager and following the inspection, we received information that appropriate professionals had been contacted, and assessments undertaken. The Herbert Protocol had also been implemented. The Herbert Protocol is a national scheme being introduced by the police and other agencies, which encourages care staff to compile useful information, which could be used in the event of a vulnerable person going missing.

These issues were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that accidents and incidents, along with any pressure ulcers and weight loss or gain were monitored. Staff recorded accidents and incidents using a form, which was then reviewed by the registered manager. The registered manager undertook a monthly audit to identify the number, time and location of any falls, with a view to identifying any themes or trends and support future risk management. However, we found that some accident forms seen within people's care records had not been included within the analysis. We discussed this with the registered manager who told us that there was a possibility that staff

had not passed on all the necessary forms to the office. The system was therefore not sufficiently robust. The registered manager said that she would address this and told us that records in future were moving to an electronic system, which should help to resolve this issue.

Staff understood their responsibility to protect people from abuse and harm. The provider had policies in place for safeguarding vulnerable adults and whistleblowing. These contained guidance on the action that should be taken in response to any concerns. Staff we spoke with had an understanding of the signs of abuse and told us that they knew how to report any safeguarding concerns. One staff member explained that the provider had a "Speak Up" policy and this information was displayed with the necessary contact numbers, in the staff room.

We asked one person whether they felt safe and they told us "staff are good." However, they also raised a concern that staff could be "rough". With the person's permission, we raised this as a safeguarding concern. The local authority were contacted and initial enquires were made. We were informed that this was not taken further because satisfactory information was provided.

We saw that the registered manager maintained a safeguarding file, which contained information about any safeguarding incidents and referrals and the outcome of these. However, we found information within an incident form, which indicated that a safeguarding referral may have been required but could not see that one had been made. The registered manager demonstrated that advice had been sought from the local authority relating to this issue but that this information had not been recorded fully to evidence that action had been taken.

We recommended that any guidance or advice received regarding safeguarding information be fully recorded to ensure that evidence of actions taken to safeguard people is complete.

During the inspection, we found there were enough staff available to meet the needs of people living at the home. We saw that there were processes in place to ensure the registered manager regularly assessed and monitored staffing levels and ensured sufficient staff were available to provide the appropriate levels of support. We looked at the staff rotas, spoke with people and staff about staffing levels. Most people felt that when they used the call bell the response was good, where staff were busy, a relative explained, "If they're busy, with someone they, will always come in and say they will be back". On the second day of the inspection, we were advised that the staff were behind with the morning routine because one of the night staff had gone home early due to sickness. We saw that people had received drinks and positional turns but that some received personal care later in the morning. We spoke with one person who told us she was quite comfortable and had received breakfast but was awaiting a wash. Staff spoken with told us that in general there were sufficient staff on duty to meet people's needs. The registered manager demonstrated that she had recently increased the staffing levels and had plans to increase the staffing levels again when more people were admitted to the home.

We reviewed records relating to the call bell response times. The registered manager told us that these were analysed by the maintenance person who alerted her to any calls where the response took more than six minutes. Some people told us that they had to wait at busy times. We viewed a sample of the response times that were satisfactory, the registered manager told us that where calls were longer this tended to be at busy periods over meal times for example and that she continued to monitor this in line with the staffing levels required.

People commented about night staff and that sometimes they found them less familiar with their needs. The registered manager told us there were some staff vacancies and the home was actively recruiting staff,

and that if necessary agency staff were used to maintain staffing levels. She explained that they tended to use one regular agency nurse, because this provided people with more consistency.

We reviewed three staff files which showed that all necessary checks had been carried out before each member of staff began to work within the home, including a full employment history check and Disclosure and Barring Service (DBS) check. The DBS is a national agency that checks if a person has any criminal convictions. Through this recruitment process, the registered manager was able to check that staff were suitable and qualified for the role they were being appointed to and not putting people they care for at risk.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building. We spoke with the maintenance person who demonstrated that routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. However, we saw the wheelchair safety checks had not been carried out routinely and the registered manager assured us that these would be re-instated as soon as possible.

We observed that a sluice room door, which should have been locked, was ajar; when we checked we found that the lock was broken. The deputy manager said that this must have occurred over the previous weekend as it had been in working order. The maintenance person fixed the lock on the day of the inspection.

The environment was very clean, well decorated and maintained to a good standard. The home was also free from odours. We observed domestic staff cleaning areas around the building throughout the inspection.

## Is the service effective?

### Our findings

We asked people who lived at Newton Court whether they found the care and support to be effective. People spoken with told us that they felt that their care needs were met within the home. They said "I'm quite happy with everything" and "I have no complaints about the food."

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had identified in some cases where people may be being deprived of their liberty to ensure their safety and wellbeing. They had appropriately applied for authorisation from the local authority (supervisory body).

However, we found in some cases that staff had not acted in accordance with the MCA. We found that one person's liberty had been restricted without the person's consent. Staff had recorded in the person's care plan that he needed to have someone with him when he went out. We spoke to the person who told us "I'm restricted to this place." Whilst the staff believed they were acting in the person's best interests to maintain their safety, procedures to ensure that the person's human rights were protected had not been followed. A mental capacity assessment and best interest decision had not been completed about this decision. Following the inspection appropriate assessments were undertaken.

We found another example where staff had not respected a person's wishes regarding their care and support. During the inspection we heard a person ask a member of staff to support them to get into bed. The member of staff declined and advised the person they would be better off if they remained seated in their chair. We reviewed the person's care records which stated that they had the capacity to make their own decisions and would request support from staff with changes to their position when necessary. Therefore the staff member should have respected the person's decision to return to bed. We discussed this with the registered manager who told us that there had been some changes to the person's mental health but this had not been recorded. Again there was no capacity assessment or best interest decision in place. Therefore, we could not be sure that people's rights were always protected and that staff always acted in accordance with the MCA.

These issues were a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff completed an induction based on the Care Certificate. This certificate has been developed by

national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. New staff spoken with confirmed they had undertaken an induction, which included four days classroom based training and then shadowing experienced staff. Staff had to complete a comprehensive induction portfolio.

We inspected the training records and found that staff undertook regular training. One member of staff commented, "Training never stops." We spoke with the area trainer who was visiting the home, who told us that training within the organisation had recently changed. Staff now undertook "knowledge tests" in different topics, either every 12 months or two years depending on the subject. They provided training if these tests identified any gaps in people's knowledge. Practical training in certain subjects including moving and handling and fire training was undertaken yearly. The trainer told us that they were flexible and would be able to provide training responsively if a specific area of training was required. We reviewed the electronic records, and were advised that the expectation was that the home should be 85% compliant with the training. The home was currently 80% compliant, which was one of the reasons for the trainers visit to the home on the day of the inspection, to support the staff to improve their compliance.

Staff spoken with told us that they felt supported within their roles. They told us that they had one to one supervision sessions with their line manager. However the registered manager explained that the regularity of supervision meetings had fallen behind recently and sessions had not been carried out as frequently as they should have been. She told us that the provider had implemented new paperwork regarding the recording of supervisions and appraisals earlier this year and she was now implementing the use of this. We saw that a supervision matrix was in place which recorded that each member of staff had received at least one supervision since August this year.

We found that people's nutritional needs were met. Most people preferred to have their meals in their rooms, but knew they could go to the dining room if they wanted to. People spoken with were happy with the quality and frequency of meals, and relatives found them to be good nutritious meals, they told us that overall options were good.

We spoke with the chef and other staff who were knowledgeable about people's nutritional needs, for example a staff member was able to tell us which people had specific dietary requirements, such as those with diabetes, at risk of weight loss or who required a pureed diet. We observed that staff supported people at meal times in an unhurried and caring manner. Some people needed encouragement and/or support to eat their meals, which staff provided. The registered provider employed a hostess whose role was to ensure that people were supported with meals and drinks throughout the day. People told us that they usually had plenty to drink, however, on the day of the inspection three people said they had not been offered an early morning drink. They told us that this happened occasionally and thought this may be due to agency staff being on duty at the time, as they may be less familiar with the routine.

We saw from the records that peoples' nutritional and hydration needs were recorded. There was evidence that staff monitored those people who were at risk of losing weight and action taken where concerns had been noted. For example, during the inspection we saw that a person had not eaten their breakfast. Staff saw this and encouraged them with an alternative option. One relative told us that the support their relative had received with their nutritional needs was positive. They explained that since their relative had moved to the home staff had been effective in encouraging them to eat and drink again.

Newton Court had been awarded a food safety rating of five, in their latest food safety inspection undertaken in December 2016. This meant that their food hygiene standards were rated as very good.

People were supported to maintain good health and receive health care support. We saw records to confirm that people had received care from chiropodists, dieticians and their doctor when required. The home had links with a local GP surgery and a GP carried out a weekly visit to the home. We spoke with a visiting GP, who told us that they found the staff communicated well and actioned any medical advice appropriately. They told us that they received good information, as staff knew the people living at the home well.

# Is the service caring?

## Our findings

People and their relatives told us that the staff were very kind, caring, understanding and always tried to meet their needs. Comments included, "They are very kind to me and others as well,"; "The staff are good" and "I'm treated very well."

During the inspection we observed how well staff interacted with people who used the service. We heard that staff were kind and caring in the way that they approached people and observed some very positive and friendly interactions. For example, one staff member was supporting a person with their lunch and we heard the staff member taking an interest and asking questions about the person's family. Furthermore, we saw that a carer was very patient and reassuring with a person who was agitated. One person spoken with said that they were happy with the support they received and explained how they had enjoyed chatting with a member of staff while they varnished her nails.

We found that staff were knowledgeable about people's needs and had developed caring relationships with them. One staff member told us, "I treat people how I would like my mum to be treated" and another said, "I would have my mum and dad living here." Relatives commented that staff interacted with them in a positive manner and actively tried to learn about their relative as a person.

We saw that people's bedrooms were personalised and the majority contained people's own items such as family photographs and furniture. Care plans detailed people's histories, preferences and wishes about the care and support they received. A relative told us that communication was good and gave an example where their relative had fallen, they commented, "The [carer] sat on the floor with her until the paramedics arrived, she didn't have to do that, and they called me again as soon as she was back from hospital."

There were a number of thank you cards and compliments about the service available to read. Some of these were complimentary about the care that people had received. One comment included, "Just to say thank you very much for the excellent, kind and exemplary care you gave (name)."

People told us that their dignity and privacy was respected. Staff spoken with were aware of the importance of treating people with dignity and respect and were able to provide examples of practice which maintained peoples' dignity such as, knocking on people's doors or covering them with a towel when providing personal care. Visitors were positively encouraged to visit whenever they liked and relatives found there were no restrictions on visiting times.

The home was involved with a care home project, which supported practice around palliative and end of life care. The End of Life Partnership within Cheshire East undertook regular visits to support staff in a number of areas, such as introducing conversations and developing care plans around end of life decisions and care. The deputy manager told us about her plans to turn one of the unused lounges into a room where relatives could stay over-night. She felt this would be particularly helpful when people were poorly and relatives wanted to be close by.

## Is the service responsive?

### Our findings

All people and their relatives spoken with generally felt that they were recognised as individuals and that staff did the best they could to meet their needs. They told us "Really, it was all done as I wanted" and "They look after me very well, I don't think they could do more. " One relative commented, "The care here is excellent."

All of the people who we spoke with told us that their preferences and choices were respected. One person commented, "I get up around 8am, I press the call bell and they come" and someone else told us staff respected their preferences if they wished to stay in bed. Staff were able to tell us about people's preferences, such as one person who liked to get up after 11am and others who preferred to get up very early. We saw during the morning that the majority of people stayed in their rooms and were in bed or in an easy chair. The upstairs lounge/dining room was particularly quiet throughout the day. We discussed this with staff and one staff member suggested there was a routine whereby staff supported people with personal care during the morning and supported people to get up after lunch. However, other staff told us that they responded to people's choices and preferences. We discussed this with the registered manager who told us they had recently carried out a piece of work and consulted with everyone, recording their preferences in their care plans. They had found that the vast majority of people preferred to stay in bed or in their rooms. We saw that this was recorded in people's care records. The registered manager told us she'd had recent discussions with staff about the importance of offering people choices and this was under ongoing review.

During the inspection, we were informed of concerns about the availability of continence products and that stocks could run very low at times, affecting the management of continence needs and staff time. We discussed this with the registered manager who was aware of the concern, she noted that the service hadn't run out of continence products because the provider had purchased these when stocks were running low. However, she advised us that they had asked the continence service to review people's continence needs to ensure that appropriate products were provided. Two care staff had a continence link role and the registered manager advised that a system was now in place to ensure that the management was alerted when stocks were running low.

Throughout the inspection, we observed staff responding appropriately to people's individual needs. For example, we saw that information was available to support a person with sight loss and that people were informed of the need to introduce themselves before they entered the person's bedroom. The person's relative also told us that staff ensured they described the colours and patterns of clothes to the person so that they felt comfortable. Another relative told us about a health condition that their relative had developed and how they felt comfortable approaching staff to discuss this and that staff had reacted quickly and positively.

People and their relatives told us that they contributed to the planning of their care. One relative explained how easy it was to be involved in their partner's care plan, and had that morning discussed a change with staff, they had found it very easy and staff had co-ordinated a way to move forward.



The registered manager explained that the provider had already identified the need to make improvements to people's care records to ensure they were up to date and reflected people's individual needs. During the inspection we found examples where care plans had not been updated to reflect changes to people's needs. Changes to a person's skin condition and treatment were not recorded within their care plan. We saw another example where a person's daily records indicated that they sometimes refused to take their medication, however this information was not included in their medication care plan or how the person's health needs were best supported. We spoke with the quality support manager who was actively working on improvements and demonstrated that he had written a care plan for staff to use as an example of good practice. He continued to visit the home to review and audit the care plans and to support staff to make the necessary improvements.

We recommend that the registered provider implements appropriate timescales to ensure that this exercise is completed fully and as soon as practicable.

The deputy manager told us that she was introducing new folders to be kept in people's rooms, which would contain people's charts and a summary of their care. These would include "my portrait" including information about people's specific needs such as communication or moving and handling needs and would enable this information to be easily available to staff. We saw that staff were receiving support within supervision sessions around care planning and appropriate recording within the daily notes.

People were supported to follow their interests and we saw that information about people's interests and lifestyle preferences were recorded within their care plans. The provider employed two activities co-ordinators, but one co-ordinator was currently off work. We spoke with the remaining co-ordinator and she told us that she received support from another member of staff with activities at the present time. She explained that she tended to support people with one to one activities during the morning and that group activities were held during the afternoon. Activities such as bingo, quizzes and musical moments took place and people were supported to go out for example for coffee. Not everyone spoken with was aware of the activities on offer. The activities coordinator told us that she consulted with people and their relatives about their interests and discussed the activities programme within residents meetings, although we noted that there had been no recent meetings so some people may not have had the opportunity to express their views. The registered provider had implemented an initiative called "The big 12," this involved taking people on a virtual tour of different cities such as Paris and included all the senses such as taste, smells, sights by use of food, drink and activities linked with that particular country.

People spoken with told us that their spiritual needs were supported. One person said that staff assisted them to attend church, which was very important to them. We saw a further example where another person told us they had regular visits from the local minister.

Information about how to make a complaint was displayed in the home. The provider had a complaints policy and process. People spoken with felt able to raise concerns and that these would be responded to. We saw that the registered manager kept a complaints folder which detailed information about any complaints and how they had been responded to. We saw that there were six recorded complaints during 2017 and that these had been responded to appropriately with any recommendations identified in response.

## Is the service well-led?

### Our findings

People and staff were positive about the management of Newton Court, comments included "(Name) is approachable; you can go and talk to her" and "Everything I've asked to do training wise I've managed to get."

There was a registered manager in place who had been registered with The Care Quality Commission (CQC) since October 2010. She was well supported by a wider team, including a deputy manager, regional manager and quality team. The management team engaged well with the inspection process and responded positively to any suggestions regarding possible improvements to the quality of care. The service had already developed a home improvement plan to make improvements and following our inspection sent us an update. The quality support manager was available during the inspection and told us that he had been providing targeted support to the service as directed by the regional director within the organisation. Medication management and care planning had been identified for improvement and action was being taken.

We saw that the registered provider had some quality assurance systems in place, however we found some shortfalls in the effectiveness of these. Regular medication audits were being done on both the nursing and residential units daily, weekly and monthly. The audits however had failed to recognise the issues that we found during the inspection and the monthly audits had been rated as acceptable when there were issues.

A home review audit had been carried out in August 2017 and an action plan had been developed in a number of areas. We saw that a number of these actions were incorporated into the overall Home Improvement plan. We noted that some of these actions had been signed off as being completed, however we identified that a number of these actions remained a concern during the inspection. For example, the home improvement plan indicated that action to ensure the sluice door was locked at all times and that people received an early morning drink, was signed off as complete. During the inspection, we saw that the sluice door could not be locked as it was broken and some people told us that receiving an early morning drink varied dependent upon the staff. We also found that risk assessments had not been undertaken effectively and the system to analyse accidents and incidents was insufficiently robust.

Therefore, we found that the registered provider had failed to have robust systems in place to recognise and address the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found as part of our inspection, which are detailed in the safe and effective section of this report. The provider did not meet all the standards set out in the regulations

We saw that there were occasional gaps in the recording on daily charts, such as charts to record that people had been supported with personal care or oral hygiene. We spoke with one person whose personal care chart had not been completed on the day of the inspection, to indicate they had received support. They were able to tell us that staff had actually supported them with a wash that day. However we also saw one person in their nightdress and we were concerned that they may not have had assistance with personal care. Care staff told us that the night staff had supported this person with personal care but we were unable

to evidence this, as it was not recorded within the daily notes or recording chart. Therefore records were not complete and up to date.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us that the registered manager was approachable. Staff said that they felt able to raise any concerns and that these would be acted upon. Comments included "It's a good team" and "You can talk to them (management team) if you have a problem, they will try and sort it out, they will never leave something." Staff members we spoke with had a good understanding of their roles and responsibilities and were positive and motivated. They said, "I love my job here" and "Staff are very friendly and work well together."

We saw that team meetings were held regularly and the records of the most recent meeting held in August 2017 demonstrated that a range of topics were discussed, including support from the End of Life Partnership, keeping records and issues around medication. The minutes demonstrated that the registered manager addressed practice issues with the staff and their focus was upon providing quality care.

The registered manager or deputy routinely observed the care being provided and carried out a daily walk round of the home to check that everything was in order. The management team also held a "take 10" meeting every day, where issues such as staffing and any risks that staff needed to be aware of were discussed. We saw that night visits had been carried out on a monthly basis to ensure that the night staff had regular contact with the registered manager and to monitor the quality of the service during the night. Handovers took place at the time of staff shift changes to ensure important information about people's care and support was known to the oncoming staff team.

We saw that resident and relatives meetings had been held infrequently. The last one had been arranged in July 2017 but no one had attended. Prior to this, we saw the minutes of a meeting that had been held in January 2017, the minutes indicated that subjects such as staffing, laundry and activities were discussed. Relatives told us that they knew who the registered manager was and felt they could talk to her any time they wanted. However, other people living at the home commented that they did not know who the manager was and felt they did not see her that often.

There was a system in place to gain views from people and relatives on their experience of the care provided. The registered provider sought people's feedback through a survey, which we saw was last carried out in December 2016. 82% of respondents said that they were happy and content, with 100% indicating that they felt listened to by staff, safe and secure and they were treated with dignity and respect. We saw that information was displayed in the reception area about the feedback received and what the service needed to do in response.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. This is called a notification. We checked our records and found that the registered managers had made the appropriate notifications to CQC as required. The current CQC rating was displayed as legally required on the registered provider's web site and within the home.

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
Treatment of disease, disorder or injury	The registered provider had not ensured that staff always acted in accordance with 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
Treatment of disease, disorder or injury	The registered provider has not done all that was reasonably practicable to mitigate any risks. The registered provider has not ensured the proper and safe use of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had not operated effective systems and processes to make sure they assessed and monitored their service.