Care Quality Commission

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Newlands Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The inspection visit was carried out on 16 December 2014 and was unannounced.

Newlands Residential Home provides care for up to 17 older people some of whom may also have dementia. The service is situated on the seafront at Walmer with accommodation on two floors. On the day of the inspection there were 14 people living at the service.

The service was run by a manager, who had been in post since 10 August 2014 and who was present on the day of the inspection. The manager was in the process of going through formal registration with the Care Quality Commission. The service had been without a registered manager for over four years. 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 and associated Regulations about how the service is run.

Summary of findings

There was a lack of empowerment for the manager and staff. The provider did not financially invest in improving the service. The provider's lack of investment prevented the manager and staff from putting the needs of people first and improving the quality of the service.

The environment at the service was not adequately maintained and there were areas that were in need of repair. Some carpets were worn and stained. One bedroom smelt strongly of urine. The staff did not have access to a carpet cleaner. Repeated requests had been made to the provider but a carpet cleaner had not been purchased. Staff said they scrubbed the carpet but the odour remained. Staff said that the carpet needed replacing but the provider would not consent to this. One person said, "When I came here the owner told me that they would replace the carpet in my bedroom, that was 18 months ago and the carpet has not been replaced. As you can see it is very worn in places". Other areas like bedrooms, hallways and ceilings were in need of repair and redecoration. The flooring in the laundry room was cracked with pieces of tiles missing. Pipe work was exposed where the plaster had fallen away from the wall. The outside of the property looked run down.

The provider had not purchased the equipment needed to make sure people received safe care and support to meet their individual needs. Weighing scales were shared between the provider's two services, one in Kent and one in Medway. At the time of the inspection weighing scales had not been at Newlands for at least two months because they were being used at the providers other location. People needed to be weighed regularly to make sure they were maintaining a healthy weight.

Three people had been assessed as being at risk from falling and for three weeks the manager had asked for special alarmed mats to be purchased. At the time of the inspection these had not arrived.

Potential risks to people were identified but full guidance on how to safely manage the risks was not always available. This left people at risk of not receiving the support they needed to keep them as safe as possible.

A system of recruitment was not in place to ensure that the staff employed to support people were fit to do so. Staff did not always have the appropriate safety checks prior to working with people to ensure they were suitable. The staff had not received all the training they needed to make sure they had the skills and knowledge to carry out their roles. There were sufficient numbers of staff on duty throughout the day and night to make sure people were safe and received the care and support that they needed. People and their relatives said there was enough staff. They said that staff came quickly when they called for them and there was always staff around. Staff were respectful, kind and caring when they were supporting people.

People said that they would like to do more activities. An entertainer came fortnightly to play music. Staff tried to spend one to one time with people, but this was limited. There had been events, such as a summer BBQ for people and their friends and family in the Summer and a Christmas fair. People's relatives took them out regularly. Staff were able to support people to go out but this was dependant on the weather. Newlands had previously had a number of people coming to the service to provide entertainment but invoices had gone unpaid for so long that they chose not to return.

Each person who used the service had a care plan which was personal to them and that they or their representative had been involved in writing. The care plans recorded all the information needed to make sure staff had guidance and information to care and support people in the way that suited them best. The staff said they were committed to providing the individual care to making sure that each person was treated and cared for as an individual. Staff were familiar with people's likes and dislikes, such as if they liked to be in company or on their own and what food they preferred.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager showed that they had considered their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The manager had undertaken mental capacity assessments to identify if people were able to make decisions for themselves or if they needed specialist support to do this. The management had considered Deprivation of Liberty Safeguards for some people who may have been restricted.

Summary of findings

People received their medicines safely and when they needed them and they were monitored for any side effects. At the time of the inspection the service was not monitoring the temperature at which drugs were stored. The manager took immediate action to rectify this.

People were protected from the risk of abuse, as staff had received appropriate safeguarding training and were aware of how to recognise and process safeguarding concerns. Staff knew about the whistle blowing policy and were confident they could raise any concerns with the manager or outside agencies if needed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Not all risks to people were assessed and guidance was not available to make sure all staff knew what action to take to reduce risks to people.

The environment was not adequately maintained inside or outside. The equipment people needed was either not available or not available when it was needed.

The provider had not followed their recruitment policy to make sure that staff employed were checked and vetted. There were sufficient numbers of staff on duty to make sure people were safe and received the care and support that they needed.

People felt safe living at the service. Staff knew how to keep people safe and protect them from abuse. People received their medicines when they needed them and in a way that was safe.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not receive the training they needed. Access to training was inconsistent. Some training was out of date and some training had not been completed at all.

The manager understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). People's liberty was not unnecessarily restricted and people were supported to make choices about their day to day lives.

When people had specific physical or mental health needs and conditions, the staff had contacted healthcare professionals and made sure that appropriate support and treatment was made available.

The service involved people and their representatives in making decisions about their care and support. People were provided with a suitable range of nutritious food and drink.

Is the service caring?

Good

The service was caring. Staff took the time needed to communicate with people and included people in conversations. Staff spoke with people in a caring, dignified and compassionate way.

People and their relatives were able discuss any concerns regarding their care and support. Staff knew people well and knew how they preferred to be supported. People's privacy and dignity was supported and respected.

People and their families were involved in reviewing their care and the support that they needed. People had choices about how they wanted to live.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was responsive. People were encouraged to maintain their interests and hobbies and some people went out with relatives. Activities on offer had been reduced as the provider had not paid for the services visiting entertainers had provided.

People and their relatives were involved in the planning and reviewing of their care needs. Staff were aware of people who stayed in their own rooms due to health needs or personal choice, and were attentive to prevent them from feeling isolated.

People and their relatives said they would be able to raise any concerns or complaints with the staff and manager, who would listen and take any action if required.

Is the service well-led?

Inadequate 

The service was not well-led. People were not experiencing care from a provider who understood that they needed to promote and improve the service that people received. The manager was restricted in the improvements they could make as they were not supported financially or personally by the provider.

There has been no registered manager at the service for four years. There was manager in post who was in the process of registering with the Care Quality Commission.

The manager led the staff in providing compassionate and sensitive care for people; and in providing a culture of openness and transparency.

The staff were aware of the services ethos for caring for people as individuals and putting people first.

The manager completed regular audits on the quality of the service. The findings were noted and the provider was kept up to date with any areas of concern. The provider did not act in a timely manner to resolve areas identified as needing improvement.

Newlands Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 16 December 2014 and was unannounced. It was carried out by two inspectors. One of the inspectors had specialist knowledge about caring for people with dementia.

We normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the provider do this as we were responding quickly to information and concerns that had been raised at another location run by this provider. We wanted to check whether the similar concerns were happening at Newlands Residential Home.

We looked around all areas of the service, and talked with eight people who lived at the service. Conversations took place with individual people in their own rooms, and with groups of people in the lounge areas. Some people were not able to explain their experiences of living at the service to us due to their dementia. We therefore used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We also talked with three relatives who were visiting people; four staff from different job roles, and the manager.

We observed staff carrying out their duties. These included helping people to eat and drink, helping people move from one place to another, and engaging people in activities. We assessed if people's care needs were being met by reviewing their care records and speaking to the people concerned.

During the inspection visit, we reviewed a variety of documents. These included four people's care plans; four staff recruitment files; the staff induction and training programmes; staffing rotas; medicine records; environmental and health and safety records; risk assessments; quality assurance questionnaires; meeting minutes; auditing records; and some of the services policies and procedures.

The previous inspection was carried out in December 2013. This was a follow up inspection as concerns had been identified at an inspection carried out in May 2013. At the December 2013 inspection improvements had been made and there were no breaches in the legal requirements.

Inadequate

Is the service safe?

Our findings

People said that they felt safe. They said that staff looked after them well and that staff were all kind and gentle. People were comfortable and relaxed in the company of staff.

People, relatives and staff said that the inside and outside of the service was in need of repair and redecoration. Carpets in some bedrooms were old, stained and threadbare in places. One person told us they had been at the service for 18 months. They said the provider had said when they first arrived that the carpet in their bedroom would be replaced as it was stained and threadbare in areas, but this had not happened. One of the bedrooms had an offensive odour coming from the carpet. The domestic staff said they cleaned it regularly by scrubbing it as the carpet cleaner had broken and had not been replaced. Staff had raised this concern during a staff meeting in November 2014 saying, “We really need a carpet cleaner”. The manager had told them that the provider had been informed and was going to buy one. At the inspection no carpet cleaner had been purchased. The provider had not agreed to pay for the carpet to be replaced even though several requests had been made.

The floor tiles in the laundry room where cracked and lifting from the floor making it difficult to keep clean. There was an exposed pipe where the concrete had fallen away for the wall. A large freezer in the laundry room had a broken seal and needed to be replaced. The décor in parts of service was old and faded. Paint work was chipped and there were water stains in various areas where there had been leaks. The leaks had not been repaired. The outside of the building was in need of attention. Paintwork was flaking, wood exposed and guttering was missing. One person had a broken window in their bedroom and staff told us, “It is boarded but it has been like it for months”. The environmental short falls had been identified by the manager and were regularly reported to the provider noting what was urgent but the provider had not released any funds to improve the service.

People did not benefit from premises that were adequately maintained. This is a breach of Regulation15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service did not have the all the equipment needed to make sure people where kept as safe as possible and receive the care and support that they needed. Some people needed special equipment called slings that staff used with a hoist to help them move people safely. Each person should have an individual sling that specifically meets their needs, size and weight and that they had been assessed for, so that it was safe. People had to share the slings as there were not enough for everyone to have their own.

A person had been referred to the dietician as they were at risk of not eating or drinking enough and their weight needed to be monitored. They needed to be weighed regularly. The person had not been weighed since the 18 October 2014 as the provider had taken the weighing scales to their other location and had not returned them. The staff were unable to monitor if the person was maintaining their weight and were at risk of any weight loss not being identified and responded to quickly. Other people were at risk of falling in the night when they got out of bed. The manager had requested that special mats were bought that alerted staff when a person got out of bed so they could get to them quickly. The provider was aware of the need for the alarmed mats, but staff had been waiting for these for three weeks.

Some of the equipment in the kitchen was not adequate to met people's needs. The cooker did not always work and was propped on a wooden block as the floor was uneven so preparing meals efficiently and quickly was difficult. This had been reported to the provider but no action had been taken to rectify this.

There was a lack of suitable equipment to meet the needs of people. This is a breach of 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to people had been identified and assessed but guidelines to reduce risks had not been consistently followed. Some people were identified at being at risk from choking and falling over. There was information and guidance available for each person to tell staff how to prevent this from happening but there was no instruction to say what to do for each individual if they did start to choke or fall over. People’s needs were diverse. Some people were in wheelchairs, some people were in bed, so staff would have to respond very differently to each individual.

Inadequate

Is the service safe?

People were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had policies and procedures when new staff were recruited, however these were not always followed. Prospective employees completed an application form, provided forms of identity and had a formal interview as part of their recruitment. Notes were made during interviews and held in staff files. References from previous employers had not been obtained for one staff. Checks with the Disclosure and Barring Service (DBS) to check that staff were suitable to work with people that lived at Newlands had not been completed for one member of staff. Where it had been identified that staff had a conviction this had not been queried or assessed to minimise any risk to people living at Newlands. Gaps in people's employment history had not always been explained. One member of staff had no job description and did not have a written and signed contract in place. The person carrying out maintenance at Newlands had not been checked to make sure they were safe to work at the service.

The provider did not make sure all staff were safe to work with people. This is a breach of Regulation 21of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us that there was enough staff on duty most of the time to give them everything that they needed. They said that when the manager was on duty they always helped out. The manager or deputy manager covered emergencies like sickness. Staff responded quickly to people when they wanted anything. Staff did appear rushed at times but no-one was kept waiting when they used the call bells in their bedrooms or if they wanted assistance. Staff said that they would like to have more time to spend with people on an individual basis. They said that they did this when they could but there was not always enough of them. When they were able, staff sat with people and manicured their nails or did their hair.

The provider had policies and procedures for ensuring that any concerns about people's safety were reported. Staff had received training in the protection of adults who might be at risk. Staff explained how they would recognise and report abuse. They told us they were confident that any concerns they raised with the manager would be listened to and fully investigated to make sure people were protected. Staff were aware of the whistle blowing policy and the ability to take concerns to agencies outside of the service if they felt they were not being dealt with properly. If any concerns were raised the manager took action to deal with them.

People said that they received their medicines when they needed them. There were policies and procedures in place to make sure that people received their medicines safely and on time. Medicines were administered from a medicines trolley which was safely secured. The stock cupboards and medicines trolleys were clean and tidy, and were not overstocked. Bottles of medicines and eye drops were routinely dated on opening. This showed that staff were aware that these items had a shorter shelf life than other medicines, and this enabled them to check when these were going out of date. Some items needed storage in a medicines fridge, the fridge and room temperatures were checked daily to ensure medicines were stored at the correct temperatures. However, the temperature was not taken in the area were the medicines trolley was stored so medicines may have been stored at a temperature which may have altered their effectiveness. The manager took immediate action to rectify this. The records showed that medicines were administered as instructed by the person's doctor.

There were systems in place to review any accidents and incidents that happened at the service. These were analysed and improvements were made if any trends or patterns were identified. This helped reduce the risk of further accidents.

There were procedures in place for emergencies, such as, gas / water leaks. Fire exits in the building were clearly marked. Regular fire drills were carried out and documented and the alarms were checked. There was a fire alarm point at the end of a corridor, where staff would need to break the glass to activate the alarm, which did not have a hammer with it. Staff told us that they were concerned that they had been told to get one from another fire point if they needed it and that this may put people and staff at risk. There were three fire doors which were due to be replaced and the measurements had been given to the provider. The fire door where the medicine trolley was stored was very difficult to open and close properly so may not be effective in the event of a fire posing a risk to people.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that they received good, effective care. They said that staff had the skills and knowledge to give them the care and support that they needed.

The majority of the training that staff received was on–line training using a computer. This system involved the provider buying credits so staff could access the training. The provider had failed to buy enough credits and so staff were not able to complete the training. Eight staff had completed moving and handling training to reduce the risk of supporting people incorrectly. A further three staff had only received the theory part and no practical exercise to assess their understanding and competence. Seven staff had not done this training at all. Half of the staff had not completed training on infection control and no staff had undertaken training on mental capacity and Deprivation of Liberty Safeguards (DoLS).

The provider had failed to ensure that staff were appropriately trained to meet people's needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager was aware and had knowledge of the Mental Capacity Act 2005 and DoLS. There were mental capacity assessments in place to determine whether people had the capacity or not to make decisions and give consent. People's consent to all aspects of their care and treatment was discussed with them or with their next of kin or representative. The manager was aware of the need to involve relevant people if someone was unable to make a decision for themselves. If a person was unable to make a decision about medical treatment or any other big decisions the service involved relatives, health professionals, advocates and social services representatives to make sure decisions were made in the person's best interest. Some people lacked full capacity to make complex decisions about their care and were given the right support. The manager had applied for and obtained deprivation of liberty safeguards (DoLS) authorisations when it was necessary to restrict people for their own safety. These were as least restrictive as possible.

The staff team knew people well and knew how they liked to receive their care and support. The staff had knowledge of people's medical, physical and social needs. When people's physical and/or mental health declined and they required more support the staff responded quickly. People had access to health care professionals to meet their specific needs. People saw diabetic nurses, speech and language therapists, district nurses and other local community specialists.

Referrals to health care professionals, such as physiotherapists and dieticians, had been made when it was necessary. Relatives told us that the service responded promptly when their family member needed to see a doctor or any other health related appointments.

People and their relatives said that the food was very good and the cook was "brilliant". One person said, "I really look forward to my meals. There is always something different and yummy. Puddings are very good". A relative said, "I am often here at meal times and the food always looks healthy and well balanced". People were encouraged and supported to eat a healthy diet. People told us that they had a choice of meals every day. People were able to eat in lounges, dining areas or bedrooms according to their choice and their state of health. Tables in the dining area were laid with napkins, table cloths and fresh flowers. The staff encouraged people to sit with others at meal times so they could chat and socialise while eating, this also encouraged people with their eating and drinking. Lunch was a calm and relaxing time where people sat chatting. Staff were discreet and sensitive when they were supporting people with their meal. Drinks were available to people throughout the day and staff encouraged people to drink to reduce the risk of dehydration. People who had specific health needs like diabetes were supported by staff to manage their diets to make sure they were as healthy as possible. The cook told us that they felt the budget for food was not enough and they had asked the provider for an increase in money provided for food but this had not happened.

The manager and deputy manager worked with staff each day to keep an overview of the service. The manager held one to one meetings with staff to mentor and coach them. Annual appraisals were being completed and there was a plan for appraisals which was being worked to.

Staff completed an induction and a probationary period. This included shadowing experienced staff to get to know

Requires Improvement

Is the service effective?

people and their routines. Staff were supported during the induction, monitored and assessed by the manager to check that they had attained the right skills and knowledge to be able to care for, support and meet people's needs.

Regular staff meetings highlighted training needs, policy or procedural changes and reminders about the quality of care delivered. Staff had the opportunity to raise any concerns or suggest ideas. Staff we spoke with felt that their concerns were taken seriously by the manager but they said that the provider did not always listen to their concerns and ideas.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff 'really cared' and that they 'did their best for the people'. One person told us, "I get everything I need. The staff are very kind". A relative said, "I visit at least three times a week. I am very happy with the care my relative receives. The staff are very friendly and kind to people".

People told us they were involved and were always asked about the care and support they wanted to receive. People talked about their care with the staff. Staff said they worked together to make sure people got everything they needed. Relatives told us they were involved in the care planning for their family member. Comments from a recent quality assurance survey stated 'We are always welcome. The staff are very courteous'.

Staff supported people in a way that they preferred and had chosen. There was a relaxed and friendly atmosphere at the service. People looked comfortable and at ease with the staff that supported them. People chatted and socialised with each other. Even though staff were busy they always acknowledged people when they walked passed them and checked they were alright. They told them what was happening or about to happen, like 'lunch will be ready shortly' or 'your son is visiting this afternoon'. Exchanges between people and staff were caring and professional. Staff involved people in conservations and valued their views and opinions. Staff explained things to people and took time to answer peoples' questions. Relatives said: "The manager's really good but you can talk with any staff, they always listen". Another told us, "It really is lovely here. The staff seem to care and are very professional. It is always clean. It has such a lovely view".

Staff spoke about respecting people's rights and supporting people to maintain their independence and make choices. People were able to choose where they spent their time. Some people chose to stay in their bedrooms. Others preferred to be in the lounge area. The staff maintained people's privacy and dignity. Staff promoted people's dignity by knocking on their bedroom doors and waiting for signs that they were welcome before entering people's rooms. They announced themselves when they walked in, and explained why they were there. Personal care was given in the privacy of people's own rooms or bathrooms.

There were a number of thank you cards on display. Comments included, "We would like to say a big thank you for all the care and compassion you have all given our mum. Her every need was supported with such care and respect. This enabled her to remain in your safe and comfortable care until she passed which meant a lot to us. She couldn't have received such high standards anywhere else". Another read, "Thank you very much for looking after (our relative) during her two years and six months at Newlands. I am very grateful for the love, care and attention you gave her especially during the last few months".

Staff took time and sat with people when they supported them with their lunch. People were not rushed. Staff explained what was on each forkful and once finished checked that the person had had enough to eat. They made sure there was a fresh drink within reach of everyone. One person had chosen not to eat their lunch and staff asked if he would like something else. He told them that he wasn't hungry and staff told him that if he wanted something later they would get it for him.

Requires Improvement

Is the service responsive?

Our findings

People said that they were well supported with their personal and health care, mobility and diet. This included assistance with everyday tasks such as washing and dressing, using the bathroom, eating and drinking and supporting people to take care of themselves.

There were some activities organised but people said that they would like to do more things. One person said that they would like to go out more. People relied on their relatives to take them out. Another person who preferred to stay in their room said, “The staff do pop in and out and they always come quickly if I call them but would like them to be able to sit and have a chat but they have other things to do”. Staff said they tried to spend one to one time with people, but this was limited as there was not the time to do this. An entertainer came fortnightly to play music. There had been events, such as, a summer BBQ for people and their friends and family and a Christmas fair. Newlands had previously had a number of people coming to the service to provide entertainment and activities but invoices had gone unpaid for so long that they chose not to return.

Staff told us about how they cared for each person to make sure they received the care and support that they needed. Each person using the service had a care plan that was personalised and said what level of assistance people needed. The care plans gave guidance to staff about how people preferred to be supported. People were encouraged to be independent and do things for themselves. The plans contained details about people's background and memories as well as their likes and dislikes. The contact details for people's next of kin and other important people were recorded in the care plans and people had support to keep in touch with their family and friends. The information was up to date and relevant to each person.

Relatives and/or health care professionals had been involved in review meetings to discuss people’s changing care needs. People’s health care was monitored closely and there was information to support people with their medical conditions, such as diabetes. There was guidance to show staff how they should respond if the person's blood sugar was too high or too low, and when to seek medical advice.

Some people were at risk of developing pressure sores. There was information and guidance for staff to tell them what to do to prevent this. Staff used special equipment to protect people's skin, like air cushions and mattresses. Staff recorded when they applied creams to skin areas that were at risk of becoming sore and breaking down. They also took action if people's skin condition changed.

Staff knew the people well and anticipated their needs. If people were unhappy about something the staff were able to recognise the signs and take the appropriate action to resolve any issues. When one person was upset a member of staff sat with them and reassured them until they felt better.

Relatives said that the manager and staff were approachable and said they would definitely listen to them if they had any concerns. They said communication was good and the service kept them informed of their relative’s care at all times. As a result they felt involved in their relative’s care and knew about any concerns or issues. A relative said, “The staff always keep me up to date with everything that is happening. They called me straight away when my relative had to go into hospital. I trust them to do the right thing”. People and relatives told us that they did not have any concerns about the standards of care, and said they knew they could talk to the manager or any of the staff if they had any worries. People were confident that any concerns or complaints would be listened to and the manager would do something about it. One person said, “I have not had any problems at all. If I had a concern I would go to any of the staff”. Throughout the day staff asked people if they were alright and if they needed or wanted anything. Staff responded quickly to any requests, like wanting to go to their bedroom or bathroom.

Inadequate

Is the service well-led?

Our findings

The provider of this service owned another service. Concerns had been identified at the provider's other service and this inspection was carried out at Newlands to make sure people were receiving safe and effective care and support.The provider had consistently not complied with the conditions of their registration because they had failed to appoint a registered manager to manage the service. The provider was fully aware of their responsibility to do this because it was recorded on their registration certificate dated 29 September 2010. When we previously inspected the service we recorded in the summary of the inspection report that there was no registered manager in post. We had previously taken action against the provider for having no registered manager. The action was withdrawn when a manager made an application. This application was subsequently rejected. The provider failed to have a registered manager in post. This was a breach of the Health and Social Care Act 2008 and Regulation 28 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Newlands had a new manager in post since August 2014. The manager said that she was in the process of registering with the Care Quality Commission. The manager was supported by a deputy manager. The manager was not able to develop and improve the service as they did not receive the financial support they needed from the provider. All of the necessary improvements had not been made to the environment and the service did not have all the equipment needed to make sure all people's needs were met. Staff told us that on occasions their wages had not been paid on time. One staff member said, "We are worrying every month if we are going to get paid".

There was a system in place to monitor the service people received. Regular quality checks were completed by the manager on key things, such as, care plans, fire safety equipment, the environment and medication. General safety checks for electrical goods and legionella had been completed and the certificates were displayed in the manager's office. Any shortfalls were discussed with the provider and the manager highlighted any outstanding areas of concern from the previous audit. The provider did not take prompt action to resolve issues. Some concerns had repeatedly been brought to the provider's attention, for example, replacing roof tiles, purchasing alarm mats and replacing fire doors and there had been no action at the time of our inspection to remedy these. People were not protected from risks of inappropriate or unsafe care by means as the provider did have effective systems in place to improve the service. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff ordered food shopping on-line and then contacted the provider for him to make the payment. Staff told us that this sometimes took three days to be done and that they had to remind the provider to complete the food order. This delayed the delivery of food stock and the cook sometimes had to be creative with meals. One staff member said, "I wouldn't see them go without".

There had been meetings with people that lived at Newlands but staff told us that these had not been well attended. There were regular meetings with people individually to measure the quality of the service they received. The manager reviewed people's views to see if there were any areas for improvement.

On a day to day basis people and staff felt that the service was well led by the manager. People, their relatives and staff spoke highly of the manager. People and relatives said that since the manager took over the role they thought the home had improved. Relatives said that they were, "Very happy with the care". The manager supported and guided the staff team. The manager's office was centrally located within the service, which meant they were available to people and visitors. Throughout the day people were welcome to walk in and out of the office and chat to the manager and anyone else they wanted to talk to. Staff told us that the manager was available, accessible and they felt they could approach them if they had any concerns. Staff told us if they did have any concerns the manager acted quickly and effectively to deal with any issues.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment Equipment was not available in sufficient quantities in order to ensure the safety of people and to meet their assessed needs. Equipment was not provided to support people in their day to day living. 16 (1) (a) (2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure the appropriate delivery of care, support and treatment to meet people's individual needs and ensure their welfare and safety. This is a breach of Regulation 9 (1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider had failed carry all the necessary safety checks to make sure all the staff were of good character and were safe to work with service users. Regulation 21(a)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Service users were at risk because staff did not receive appropriate training. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person was not protecting service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of health and safety and quality monitoring systems. Regulation 10(1)(a)(b).