HC-One Limited

Newlands Nursing & 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?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 22, 23 and 28 February 2017 and the first day was unannounced.

Newlands Nursing and Residential Home is located in the residential area of Heaton Moor, Stockport. The home is registered to accommodate a maximum of 72 people for residential and nursing care, although as double rooms were not in frequent use, HC-One Limited who are the registered provider of the home advertise it as providing care for up to 68 people. Care is provided over four floors, with residential care being provided on the basement level (Oak), nursing care on the ground and first floors (Cedar and Willow), and intermediate care on the top floor (Beech). Beech provided primarily nursing care to up to 19 people, often to allow earlier discharge from hospitals. There is parking on site and in streets nearby. At the time of our inspection there were 57 people living at the home.

We last inspected Newlands Nursing and Residential Home on 02 and 04 August 2016 when we rated the home inadequate overall and placed it into special measures. At that inspection we identified breaches of the regulations in relation to care plans, premises and equipment, safe recruitment processes, safe care, governance, records, staffing levels and staff supervision. We asked the provider to make improvements to the service and they provided us with an action plan of how they would do this. We also issued two warning notices to the provider that instructed the provider to make improvements to the service. At this inspection we found on-going and multiple breaches of the regulations in relation to safe care and treatment, staffing, supervision, governance, premises and equipment, person centred care and safeguarding. You can see what action we told the provider to take at the back of this report.

The home did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Since our last inspection six months previously, two acting managers had left the service. The provider had appointed a new acting manager who was recruited internally and was in the process of applying for their registration with the CQC.

We identified concerns in relation to the safe management of medicines that put people's health and wellbeing at risk. We found staff were not aware that one person's medicine needed to be given on an empty stomach, and also found evidence of people having missed a dose of medicines, or having been given another person's prescribed medicine. Staff did not always have clear instructions that would allow them to administer medicines safely and when required. This included information in relation to any difficulties people might have in relation to swallowing.

The provider had assessed potential risks to people's health and wellbeing. However, we found staff were not always aware of the guidance in place, which put people at risk of potential harm. The provider had also not taken reasonable steps to ensure the safety of the premises and equipment. For example, we found regular maintenance checks of the water system to control the risks of legionella had lapsed, and one

person's wheelchair was missing a footplate and arm rest. We also found a number of areas being used inappropriately for the storage of furniture and equipment. The provider sent us evidence after the inspection to show they were now completing the required checks in relation to controlling the risk of legionella.

There were sufficient numbers of staff on duty to meet people's needs. However, we were concerned about the lack of clinical oversight as no member of management staff at the home was a registered nurse. The provider informed us shortly after the inspection that they had appointed a 'clinical lead' from one of the other homes they ran. The home had continued to rely on the regular use of agency nursing staff due to difficulties recruiting permanent nursing staff.

The home was undergoing an extensive refurbishment at the time of our inspection that had been ongoing for approximately the last six months. The provider was not able to show us any evidence that they had consulted people living at the home or their representatives in relation to this project, or considered how they could minimise the potential disruption.

People had care plans that in most cases reflected their preferences and had been regularly reviewed. However, staff were not always aware of the content of care plans, which meant they were not working in a person centred way. One person had requested to see a dentist on their admission to the home, but no action had been taken to enable this. Another person required the use of hearing aids but staff had not supported the person to wear them. Whilst we saw some people had been involved in reviewing their care plans, this was not consistent across the home. Relatives also gave variable reports about how well staff communicated with them and involved them in their family member's care.

There was a lack of planned activities or meaningful stimulation in place for people. During the inspection we found activities staff were also used to cover care staff shifts. Some people reported they could be bored or feel isolated. The provider acknowledged that the provision of activities required improvement and told us they planned to work with activities staff to achieve this.

People gave positive feedback about the food on offer. The chef was knowledgeable about how to support people's dietary needs and meet people's preferences. We saw drinks and fresh fruit were freely available around the home.

The home was not operating effective procedures in relation to the Deprivation of Liberty Safeguards (DoLS). This meant there were people who were at risk of having their liberty deprived without proper legal authorisation.

We received mixed reports from relatives and people living at Newlands in relation to whether staff were caring in their approach. This was also reflective of our observations during the inspection where we observed both very positive, caring interactions, and less caring approaches, such as not acknowledging a person's request to use the toilet.

People had been supported to access services to a range of health professionals including GPs, tissue viability nurses (TVNs), and dieticians. We found that people had received the support they required in relation to dietary support and repositioning to reduce the risk of pressure sores. However, in some instances we found improvements were required to the records kept so that they provided a clear record of care given and the reason for taking particular decisions in relation to people's care.

Complaints were effectively monitored, investigated and responded to. People we spoke with told us they

had been satisfied with the outcome of their complaints.

The provider's quality assurance systems and systems to monitor and improve the safety and quality of the service had not been operated effectively. For example, there were no meetings to review falls or weight loss as is part of the provider's normal process. The provider had recognised many of the issues we found during the inspection but had not taken effective action to ensure they were resolved.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Medicines were not managed safely, which placed people's health and wellbeing at risk.

Checks and maintenance to help prevent risks in relation to Legionella bacteria developing in the water system had not been completed as required.

Staff were aware of their responsibilities in relation to safeguarding, and the provider had reported and investigated concerns appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had access to snacks, drinks and fresh fruit. The chef had a good knowledge about people's dietary requirements and how to meet their needs and preferences.

The provider had not managed deprivation of liberty safeguards (DoLS) applications well. This meant people were at risk of being deprived of their liberty without proper authorisation.

Staff had received supervision from a manager. However, the majority of supervisions were group supervisions that did not demonstrate staff had received appropriate individual support to undertake their roles.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Whilst we observed many positive and caring interactions from staff, we also observed one instance when a staff member did not respond to a person's request for assistance.

Reports from relatives were variable in relation to how well the home communicated with them, and how they were involved in their family member's care.

People's care plans in relation to their communication support needs were not always clear. In one instance staff had not supported a person to wear their hearing aids.

Is the service responsive?

Inadequate

The service was not responsive.

Staff were not always meeting people's assessed needs and preferences.

Handover of information between staff was not always detailed, and meant there was a risk staff were not aware of their changing care and support needs.

There were few organised activities, and little in the way of meaningful stimulation provided for people. People reported they had little to do and people's social support needs were not always met.

Is the service well-led?

Inadequate

The service was not well-led.

At the time of the inspection a registered manager was not in place and there was no qualified clinical leadership at the home. A registered nurse told us they were unsure who to go to for support and clinical decision making.

There continued to be a high turnover of managers at the home. Staff told us this had an impact on staff morale and support.

The provider's quality assurance systems had not been followed consistently. They had not been effective at ensuring identified issues were addressed in a timely way.

Newlands Nursing & 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 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 22, 23 and 28 February and the first day was unannounced. The inspection team consisted of three adult social care inspectors, a pharmacist 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.

Prior to the inspection we reviewed information we held about the service. This included notifications the provider is required to send us in relation to safeguarding, serious injuries and other significant events that occur within the service. We reviewed previous inspection reports and any information shared with us about the service via our contact centre, by email or online via a 'share your experience' web form. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

We sought feedback from other bodies with experience of working with the home. We sought feedback from the local authority quality assurance team, the clinical commissioning group (CCG), the CCG medicines management team, Stockport Healthwatch and the local authority health protection nurse. We received feedback from the quality assurance team, medicines management, CCG and health protection nurse. We used the information received to help plan our inspection.

During the inspection we spoke with 15 people living at the home, and seven friends or relatives who were visiting. We carried out observations of care in communal areas of the home and used the Short

Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 14 staff members. This included three registered nurses, seven care staff, the acting manager, the deputy manager, the chef and an assistant operations director. We also spoke with one visiting health professional. We reviewed records relating to the care people were receiving including nine care plans, daily records of care and 17 medication administration records (MARs). We reviewed other records in relation to the running of a care home, including records of training and supervision, four staff personnel files and records of maintenance, servicing and quality assurance.

Inadequate

Is the service safe?

Our findings

At our last inspection in August 2016 we identified concerns in relation to the safe management of medicines. Medicines were not always stored safely and records did not always provide staff with the required information to ensure people received their medicines safely and as prescribed. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had not been made, and there was a continued breach of the regulations in relation to the safe management of medicines.

Six people were prescribed a thickener to be added to all their fluids to prevent them from choking. The agency nurse on duty was unable to explain how thick each person's drink should be made. There was no information recorded to on the medication administration records (MARs) or on the nursing handover sheet that would quickly provide this information for the staff member. Care staff made drinks for people and were aware of the required consistency of most peoples' drinks as recorded in their care plans. However, we saw one person who should have had all their drinks thickened, had un-thickened beakers of juice and tea on their over-bed table which were used by the agency nurse when administering their tablets. This placed this person at risk of choking when being supported to take their medicines. The management in the home responded to our concerns and redesigned the handover sheets to include information in relation to peoples' requirements for thickened fluids.

People's medicines were stored in individual storage boxes inside the medicines trolley. We found medicines in peoples' storage boxes that did not belong to them. One person was given the wrong strength blood pressure tablets because they belonged to a second person. It was not possible to tell if the second person had missed a dose of their tablet. A third person had Paracetamol in their box belonging to a fourth person, and a fifth person missed a dose of their blood pressure tablets because the nurses recorded they could not find the tablets. We also found that one person had two different types of anticoagulant tablets in their storage box despite the fact one of them was not currently prescribed for them. Anticoagulant medicines are prescribed to prevent potential blood clots, but also mean people can be at higher risk of excessive bleeding if not closely monitored and controlled. Although there was no evidence to suggest this person had been administered their medicines incorrectly, the storage of the discontinued medicine along with the person's other current medicines increased the risk it would be administered inadvertently, putting this person at risk. The management responded to our concerns and spent time during the inspection checking that people had the correct medicines in their individual storage boxes.

Medication was not always administered safely and as prescribed. For example, we saw that medicines that must be given 30 to 60 minutes before food had been signed as given with medicines that had to be given with or after food. One person was prescribed an antibiotic to be given on an empty stomach. The nurse told us she had not made any arrangements to give this medication on an empty stomach because she did not know it could not be given with food. If medicines are not given in accordance with the manufacturers' instructions they may not work effectively. Another person was not given their morning medication on the first day of the inspection because the nurse told us they had forgotten to give it to them. One nurse told us they experienced frequent interruptions when carrying out the medicines rounds, which they told us they

thought was 'dangerous'. We observed some staff administering medicines wore tabards to indicate this and to help prevent disruptions that could increase the risk of errors occurring. However, we noted the nurse who raised the issue of interruptions was not wearing a tabard when they administered medicines.

People were prescribed medication to be taken when required or with a choice of dose. As at the last inspection there were still not always protocols in place on the top floor to guide nurses how to give medicines prescribed in this way safely and consistently. On the upper nursing floor we found that some people had protocols in place for some of their medicines, including laxatives, which were prescribed when required. However, the protocols directed nurses to check if people had opened their bowels, but there was no evidence that nurses had made any checks which put people at unnecessary risk of becoming constipated. Other people had no protocols in place for medicines prescribed in this way. One person was prescribed medication to be used in the event of having a seizure but the information in the plan was incomplete and failed to give robust guidance to staff as to when to administer the medication or call the emergency services. Although staff told us this person had not had a seizure that they could recall, this presented a risk that important medication required to ensure their safety would not be administered correctly. Staff did not have sufficient information to ensure people were given when required medicines safely and consistently. The managers took action and wrote "when required" protocols for people. However they were lacking in detail and still did not provide sufficient guidance to enable staff to administer these medicines safely.

The records were not clear enough to support the safe administration of the medication and were not always accurate. The records in relation to administration of creams could not always be located, and did not always show that creams had been administered properly. We saw that one nurse signed for medication that had not been given because it was out of stock. Some peoples' medicines records did not have photographs to identify them when they were being given their medicines. The management took actions to addressed this. However, this had placed people at risk of not being given the correct medication.

At the last inspection in August 2016 the medication rooms were not always kept within guideline limits. At this inspection the rooms were of a suitable temperature. However there were still no fridge temperatures recorded on the top floor, which meant we could not be certain that medicines stored in the fridge were consistently kept at an appropriate temperature.

This issues outlined above were a further continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medicines.

At our inspection in August 2016 we found the provider was not effectively assessing risk, or taking reasonable steps to reduce the risk of harm to people. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found ongoing issues in relation to taking reasonable steps to reduce risk, and found evidence of a continued breach of the regulation.

We saw staff had completed risk assessments in relation to a range of potential hazards to peoples' health and wellbeing. This included risk assessments relating to falls, pressure ulcers, mobility, choking and use of equipment such as bedrails. Risk assessments had been regularly reviewed, and there were plans in place that detailed the actions staff should take to help keep people safe. We checked whether measures identified in risk management plans were in place, and saw where required, equipment such as pressure sensors used to help reduce the risk of falls occurring was in place. However, we found staff were not always aware of plans in place to reduce risks to people.

We reviewed one person's care plan, which identified they should be offered a fork mash consistency diet or

soft sandwiches with the crusts removed. We saw staff had given this person sandwiches with the crusts on and queried this with the staff supporting them. The staff were unaware of the advice to remove the crusts, but did so when we informed them of the instructions recorded in this person's care file. Although this person did not appear to have difficulty eating the sandwiches, this had placed them at unnecessary risk of choking. On the third day of our inspection we saw this person was eating an appropriate diet, and the staff were aware of the guidance in place in relation to their eating and drinking. We found another person was left to take their medicines independently and there had been no assessment undertaken in relation to any risks this might pose to the individual or other people using the service, despite a known risk that this person could refuse to take their medicines. The management took action and produced a risk assessment and updated the care plan during the inspection.

These issues show that reasonable measures were not consistently taken to help control the risk of harm to people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2016 we found staff shifts had not always been covered when staff were absent. This included providing cover for a person funded for one to one support due to their support needs. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified continued concerns and an on-going breach of this regulation.

People told us staff responded promptly if they required assistance or used their call bell. This was generally supported by our observations during the inspection. We saw staff responded quickly if people required assistance with walking for example, and staff answered call bells without undue delay. One person we spoke with told us they thought more staff were required in the morning as there could be a delay in receiving support to use the toilet at this busy time. We also observed three occasions where people had to wait for periods of up to 10 minutes for staff to be available to support them to the toilet. Staff consistently told us they thought more staff were required, which would allow them to spend meaningful time with people and to provide them with person-centred care. However, they told us they did not feel the current staffing levels had an impact on the safety of the service or prevented them from meeting peoples' care needs.

At our last inspection in August 2016 we found the provider was not able to provide evidence of how they had determined staffing requirements, and staff absences had not always been covered on the rota. At this inspection staff told us staff absences were covered by regular or agency staff if required. The rotas reflected that staff cover was consistently provided for any absences. Whilst we found sufficient numbers of staff were on duty, we expressed concern that the home was not deploying staff with a suitable mix of skills, competence and experience to meet peoples' assessed needs. The management based at the home were not registered nurses, and there was no senior person in position to oversee and manage the clinical aspects of care. We met with the provider shortly after the inspection and they informed us they had appointed a clinical lead from another home that they ran in the area.

There was also a high use of agency nursing staff, and there were four full-time vacancies for registered nurses. This had impacted on the provision of safe care, for example, in relation to medicines management. Whilst the home employed two activities co-ordinators, we found these staff were working as carers at points during the inspection, and there was a lack of activities or meaningful stimulation for people. The maintenance person was also new in post, and shortfalls in relation to the maintenance of a safe environment were identified.

The provider had failed to ensure there were sufficient numbers of suitably qualified, competent and experienced staff employed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2016 we found a person's call bell had not been placed within their reach to allow them to call for assistance. We found this to be a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found staff had ensured peoples' call bells were within easy reach. However, we identified other issues in relation to the premises and equipment, which were an ongoing breach of this regulation.

During our tour of the building we found several areas that were being used inappropriately for storage of equipment and other items. For example, we found a crash mat propped up against the wall in a lounge, one person's en-suite contained seat cushions, a bed-pan lid and wheelchair parts. We also found one of the bathrooms contained equipment including a commode, stand aid and transfer board. At our last inspection we found an area in a stairwell that was used for storage of furniture and equipment, despite a sign in this area stating 'Do not use as a storage area'. We again found this area to be used for the storage of furniture and equipment. We raised this issue with the management who took action to clear these areas.

We found the premises and equipment was not always kept clean and tidy. The home was undergoing a significant refurbishment at the time of our visit, which the provider had informed us would be completed by the end of February 2017. However, we found areas where refurbishment had not been completed where paintwork was chipped and where there was torn and marked wallpaper. The management were not clear as to when or whether these particular areas would be redecorated. We also found a fridge in one of the communal lounge/dining areas contained what appeared to be spilt milk that gave off a bad odour, and another item of food that was past its' expiry date. One person's bedroom we visited contained a chair that had no cushion on it and was heavily stained. This shows adequate steps were not taken to keep the environment clean, which could pose a potential risk in relation to the prevention and control of infection.

We also identified shortfalls in relation to the maintenance of equipment and the environment. One person's wheelchair was missing a foot-plate and an armrest. If the chair was used in this condition it would present a risk of discomfort or injury because appropriate wheelchair maintenance had not taken place. The person told us they had recently used the chair and found it uncomfortable due to its condition. The chair was also unclean and stained. Management told us the chair was not used without footplates in place, but confirmed there had been no audits of wheelchairs carried out. We saw routine maintenance and servicing of lifting equipment, electrical and gas systems at the home had been carried out in accordance with relevant guidance. However, routine maintenance procedures to control the risks of legionella in the water system had not been completed as required according to the homes' legionella survey. For example, flushing of infrequently used outlets should have been completed weekly, but there was no record of flushing since December 2016. The provider was also unable to locate records of hot and cold water temperature checks, which should have been completed monthly. The provider told us a new maintenance person had been recently recruited and was in the process of being trained to undertake these tasks at the time of the inspection. They also provided evidence that the required checks were now being completed. Legionella is a bacteria that can result in serious illnesses, to which people living in care home can be particularly susceptible.

These shortfalls in relation to the maintenance of a safe and clean environment were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2016 we found systems in place for checking the registration status of

nursing staff had not been effective, and checks were not recorded for all nursing staff. We found this to be a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, and the provider was meeting the requirements of this regulation.

We saw the provider had followed robust recruitment procedures when employing staff to help ensure they were of suitable character for the position they were being employed for. This included carrying out an interview, receiving references from former employers, and obtaining a full employment history. The provider had received evidence of disclosure and barring service (DBS) checks prior to employing staff. DBS checks indicate if an applicant has any convictions or is barred from working with vulnerable people. We saw the provider had followed safe practices where DBS checks highlighted potential concerns by conducting a risk assessment that considered the applicants suitability for the job role, and whether any steps were required to reduce any potential risk posed. We saw checks of nursing staffs' registration with the nursing and midwifery council had been completed on a regular basis.

Prior to the inspection the provider made us aware there had been a delay in the reporting of a serious safeguarding concern. We found the provider had acted appropriately to address this issue. Staff we spoke with were aware of how to identify potential signs of abuse or neglect, and of how to report such issues. They told us they felt confident to raise any concerns they might have with management at the home and that their concerns would be acted upon. One staff member told us; "If we know something is not right we speak to someone in charge." The acting manager had a good knowledge of recent safeguarding concerns, and we saw they kept a log of any safeguarding concerns raised. Records showed that concerns had been thoroughly investigated by the provider when it was appropriate for them to do so, and the provider had taken appropriate actions to keep people safe, including following their disciplinary procedures when required.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in August 2016 we identified concerns that records did not demonstrate peoples' healthcare needs were being met in relation to areas including pressure care, wound care, and care provided to people with a percutaneous endoscopic gastrostomy (PEG) in place. A PEG is a tube that is inserted into the stomach, often to provide food, fluids or medicines to people who are not able to take them orally. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, and the provider was meeting the requirements of the regulation in relation to this previously identified concern.

A range of health professionals including GPs, dieticians, speech and language therapists (SALTs) and tissue viability nurses (TVNs) had been involved in peoples' health care. We saw that staff identified and acted on potential health concerns. For instance, we heard a member of care staff informing the nurse that a person had been awake a lot of the night and had appeared confused. The nurse directed the care staff to obtain a urine same to rule out a possible urine infection. The records we reviewed showed that plans of care in relation to wound management, pressure relief and PEG care had been followed as required.

At our last inspection in August 2016 we found staff had not received regular supervision, there was a lack of evidence that nursing staff were competent in specific tasks and evidence could not be provided that agency staff had received an adequate induction. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst we identified some areas of improvement at this inspection, we had continued concerns in relation to the provision of appropriate support and supervision to staff, which was an ongoing breach of this regulation.

At our last inspection the provider was not able to show us evidence that agency staff received an adequate induction. At this inspection we saw agency staff had a profile in place that reflected their areas of training and competence, as well as details of their induction at the home.

Two relatives expressed some reservations in relation to staff competence. One relative told us; "If [named staff] are on duty, I don't need to worry. Otherwise I do worry about [family member]." The second relative told us; "One or two staff I don't feel are capable. The regular staff understand [family member]. The new [staff] don't support [family member] to the toilet regularly." One health professional told us they thought the home provided good care to people and that staff met their needs. Staff told us they felt they received sufficient training that enabled them to undertake their roles competently. We saw staff had completed training in a range of areas including; moving and handling, safeguarding, food safety and falls awareness. We saw evidence that new staff were supported to complete the care certificate, and were regularly supervised during the induction period. We spoke with a member of staff who had recently been through the induction process who told us they had received a good induction that included opportunity to 'shadow' experienced staff members before they were signed off as competent by the acting manager.

We viewed the providers' supervision tracker, which showed approximately 80% of the 62 staff had received a recent supervision. Staff we spoke with told us they received supervision with varying frequency of

between around two and six months, and one staff member told us they thought the regular turnover of manager had impacted the frequency with which supervision was provided. We looked at records of recent supervisions and saw the majority of these consisted of pre-typed forms that related to specific issues the acting manager wanted to address such as time-keeping and records. These records did not demonstrate that staff had been given opportunity to reflect on their practice, discuss areas of concern or receive support from their manager, which are important aspects of supervision. The acting manager told us these records were group supervisions, and that they would be holding more one to one sessions with staff in the future. We also found there had been no recent appraisals of staff performance carried out. The acting manager told us they were currently getting to know staff and would carry out appraisals in the near future. Staff appraisal is an important mechanism by which supervisors can support a member of staff's development and assess their performance.

These shortfalls in the support of staff were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received positive feedback in relation to the food provided at the home. People told us the enjoyed the food, were given choices and were able to request alternatives if they didn't like what was on the menu. One person told us; "The food is very good, you get variety." Another person said; "The food is very nice, I like it. It's much like a restaurant." We saw drinks and snacks, including fresh fruit were freely available for people to help themselves to throughout the home. We observed the support provided to people at meal times and saw the meal times were a social and relaxed experience. Staff interacted well with people and provided discreet assistance to ensure people received the encouragement and support they required to eat and drink.

We saw peoples' preferences in relation to the support they received in relation to eating and drinking, as well as where they ate their meals was recorded in their care plans. Records of preferences and dietary requirements were also made and shared with the chef, which would help them to plan meals that met peoples' needs and preferences. We spoke with the chef who was enthusiastic and demonstrated a good understanding of how to prepare foods that met peoples' needs and preferences, and supported good health.

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 provider had submitted DoLS applications to the supervisory body for 10 people where they had identified restrictive practices may be required. We identified one person that would be likely to require a DoLS due to staff reports that they had appeared confused and wanted to leave to the home during the night. The provider accepted that this person would require a DoLS and told us their condition had recently declined. They also accepted other people living at the home may require a DoLS and said they would carry out a full review and submit any required applications. We also found authorised DoLS applications for three people had been allowed to expire as re-applications had not been made. The provider informed us they had submitted the required applications to the supervisory body during the course of our inspection.

These shortfalls in practice in relation to DoLS meant people were at risk of being deprived of their liberty without proper legal authorisation. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

We saw people had assessments in their files to assess their capacity to consent to their care. Where the individual was able, they had also signed to indicate their agreement. Staff were able to tell us how they would seek consent from individuals, including people who might have limited verbal communication. There was also information in peoples' care plans that explained how that person could communicate their consent if unable to do so verbally, for example through the use of different gestures or facial expressions. During the inspection we saw staff routinely asked for peoples' permission prior to providing any support, such as assisting people with a hoist.

Where people lacked the capacity to consent to more significant decisions, such as the use of bedrails, we saw best interests decisions had been recorded that included the views of staff and appropriate representatives for that person. We also saw evidence of good practice in relation to people who declined to follow the advice of health professionals in relation to their diets for example. Staff had explained the risks to these people and had carried out capacity assessments to help determine whether these people could understand the information and make an informed decision in relation to choosing not to follow the advice given to them.

Requires Improvement

Is the service caring?

Our findings

We received a mix of responses from people and relatives in relation to the staff approach. Some people reported negative experiences. For instance, some people told us staff were friendly, approachable and looked after them well. One person said; "The staff are very good and we are all good friends." However, other people reported less positive experiences. One person said; "I asked a nurse to get me water once and she said, 'it's not my job' so I never asked again. A relative we spoke with told us; "There seems to be a lack of care. They don't seem interested."

During the inspection, the majority of interactions we observed between staff and people living at the home were positive and caring. Staff addressed people by their preferred names, and the staff we spoke with demonstrated a good understanding of the needs and preferences of the people they supported. We saw staff supported people at a comfortable pace and engaged people in conversation when there was opportunity to do so. At one point in the inspection we observed a member of staff express concern for a person's welfare who had told staff they were going to go to the shop in poor weather conditions. The staff member reassured the person that it was their choice if they wanted to go to the shop, but expressed their concern in relation to the poor weather. They then offered to get the items the person wanted from the kitchen and from the shop later on to save the person from having to go out. The person was happy with and agreed to this arrangement.

We also observed instances where interactions and support were not caring. Staff told us it was required that one member of staff constantly supervised the main communal areas on each floor of the home when they were in use. They told us this created difficulties when more than one member of staff was required to provide support to people with mobility needs. Whilst there was a good reason for the communal areas to be supervised to help keep people safe, this also meant there could be a delay in providing support to people. We observed people who asked staff for support to use the toilet had to wait for periods of up to ten minutes. Also, staff did not always reassure people that support would soon be provided, and in one case did not acknowledge a person's requests to use the toilet. This meant the delays in providing support to people might have a negative impact on a people's dignity. We raised this with the management who told us they would address this with the staff team.

Care plans contained information on how staff should support effective communication with that person, including details about any non-verbal communications the person used. However, we found two peoples' care plans were not clear about their needs in relation to their hearing. One care plan contradicted their pre-admission assessment in relation to a potential hearing impairment. Another person's care plan stated their hearing was 'good' and it was only mentioned in a previous review of the care plan that this person required two hearing aids. We saw this person was not wearing any hearing aids. When we asked staff about this, one staff member told us they didn't think the person used hearing aids, and the second staff member told us the night staff should have supported the person to put the hearing aids in. This meant staff were not providing care in accordance with their assessed needs to support them to communicate effectively.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Records of training showed that only one staff member had received training in end of life care. The acting manager told us there was no-one at the home at that time who was receiving end of life care, and that they had requested training in this area. We saw a record of positive feedback that staff at the home had received in relation to the care they provided to a person's family member at the time of their death. The relative complimented the kind and caring approach of staff to their family member, and also the 'kind, personal, professional and caring' way that staff had delivered the new of their family members passing to them.

Staff told us they would ensure people's privacy and dignity was respected by allowing people to sit in their rooms if they preferred, speaking to people and asking their preferences and ensuring people were covered when providing personal care. One staff member also talked about the importance of acting in a friendly, but professional manner and offering distractions to help avoid people becoming embarrassed. We saw that people looked clean and well cared for, and this was also reported by relatives we spoke with. Several people we spoke with talked about enjoying being supported to see the visiting hairdresser on a regular basis. Care plans also contained guidance for staff in relation to supporting peoples' dignity. For example, one care plan directed staff to observe the person 'discreetly' to ensure assistance could be provided if required, but to avoid this person feeling like they were being treated as a child.

At our last inspection in August 2016 we found that confidential records were not always stored securely. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the requirements of the regulation in relation to this area of concern.

Since our last inspection most of the former 'nursing stations' located on the corridors of each floor had been removed and replaced with secure office areas as part of the ongoing refurbishment. However, this work had not been completed on the top floor where we saw a large wipe board that showed details about peoples' care needs, including dietary requirements, falls risk and any equipment used detailed against their room number and initials. The top floor provided care to people on a generally short term basis as they were discharged from hospital care. It was therefore important that this information was easily updated and accessible, however this information was also freely accessible to any person accessing this area of the home.

We recommend the provider reviews their procedures in relation to the handling of personal information.

We received a varied response from relatives we spoke with about how they were involved in their family member's care, where this was appropriate. We saw evidence that reviews of care had taken place for people living on two of the four floors of the home. Where carried out, these reviews involved the person, staff at the home and others involved in that person's care, including family members. However, there was no evidence of such reviews for people living in the Cedar (nursing) part of the home. Relatives told us they were made to feel welcome, however we received reports that communication between relatives and staff at the home was not always good. One relative told us they informed staff of a planned meal out with their family member, but when they arrived at the home their family member was in the dining room eating their meal. Another relative told us they were not always updated about their family member's care and said; "We know things will happen, but we are not being told what is happening." A third relative said when they enquired with staff how their family member had been over night, they were usually told; "fine", but felt this was due to poor communication between the day and night staff.

Inadequate

Is the service responsive?

Our findings

At our last inspection in August 2016 we found care plans had not been regularly re-written to ensure they were reflective of peoples' current needs. We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found adequate improvements had not been made and there was an ongoing breach of this regulation.

Pre-admission assessments had been completed prior to people moving to Newlands to help determine if the home could meet peoples' needs and preferences, and to provide staff with this information when a person first moved in. Pre-admission assessments were completed either by staff at the home, or in the case of the 'intermediate care unit' (Beech) by a liaison nurse from the clinical commissioning group (CCG). We saw peoples' needs had also been re-assessed if they moved between the different care settings within the home.

We found care plans contained a good level of detail in relation to peoples' needs and preferences, and had been regularly reviewed. Staff had assessed people's preferences in relation to a range of areas, including food, gender of carer and how they were supported with personal care. People and their relatives had also been involved in putting together information about their social history, significant events in their lives and people who were important to them. This information would help staff get to know people and deliver care in a more person centred way.

However, as at our last inspection, we found care plans did not always clearly document the most recent information in relation to peoples' care needs and preferences. As discussed in other sections of this report, we found one care plan didn't clearly document a person's communication support needs, and another care plan was difficult to follow in relation to a person's dietary requirements. On Beech, we found a number of peoples' care files contained blank assessments. The provider told us these assessments were not relevant, and they would review the care plan package for people living on Beech to ensure they were fit for purpose. We also found people with health care needs did not always have corresponding care plans in place. For instance we found care plans were not in place for a person whose assessment indicated they had Parkinson's, which is a progressive neurological condition. This meant people using the service might not receive additional support for meeting their care and treatment needs when required.

We found evidence that staff were not always following care plans to meet peoples assessed needs and preferences. For example, we saw one person's care plan detailed that they liked one sugar in their tea/coffee. However, we observed staff did not put any sugar in this person's drink and did not offer this person any sugar. Another person told us they had asked staff to see a dentist when they had moved to the home, and this was also recorded in their pre-admission assessment that had been completed one month prior to our inspection. The person told us they had not seen a dentist, and staff were also unable to confirm that any action had been taken to meet this request. We also found there was no information recorded in this person's care documents about the support they required in relation to oral hygiene. This meant this person's care needs had not been fully assessed and meant there was a risk staff would not deliver the care they required.

These issues in relation to the assessment and meeting of needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Over the course of our three day inspection we saw limited activities taking place, and there were few attempts by staff to engage people in meaningful activities or social interaction that would prevent them from becoming isolated. Staff told us they felt there was not sufficient provision of meaningful activities and stimulation for people and told us staff had limited opportunity to support activities due to other demands on their time. The provider acknowledged that the provision of activities needed to be developed, and they told us they were working with the newly recruited activities co-ordinator to achieve this. During the inspection we also found activities staff were being used to cover care staff shifts rather than to provide activities. People living at Newlands also reported there were limited activities available that interested them. Comments made included; "I don't do much. I like to read and I've got a crossword book," "There is not a lot of activity for people. There is something once a week. Last Thursday it was baking, but there is no list of entertainment or activities," "I read a book and watch TV. I used to go to painting classes, but haven't been for over a year. I miss that. I miss the people," and "I'm pretty lonely. They [the staff] are alright, I get on with them, lonely but okay." It is important that people are offered the opportunity to engage in meaningful activities as a way of supporting social interaction, physical health and mental wellbeing.

Staff told us they would not always be confident that changes in peoples' care needs would be communicated to them, for example, following a period of absence. This was also an issue we identified at our inspection in August 2016. One member of staff told us they would look back over previous handover records to help ensure they were aware of any changes to peoples' needs. However, we found handover records were completed to a variable standard. One handover record we viewed that had been provided to an agency nurse provided very limited details in relation to people's presentation or care needs, for example stating 'slept well' or 'settled'. The agency nurse also told us the handover provided to them was, 'not very good'. Poor quality staff handover would increase the risks that staff would not be aware of people's current needs. We raised this concern with the management who revised the template for handover records to include pre-populated details in relation to peoples' key care and support needs. The provider also informed us they had introduced 15 minute handovers between shifts to help ensure staff received the information they needed to provide safe and effective care.

The provider was not meeting peoples' social support needs, which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with who had raised concerns or complaints told us they had been satisfied that the provider had taken reasonable action to address any issues. One person told us; "I'm well looked after. There have been one or two occasions when it has not been good, but they have sorted it out." We saw a record of concerns, complaints and compliments was kept on the providers' electronic care management system. This showed that complaints raised had been investigated and responded to appropriately. We also saw the provider logged, and where possible acted upon information of concern received via third parties such as online review websites and any concerns raised with the management by the Care Quality Commission (CQC).

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection and the service had been without a registered manager for the past six months. At our last inspection in August 2016 there was a newly appointed acting manager in post. At that time we reported on the high turnover of registered managers at the home, finding there had been three registered managers in post in the preceding three years. Since our last inspection, there had been further changes in the management of the home. The acting manager in post at our last inspection had left and been replaced by a second acting manager who also left the service whilst in the process of registering with CQC. The provider had appointed the current acting manager internally from another home they ran. The provider told us the current acting manager had a 'long service' with the provider and an 'impressive track record'. The acting manager was in the process of registering with the CQC, and told us they intended to stay at the home until at least December 2017.

We expressed concern about both the high turnover of managers at the home, and the level of support in the home available to the manager. This was particularly in relation to the size of the home, scale of the work in relation to improvements required at the home, and the complexity of the service given the different models of care provided within the service. The acting manager was supported by a deputy manager. However, they provided direct support to people using the service three of the four days a week that they worked, and as a result had limited time to support the acting manager with their management responsibilities. An 'assistant operations director' also provided support to the acting manager, although they were responsible for a portfolio of homes run by the provider, and as such were not based full-time at the home. The provider told us they would discuss the issue of support with the acting manager and review whether any changes to the management structure at the home were required.

The majority of the people living at the home received nursing care however there was no clinical lead in place at the home. Neither the acting manager nor the deputy manager, were registered nurses, and one nurse we spoke with questioned who they could go to if they required support in relation to making clinical decisions. There was also frequent use of agency nurses at the home. This increased the risk that the home would not be able to provide consistent and effective nursing care. The lack of effective clinical leadership meant the provider could not ensure consistently good quality, safe and efficient care to meet people's identified needs. The provider informed us shortly after the inspection that they had appointed a clinical lead to work at the home.

Staff told us they found their colleagues supportive, and said that they worked well as a team. However they also felt the high turnover of managers at the home had an impact on staff morale, how well the home ran, and the support they received. One staff member told us; "I find the turnover of managers has an impact on staff. You get used to one and things change… [Acting manager] is here, but they are new and busy implementing new things." Staff told us they felt valued and appreciated by people living at the home, but not always by the provider. The provider ran a reward scheme where staff, managers and people using the service could nominate teams or individuals who had made particularly positive and caring contributions. We were told no recent nominations had been received at this home.

At our last inspection in August 2016 we found accurate records of care were not consistently maintained. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although further progress was required in relation to the keeping of accurate records, we found the provider had made improvements and was now meeting the requirements of this regulation.

We saw that where peoples' health or particular aspects of their care needed to be monitored that appropriate records were usually in place. This included records of food and fluid intake, support to reposition and records of PEG care. These records had been regularly updated and showed that people had received their care as planned. However, we found one person did not have a record of output for their catheter, and a second persons' documentation in relation to wound care had not been correctly completed. Whilst we could see from the records that this person had received the correct care, the inconsistency in documentation would increase the risk that this person's wound condition would not be appropriately monitored. On Beech (the intermediate care unit) we found there were weekly 'ward rounds' that included a GP, nurse from the CCG, and staff from the home. There were no records kept by staff at Newlands of these meetings, which meant the home would not always be able to demonstrate a clear rationale for taking particular decisions in relation to peoples' care. The provider informed us they would introduce a signed check of supplementary records, and would introduce a record of the 'ward rounds'.

At the time of our inspection extensive refurbishment and re-design of the home was taking place. Areas including communal lounges, dining areas, clinic rooms and the reception areas had been redecorated, re-furnished and their layouts changed. The provider had informed us of the pending refurbishment at our last inspection in August 2016, but was unable to provide evidence of any consultation with people using the service or their representatives in relation to the plans, and potential impact of the works being undertaken. During our inspection we saw the team completing the refurbishment interacted considerately and politely with people using the service, and took appropriate steps to help ensure the environment was safe. However, there was also evidence of disruption and impact on people using the service due to the works that had been ongoing for around six months. For example, when we arrived at the home on our first day of inspection at approximately 7:40am we saw works had already started and there was the noise of sanding taking place. We also saw sections of the home were temporarily closed, such as a main corridor whilst a carpet was replaced and one of the main dining areas on Cedar. It was apparent two people who used the service were agitated as a result of the increase in builders and maintenance works taking place in the home.

The provider shared the project plan with us, but there was no evidence in this that they had considered the potential disruption to people living at the home, or how to minimise this. The provider told us consultation would have taken place with people using the service, and that resident and relatives meetings had been scheduled to discuss the works, but were not attended by anyone.

The provider had not taken reasonable steps to seek and act on feedback from people using the service or their representatives, and could not demonstrate they had considered how to minimise the impact of works being undertaken to the home. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed the concerns we identified with the provider and acting manager during the course of our inspection. We found they went to significant efforts to make immediate changes at the home to help ensure people were safe and not being put at risk. This included a full stock-check of medicines and the production of a new handover record that detailed key information that staff would require to ensure they were able to provide people with safe care. We were also informed shortly after the inspection that a registered nurse from one of the providers' other homes had been appointed to work as the clinical lead at

the home. However, these actions had not been taken until prompted by our inspection.

At our last inspection in August 2016 we found systems in place to assess, monitor and improve the quality and safety of the service had not been operated effectively. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had not been made, and there was a continued breach of this regulation.

The provider had comprehensive quality assurance systems in place, but we found these had not always been fully utilised. This shortfall had also been recognised by the provider during their audits of the service, but not effectively addressed. For instance, we found records of daily walk arounds by the manager had not been completed consistently, two audits of meal time experience were incomplete and there were no audits of care plans on Beech. Whilst the provider was able produce information in relation to trends in relation to accidents and hospital admissions for example, there was no evidence this information had been reviewed at home level to help monitor or improve the safety of the service. The providers' systems in relation to risk management for falls and weight loss were also not consistently followed. There had been no recent team meetings held to review incidents and to review what actions were required to improve the safety of the service. We also found checks required to monitor the safety of the premises and equipment had not been completed as required, including checks relating to the control of legionella and wheelchair audits. The provider had also not taken actions they had identified in their provider information return (PIR) that they submitted to CQC in August 2016 to make improvements to the service such as making more use of a minibus to provide outings from the home, and to provide staff with end of life care training.

We identified ongoing concerns first identified at our inspection in August 2016, as well as ongoing breaches of the regulations. Despite the service having been rated as inadequate at our last inspection, we found limited evidence of improvement at the home. Audits of the service conducted by both the acting managers, and by the provider also recognised a number of the issues we found, including audits of medicines, which showed that medicines had 'failed' to meet expected standards in all areas of the home. The provider had recently conducted an 'internal inspection' that was carried out on 01 February 2017. This highlighted that medicines were not safe in addition to finding issues in relation to the management of DoLS and following the providers' quality assurance systems. These were also areas of concern identified in the course of our inspection. Despite the provider being aware of such concerns, that they had identified as being potential breaches of the regulations, there had been a lack of effective action to ensure these issues were addressed to ensure the service was safe and meeting people's needs.

The issues identified in the previous two paragraphs show that the provider was not operating effective systems to adequately assess, monitor or improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not adequately assessing, nor meeting people's needs and preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Reasonably practicable steps were not taken to assess and mitigate risks to people using the service. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were being deprived of their liberty without proper legal authorisation. Regulation 13(1)(2)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider was not ensuring the premises

	and equipment were clean and properly maintained. Regulation 15(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not adequately assessing or monitoring the quality and safety of the service and was not taking appropriate steps to mitigate potential risks. The provider had not sought and acted on feedback from people using the service or their representatives in relation to planned changes at the home. Regulation 17(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff with an sufficient skill mix were deployed in order to meet people's needs. Regulation 18(1) The provider had not ensured staff were adequately supported through the provision of supervision. Regulation 18(2)