

Regency Healthcare Limited

Newlands Hall

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

The inspection of Newlands Hall took place on 15 and 18 January 2018. We previously inspected the service on 14 and 19 June 2017; at that time we found the registered provider was not meeting the regulations relating to consent, safe care and treatment, staff recruitment, supporting staff and good governance. We rated them as inadequate and placed the home in special measures. Following this inspection, we met with the provider and asked them to complete an action plan to show what they would do and by when to improve the key questions; Safe, Effective, Responsive and Well-led to at least good. The purpose of this inspection was to see if significant improvements had been made and to review the quality of the service currently being provided for people.

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 28 people were living at the home on both days of the inspection.

At the time of our inspection a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Newlands Hall. People said there were sufficient staff on duty to meet their needs and we found staff recruitment procedures to be safe.

Improvements had been since the last inspection regarding risk assessments although some records lacked sufficient detail regarding the hoist and slings to be used. People had a Personal Emergency Evacuation Plan in place although where people were not independently mobile, the equipment required to enable staff to evacuate them was not recorded. External contractors were used to service equipment and we saw regular internal checks were completed on the fire alarm system.

Medicines were stored safely and records evidenced people had received their medicines as prescribed. Staff who were responsible for administering people's medicines had received training and an assessment of their competency.

Staff received induction, on-going training and supervision although we noted some supervision were not always for the purpose of enabling staff to raise concerns, reflect on practice and discuss areas of future development.

People were complimentary about the meals. Lunchtime was relaxed with staff supporting people to make choices and regarding the meals they were served. Improvements had been made to staffs recording of people's diet and fluid intake but further work was needed to ensure adequate details were consistently recorded.

Staff communicated well as a team and we saw people had access to other healthcare professionals as the need arose.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff had received training in the principles of the Mental Capacity Act 2005 and we saw staff encourage people to make choices and decisions regarding their lives. However, the requirements of the Mental Capacity Act had not been met as assessments of capacity pertaining to specific decisions were not always completed. A record of consent was not evident in all the care files we reviewed.

People were treated with kindness, relationships between staff and people who lived at the home were friendly, relaxed but professional. Staff were respectful of people's individuality, people's privacy, dignity and independence were respected and information was stored confidentially.

There were a range of activities provided for people to participate in as well as trips out.

Care plans were person-centred and contained information to enable staff to provide deliver peoples care. Although we identified one care plan which did not provide relevant information regarding a person's particular preferences.

People did not raise any complaints with us but said they would be happy to raise a complaint if they were not happy with the care provided.. The registered manager told us they had not received any complaints since our last inspection.

The registered manager was aware of how to access relevant support and advice from other healthcare professionals as a person entered their final days. However, advance care plans were not in the care plans we reviewed. We have made a recommendation in regard to end of life care planning and record keeping.

Since the last inspection the registered manager had received support and mentorship from an operations manager. Audits had been completed on a regular basis and a new system of governance was being implemented. An action plan instigated by the registered provider documented the progress the home was making in achieving regulatory compliance.

Regular meetings had been held with staff and people who lived at the home.

This service had been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. However, we found a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 regarding safe care and treatment, 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.

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.

Improvements were still needed to the management of risk and to ensure people were adequately protected from the risk of fire.

People told us they felt safe and there were sufficient staff to meet their needs.

The management of people's medicine was safe.

Is the service effective?

Requires Improvement ●

The service was not always effective.

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

Staff received induction, supervision and on-going training.

Feedback regarding the meals people received was positive.

Is the service caring?

Good ●

The service was caring.

Staff were caring and kind, respecting people's individuality.

People's privacy and dignity was respected.

Personal information was stored confidentially.

Is the service responsive?

Good ●

The service was responsive.

People were provided with a range of activities to participate in.

Care plans were person-centred and provided adequate detail to enable staff to provide people's care and support.

There was a system in place to address concerns or complaints.

Is the service well-led?

The service was not always well-led.

Improvements had been made since the last inspection but there were still a number of areas as identified within the inspection report where further work was needed to ensure regulatory compliance

There was a registered manager in post.

Regular meetings were held with staff and people who lived at the home.□

Requires Improvement 

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 took place on 15 January and 18 January 2018, the first day was unannounced. The inspection team consisted of an adult social care inspector and an expert by experience. 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 expert by experience on this occasion had experience of using health and social care services. The inspector also visited the home again on 18 January 2018. This visit was announced and was to ensure the manager would be available to meet with us.

Prior to our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. We contacted commissioners of the service, safeguarding and Healthwatch to ascertain whether they held any information about the service. This information was used to assist with the planning of our inspection and inform our judgements about the service. On this occasion we had not asked the provider to complete a Provider Information Return (PIR).

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 eight people who were living in the home, one visiting relative and to a visiting healthcare professional. We also spoke with the operations manager, registered manager, deputy manager, one care assistant, the activity organiser, cook, laundry assistant and maintenance person. We reviewed six staff files, six people's care plans in detail and a further care plan for specific information. We looked also looked at eight 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 last inspection in June 2017 we found the assessment of people's skin integrity was not always robust and moving and handling risk assessments did not contain sufficient information.

At this inspection we reviewed the care files for two people who required support to maintain their skin integrity. We saw skin integrity risk assessments were in place which had been reviewed at regular intervals. Both people were nursed on an alternating pressure mattress, and the setting for their mattresses was recorded in their care files. When we checked the mattresses we found the settings matched the information in their care files. This evidenced improvements had been made and sustained.

Each of the care files we reviewed contained a mobility assessment record which noted the equipment and number of staff required to assist them to mobilise and use the shower or bath. Although some improvements had been made to people's moving and handling records further work was still required to ensure they were robust. For example, at the last inspection we reviewed a care file for a person who often put themselves on the floor but no information was recorded as to how staff were to support them to get up safely. At this inspection we saw a risk assessment was in place instructing staff to use the hoist, however, no information was recorded as to which hoist or the appropriate size of sling staff should use.

We saw a stand-aid hoist and a sling in a person's bedroom. Their care file referred to them sometimes requiring the use of the stand aid, and this was corroborated when we spoke with a member of staff. But their care file made no reference as to which sling staff should use. This information is important as using the incorrect sized sling could result in injury to the person.

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.

Each of the care files we reviewed contained a falls risk assessment which had been reviewed and updated on a regular basis, although where people had fallen, we saw the falls risk assessment was not automatically reviewed. Equipment was in place to reduce people's risk of falls, for example, bed rails and crash mats and where people had suffered a fall we saw an accident form was completed along with a 24 hour post incident observation record. This showed peoples wellbeing was checked at regular intervals following a fall.

At our last inspection in June 2017 we found people were not adequately protected from the risk of fire. As a result of our concerns we contacted the fire authority and requested they visit the home. Prior to this inspection we asked the fire service for an update, they told us most of the concerns had been addressed.

At this inspection we found a number of improvements had been made but further work was still needed to ensure the approach to fire safety was robust. A fire risk assessment had been completed in September 2017, where issues required attention; we saw hand written entries on the document to evidence the action taken to date. We also saw regular checks were carried out on by the maintenance person to ensure the fire

system was working correctly. A Personal Emergency Evacuation Plan (PEEP) was in place for each of the people whose care files we reviewed. This is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. However, we identified improvements still needed to be made to ensure they were appropriate to people's needs. For example, we reviewed the PEEPs for two people whose bedrooms were on the first floor and were not independently mobile but neither PEEP recorded the equipment staff would need to use in the event they needed to evacuate them from the premises. We brought this to the attention of the operations manager and the registered manager.

This also demonstrates 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 the last inspection we were concerned staff had not received sufficient training in fire awareness and evacuation. The registered manager told us all staff had completed a fire drill, one of the staff we spoke with said, "There is a weekly fire practice, I did a practice evacuation some months ago." Following the inspection we reviewed the registered managers' training matrix, this evidenced all staff had attended a fire drill within the previous twelve months. Participating in regular fire drills helps to ensure staff are confident in their role in the event the fire alarm is activated.

We saw evidence the premises and equipment were routinely serviced by external contractors, including gas appliances, electrical wiring and the fire system. It is a requirement of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) that all lifting equipment is regularly checked to ensure it is safe, we saw LOLER checks were in place for the lift, hoists and slings.

No one we spoke with expressed any concern regarding the staffing levels at the home. One person said, "The carers come quickly if I need them." During the course of the inspection we noted staff members were clearly visible throughout the home and although staff were not always present in the lounge areas we saw they responded promptly if needed.

At our last inspection in June 2017 we were concerned staff had not always been recruited in a safe way. At this inspection we checked the files for two staff who had been recruited since the last inspection and found appropriate procedures and checks had been made to establish the suitability of each candidate. Both files included a completed application form, a record of the interview and written references. A disclosure and barring service check (DBS) had also been completed. The DBS is a national agency that holds information about criminal records.

Our previous inspection identified concerns regarding the management of some people's medicines. At this inspection we found medicines were stored securely and safely. We checked five individual medicines and found the recorded number of administrations tallied with the medicines stock. We also checked how the home was administering controlled drugs, there are specific regulations regarding their management and administration. We saw this medicine was stored and administered in a safe way. Where people were prescribed a medicine which they could take 'as required' (PRN); we saw a protocol was in place. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. The deputy manager told us the night staff administered some medicines which needed to be administered before breakfast.

The deputy manager was able to tell us how they disposed of unwanted medicines safely and about the action they would take in the event a mistake was made with someone's medicines. The deputy manager

said all staff who were responsible for administering people's medicines had completed an online training course and received an assessment of their competency. This was confirmed when we spoke with the registered manager and we saw evidence of completed competency assessments. This meant people received their medicines from staff who had the appropriate knowledge and skills.

We found the home to be visibly clean, odour free and tidy. Feedback from the local authority infection prevention and control team was positive, with a number of identified areas for improvement having been addressed.

People told us they felt safe. One person said, "I feel safe and I like my room, I'm quite happy." A relative said, "I couldn't choose anywhere better." We asked if they felt their relative was safe, "Oh yes, definitely. I can't praise them enough."

We saw information was on display in the reception area should staff, visitors or people wish to report any concerns regarding people's safety to a senior manager within the organisation. We also saw details of how to refer concerns to the local authority safeguarding team were predominantly displayed in the office. The member of care staff we spoke with told us they felt people were safe but they said in the event they had any concerns they would report them promptly. This showed this staff member recognised their responsibility in keeping people safe.

We asked the management team how they learned lessons when things went wrong. The deputy manager told us where needed learning was shared through staff meetings, supervisions and at shift handover. We also saw action was taken in response to accidents and incidents and a monthly analysis was carried out.

Prior to the inspection the registered manager submitted a notification to CQC in relation to a person developing a pressure ulcer. We asked the operations manager and the registered manager if they had completed a root cause analysis of the incident; this is a method of problem solving used for identifying the root causes of faults or problems. The operations manager told us the incident had highlighted a weakness in the communication between staff at the home and the district nurse team, they explained what action had been taken to as a result. This meant the service learned lessons when things went wrong although no documented record of this analysis had been made.

Is the service effective?

Our findings

At our last inspection in June 2017 we were concerned the service was not acting in accordance with the Mental Capacity Act 2005. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 a DoLS tracker in place. This recorded eight people currently had a DoLS in place and a further 14 applications had been submitted to the local authority and were still awaiting assessment. No conditions were attached to any of the authorised DoLS.

The training matrix evidenced staff had completed training in MCA and DoLS. A member of staff told us, "Most people can make their own decisions about what to eat or what to wear. Some can make some decisions; we establish this by talking to them. We get to know people well; we do what is best for them." Throughout the time we spent at the we heard and saw staff offering people choices and prompting people to make decisions, for example, where they wanted to sit, what they wanted to eat and drink and the activities they took part in. This demonstrated staff respected people's right to make their own decisions.

From our conversations with the registered manager and deputy manager it was clear they understood the principles of the MCA but when we looked at people's care files we found the requirements of the MCA had not been consistently applied as not all capacity assessments related to specific decisions. For example on person; had a capacity care plan dated 15 June 2017 which recorded '[person] lacks the mental capacity to know who to deal with their own personal cares and medication', they also had a DoLS in place. The only assessment of capacity we saw in their care plan was dated 12 February 2015 and was in relation to weight loss and diet. A further care file for a person who also had a DoLS in place, there was no evidence of a capacity assessment or best interests decisions regarding either living at the home or the management of their medicines.

We reviewed the care files for two people who required the use of bed rails to reduce the risk of them falling out of bed. In the first file we saw a bed rail risk assessment had a section 'agreed to bed rails' this was signed but not dated. We saw a capacity assessment in their care file, dated 1 June 2016 which recorded 'wouldn't be able to make any decisions', this made no reference to the use of bed rails and was not decision specific. In the second file we could not see consent had been gained regarding the use of bedrails. Following the inspection the registered manager emailed a copy of a signed consent form which included

the use of bed rails. However, we were unable to establish who the signature belonged to for either of the two people or if the signatory had the legal powers to consent on the person's behalf.

Where people were able to consent to the care and support they received at Newlands Hall, this was not always evidenced. We reviewed the files for two people but saw no record of their consent either verbal or written to any aspect of their care within their care records. We brought this to the attention of the registered manager and they emailed a signed consent form dated 20 January 2018 for one of the people whose file we had reviewed.

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.

We asked the deputy manager how they ensured people's care and support was provided in line with current good practice guidance. They told us they were taking on extra responsibilities relating to the prevention and control of infection and they said they had completed further training to support them in this role. We noted information on best practice in regard to managing people's medicines was kept in the medicines room; the key aspects of the Mental Capacity Act 2005 were on display in the registered manager's office. This showed staff had some access to current evidence based practice guidance.

At our last inspection in June 2017 identified staff had not received regular management supervision and induction for new staff was not consistently applied, we found improvements had been made at this inspection.

The registered manager told us a new induction pack had been implemented. We reviewed the recruitment files for two staff who had been recently recruited; we saw evidence of a completed induction for one staff member but the second staff's induction was not in their file although when we spoke with them they told us they had received an induction. We spoke with the registered manager and they supplied evidence of the induction following the inspection.

The registered manager told us staff should receive four supervisions and an appraisal over a twelve month period; they provided us with a matrix which gave an overview of this. The dates of supervision on the matrix did not tally with the records in staffs' files. We queried this with the registered manager after the inspection; they sent us evidence of further group supervision for the staff whose files we had reviewed. We noted the tone of both group supervisions were highlighting single topics where improvements were required to staffs work. However, the purpose of the supervision process is to provide a safe, supportive opportunity for individuals to engage in critical reflection in order to raise issues, explore problems, and discuss future professional development.

Staff told us they had completed training in a variety of topics, this was predominantly delivered via e-learning although they received practical training in moving and handling. Following the inspection we reviewed the registered manager's training matrix which recorded the details of the training completed by each staff member. However, when we checked the staff listed on the matrix we noted a member of staff who we had spoken to at the inspection and whose file we had reviewed, was not on the matrix. We brought this to the attention of the registered manager. The registered manager told us they had arranged for a dietician to come to the home to provide further information to staff regarding nutrition for older people. Ensuring staff receive thorough training and regular updates ensures staff have up to date skills and knowledge to enable them to meet people's needs.

Everyone we spoke was complimentary about the meals. People said; "It's really good but not as good as what I made", "Nice dinners", "Ooh yes, the food is lovely" and "There's plenty to eat." A relative told us their family member required a soft food diet, they added "This is always taken care of." We observed lunchtime on the first day of the inspection. People were able to choose where they wished to eat and people were assisted to their chosen table if needed. We observed staff asking people about their choice of meals and drinks. The service was prompt but not rushed and we saw friendly chat between people and staff.

Each of the care files we reviewed had an eating and drinking care plan. This provided sufficient information regarding people's needs and preferences. For example, one care plan noted the person was able to choose what they wanted to eat but may need staff to cut up their food. Another care plan recorded the person used coloured crockery to help them to see the food on the plate; we saw this in use on the day of the inspection.

People were weighed at regular intervals. One of the staff we spoke with said if there were concerns regarding a person's weight, the registered manager or deputy manager would review them and a referral would be made to the dietician. We also noted from the registered provider's action plan, training had been provided to staff in how to effectively use their malnutrition risk assessment tool. The registered manager showed us a matrix they updated which provided them with oversight of people's weights. This showed there was a system in place to identify concerns regarding people's weight which would enable timely action to be taken.

At the last inspection we found staffs' recording of people's dietary intake was not accurate. At this inspection we found improvements had been made but further work was needed to ensure a consistently high standard was maintained. For example, staff recorded how much a person had eaten, such as, all or half, but did not always record the amount of food a person had been offered. This level of detail is important to ensure accurate records are retained.

The registered manager and deputy manager told us information was shared amongst the staff team at team meetings and shift handovers. During our inspection we saw and heard staff communicating with each other about people's needs and choices, including between care staff and kitchen staff. When we spoke with a member of the kitchen staff they were knowledgeable about people's needs and we saw information was available to them regarding people's needs. For example if people required a soft or diabetic diet. Effective communication helps to ensure people receive effective care and support.

The registered manager said staff at the home had a good relationship with the GP surgeries and district nursing service. We spoke to a visiting healthcare professional, they told us they had not visited the home before, but they had found staff welcoming and knowledgeable about people's needs. In each of the care file we reviewed we saw evidence other health care professionals were involved in people's care. This included GP's, district nurses, podiatrists and speech and language therapists (SALT). This showed people received additional support when required for meeting their care and treatment needs.

Newlands Hall is a converted property with bedrooms on both the ground and first floor, each of the bedrooms we saw were personalised with pictures, photographs and personal mementoes. There were two communal lounges, seating in the reception area and a dining room all on the ground floor. The dining room provided access to an outside patio with seating. Communal toilets and bathrooms had signs on them to enable people to locate them.

Is the service caring?

Our findings

Everyone told us staff were caring and kind and they felt 'well cared for'. One person said, "I don't ask for help a lot but they give it when I do." Relatives told us they felt involved, one relative said, "They phoned me every morning when [relative] was bad." Another relative said they had been encouraged to bring in furniture and personal items to make their relatives room more familiar.

The atmosphere within the home was warm, friendly and relaxed. It was clear from our observations of the interactions between staff and people who lived at the home, staff knew people well and people felt comfortable in the presence of staff. Staff spoke with people as they went about their daily duties and chatted with them when supporting with tasks, consistently calling people by their name. At lunchtime we heard a member of staff chatting about their dog, people were laughing and actively joining in the conversation. We also heard a person ask "How much?" in reference to the cost of their meal, we heard a member of staff respond in a jokey manner, "2 and 6." We saw the person smile in response to this comment.

We saw from the training matrix only 17 of the 26 listed staff had completed dignity and respect training. One of the staff we spoke with told us, "We knock on doors (before we enter), close windows and curtains. If it is safe, we leave people when they are using the toilet and they buzz us when they are finished." From our observations we saw staff respected people's privacy, for example, staff spoke discreetly to people when appropriate and knock on bedroom doors prior to entering. We heard a person in their bedroom shout for assistance, we saw a member of staff knock on the door as they entered the room to announce their presence, asking the person about the help they needed. Doors to communal bathrooms and toilets had operational locks; this meant people would not be disturbed when accessing these facilities.

Care plans recorded if people had a preference for the gender of the staff member delivering their care, the clothes they preferred to wear. The registered manager, deputy manager and a member of care staff each spoke with us regarding the particular lifestyle choices and preferences of a person who lived at the home. Their choice of words demonstrated they respected the person's individuality but also evidenced their understanding of the need to reduce the risk this person may be discriminated against by others who may be less tolerant.

Care plans recorded the tasks people were able to manage independently. For example, one care plan recorded 'I can wash my own hands and face'. This showed care planning and assessments encouraged people to be independent, wherever possible.

No one at the home currently had an advocate, but when speaking to the deputy manager they were understood the role of an advocate and how to access the service. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

Personal information was stored confidentially. People's care files and related documentation was stored in a locked cupboard and staff's personal information was stored in the registered manager's office with access restricted to relevant senior management. These steps reduced the risk of unauthorised access to

information.

Is the service responsive?

Our findings

A programme of activities was provided at the home. One person said, "I don't go out a lot but if I wanted to I could." They told us about their recent birthday party which included balloons and cake. Another person said, "We usually do plenty of things in the dining room, cards, snakes and ladders but not today, we're just watching telly I suppose." A relative told us staff respected their family member's preference for a quieter environment and said staff did not pressure their relative to leave their room if they did not want to.

A notice board listed a range of activities available for people to participate in. We spoke with the activities organiser on the second day of the inspection. They told us about the programme of entertainment over the recent Christmas period and the trips out to the supermarket, a local mill shop and a café. They also told us about a local children's nursery who visited the home every couple of weeks and how people enjoyed the interacting with the children, we saw information regarding this was also on display in the reception area. The activity co-ordinator spoke with enthusiasm about their role telling us about a course they had been on to enable them to provide regular chair based exercises for people.

At the last inspection in June 2017 we found care plans were not always an accurate reflection of people's current needs. At this inspection we found improvements had been made. Care plans were person-centred and provided sufficient information to enable staff to provide appropriate care for people. One care plan recorded 'I like to wear warm clothes and a blanket as I feel the cold'. Each care plan also contained information about the person's life history although the level of detail was variable dependent upon how staff had been able to obtain the information. Life histories can help staff to engage people in meaningful conversations and encourage social interaction and communication.

However, we also reviewed the care plan for a person who staff had told us had particular lifestyle preferences, but this information was not recorded in any of their care file. We brought this to the attention of the registered manager who assured us they would rectify the matter.

The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services. Each of the care plans we reviewed detailed people's communication abilities, for example, one care plan recorded 'chooses not to wear hearing aid. Speak slowly and clearly, [person] will speak back but may get words jumbled'. The deputy manager also told us how they used basic gestures to communicate with another person, for example, placing their hands against their head to mimic sleep. This showed staff adapted their communication to meet people's abilities.

We looked at how complaints were received and responded to. One person told us they were confident to tell staff about anything they were dissatisfied with, they went on to tell us they planned to speak with the registered manager about the new toilet roll holders as they felt they were 'too tricky to use'. A relative we spoke with said, "I could talk to them about anything if it's wrong but I've never needed to."

The registered manager told us they had not received any complaints since our last inspection. From our

discussion with the registered manager we were satisfied they would take appropriate action, for example, recording, investigating and responding to the complainant, in the event of a complaint being raised regarding the service people received.

Where people had a Do Not Attempt Resuscitation (DNAR) in place we saw these were consistently stored at the front of people care files to enable staff to locate them easily. In one of the care files we reviewed we saw information was recorded as to the person's preferred funeral director in the event of their death.

We spoke with the deputy manager about the care provided to people who were entering their final days. Their answers demonstrated an understanding of how to access support from the relevant GP surgery and the district nursing service, as well as ensuring people's anticipatory medicines were in place so that any pain or distressing symptoms could be managed promptly.

Advance care plans were not routinely included in the care plans we reviewed. We spoke with the registered manager about this and they showed us a specific care plan document which they said would be implemented as someone neared the end of their life. However, we recommend the registered manager seeks guidance from a reputable source about taking a more pro-active approach to advanced care planning. Advance care planning is a way of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing. It enables people to discuss and record their future health and care wishes and also to appoint someone as an advocate, thus making the likelihood of these wishes being known and respected at the end of life.

Is the service well-led?

Our findings

People and their relatives were satisfied with the service they received and had confidence in the registered manager. One person said, "I don't know the manager but they must be ok," A relative said, "He [registered manager] is really good, I can ask anything."

One of the staff we spoke with said they liked the registered manager. Throughout the inspection the registered manager was visible within the home. During our discussions with the registered manager they spoke with knowledge and understanding of individuals support needs and preferences, staff understood their roles and responsibilities. A member of staff told us, "We are here to look after the residents as best we can. Make sure they are safe. I treat them the way I want my mum and dad treating." Two of the staff told us they had a parent who lived at Newlands Hall.

At our previous inspection we found the systems of governance were ineffective. The registered manager told us since the last inspection they had received support and mentoring from the registered provider's operations manager. They also said they had delegated some tasks and responsibilities to other staff as they felt they had tried to 'do it all'. When we spoke with the deputy manager they said, "Since the last inspection we have all pulled our socks up." They also told us about a new quality compliance system the registered provider was implementing which would further improve the systems and processes of governance.

The operations manager told us they had been working with the registered manager since October 2017. The purpose had been to provide support and mentorship in addressing the areas highlighted in the previous CQC inspection report. We saw a record was kept of visits to the home by both the registered provider and the operations manager. An action plan had been implemented following the previous inspection which included the shortfalls identified by CQC as well as concerns raised by the fire officer and the infection control team. The action plan had been updated at regular intervals and charted the progress being made in addressing the concerns. The operations manager also told us a monthly management report had been implemented the previous month as an additional audit tool. They said the home had achieved compliance with the requirements of the local authority contract following a recent visit to the service by the contract monitoring team.

We saw a range of audits were completed on a monthly basis, these included accidents, weights, infection control and medicines. However, as evidenced within this report there were still areas where improvements were needed which had not been identified through the registered provider's governance systems. For example, assessing and recording of risk, robust fire procedures and ensuring compliance with the requirements of the Mental Capacity Act 2005. This was evidenced in an audit dated 3 January 2018; the audit listed the people who had bed rails in place and confirmed consent had been obtained. However, the audit had not addressed the concerns we have recorded earlier in this report regarding the need to ensure consent is obtained from those who have the legal authority to do so.

The examples within this report demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to address all the issues we raised at the previous inspection and the systems of governance were still not robust or effective.

At our last inspection in June 2017 we found a number of policies at the home were generic and contained inaccurate information. At this inspection the registered manager told us all the policies had been replaced as part of the roll out of the quality compliance system. They said the policies were available for staff in both paper and electronic format. Having up to date and service specific policies are important as they provide a protocol for staff to follow to ensure people receive a safe and effective service.

The activities organiser told us they chaired the monthly resident and relative meetings. Meetings planned for 2018 were going to alternate between afternoons and evenings as they hoped this would make the meetings more accessible for relatives. We saw minutes of these meetings were recorded and retained in the registered manager's office, the minutes recorded who had attended and the topics discussed, for example, how people were feeling and a plan for future trips and activities.

We saw regular meetings had been held with staff throughout 2017. We noted a meeting had been held between staff and the registered provider to discuss the content of the previous CQC inspection report. We saw other topics discussed included; record keeping, the quality compliance system and team working. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service people receive.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner.

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 There had been a failure 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 There had been 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.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure systems of governance were robust and effective.