Highcliffe Nursing Services Limited

Newtown House

Inspection report

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Date of inspection visit:
03 October 2018
04 October 2018

Date of publication:
07 November 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 3 and 4 October 2018 was unannounced on the first day and announced on the second. The service provides residential nursing care to older people some of whom are living with a dementia. The service is registered for 26 people. At the time of our inspection there were 19 people receiving care. The accommodation is over two floors and includes specialist bathrooms, in-house laundry and catering facilities.

Newtown House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Risks identified for people had not been monitored and reviewed in order to minimise the risks of avoidable harm. People were at risk as medicine administration was not always carried out in a safe way.

People had a well-balanced diet and drinks were always available. The dining experience was not dementia friendly. Pictorial information was not available to assist people make choices, dining table space was very limited and main meals and deserts served together which created confusion for some people eating independently.

We recommended the service consider NICE guidance on dementia friendly care home environments or similar professional guidance when reviewing peoples eating and drinking needs and experiences.

Auditing processes were in place but had not been effective in highlighting the areas requiring improvement found at inspection. Throughout our inspection the registered manager was responsive to our findings and provided an action plan on our second day detailing how the shortfalls would be addressed.

People were supported by staff that had completed safeguarding training and understood their role in recognising and reporting any suspected abuse. People were protected from discrimination as staff had completed equality and diversity training. People were protected from avoidable infection as infection control practices were followed by the staff team. When things went wrong such as accidents and incidents these were used as opportunities to reflect, learn and continually drive improvement.

Prior to admission people had been involved in assessments which captured their care needs and choices. This information had been used to create person centred care plans that reflected people's individuality and diversity. People had an opportunity to be involved in end of life care plans that reflected their diversity and

choices. Staff had been recruited safely ensuring they were suitable to work with vulnerable adults. They completed an induction and on-going training which provided them with the skills for their roles and had opportunities for professional development. Partnerships with other agencies such as mental health specialists enabled effective care for people. People were supported with access to both emergency and planned healthcare.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their families described the staff as kind, patient and caring. People felt involved in decisions about their care and day to day life's and had their privacy, dignity and independence respected. A complaints process was in place that people felt able to use and told us they would be listened to and actions taken.

People, their families and the staff team described the service as well led and described the registered manager as visible and somebody who listened and got things done. Staff understood their roles and responsibilities, felt appreciated in their role and spoke positively about teamwork and communication.

Opportunities were available for people, families and the staff team to be engaged in developing the service through meetings, a regular newsletter, quality assurance processes and a suggestion box.

The staff team worked with other organisations and professionals to ensure people received good care. These included 'Skills for Care' and the National Institute for Clinical Excellence to keep up to date with best practice guidance. Links had also been made with a local university and Newtown House offered student nurse mentored placements. Information had been shared appropriately with other agencies such as the safeguarding teams and social care commissioners.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People had their risks assessed but actions to minimise avoidable harm had not always been effective in monitoring and reviewing change.

People did not always have their medicines administered safely. Details were not always available to ensure the correct application of topical creams or medicines prescribed for as and when required.

People felt safe and were supported by staff who had been trained to recognise and take the appropriate actions if they suspected abuse.

Staff had been recruited safely and staffing levels met people's needs.

People were protected from avoidable infections.

When things went wrong lessons were learnt and used as opportunities to improve practice.

Is the service effective?

Requires Improvement

The service was not always effective.

People received a well-balanced diet and enough fluids but the dining experience was not dementia friendly.

The indoor space provided private areas and places to socialise but did not have enough dining space for people to sit and eat together.

People were involved in pre- admission assessments which captured peoples care needs and choices reflecting people's diversity.

Staff had completed an induction and on-going training and support that enabled them to carry out their roles effectively.

Working with other organisations had enabled effective outcomes for people.

People were supported in line with the Mental Capacity Act and had their rights upheld.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and patient and provided support to people at their pace.

People felt involved in decisions about their care and day to day lives.

People had their privacy, dignity and independence respected.

Is the service responsive?

Good

The service was responsive.

People had person centred care plans that reflected their care needs and lifestyle choices and were regularly reviewed.

People knew how to raise a complaint and felt if they did they would be listened to and actions taken.

People had an opportunity to be involved in end of life planning and had their wishes respected.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality audits had not been effective in identifying areas that required improvement highlighted at inspection. When areas of improvement had been identified actions were taken in a timely manner.

People, their families and staff had an opportunity to be involved and engaged with the development of the service.

Staff understood their roles and responsibilities, felt appreciated and part of a team.

The service worked with other agencies and had promoted learning and best practice.

Newtown House

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.

The inspection was carried out by one inspector and began on the 3 October 2018 and was unannounced. The inspection continued the 4 October 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with six people who used the service and two relatives. We spoke with the registered manager, deputy manager, two nurses and four care staff, two chefs and a catering assistant. We reviewed six peoples care files and discussed the accuracy with the people and care workers. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

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

After the inspection we spoke with a community mental health nurse who had experience of the service.

Requires Improvement

Is the service safe?

Our findings

People had their risks assessed and actions put in place to minimise avoidable harm. However, these actions had not always been monitored effectively which meant changes to people's risks had not always been identified or reviewed. Medicine administration had not always been carried out in a safe way.

One person was at risk of malnutrition and had their weight recorded each week. In July 2018 their weight record showed a loss of 12kg over a one week period and the loss was recorded for a further three weeks. The record then showed in one week they had gained 11kg but the staff comment noted a loss of 0.7kg. No actions had been taken to review the recorded changes in weight accuracy or any impact on the person. Risk assessments for malnutrition in June and July 2018 had not been completed. We spoke with the registered manager who agreed the changes in recorded weight should have been explored and arranged for an immediate review of their weight. They allocated the deputy manager the responsibility of monitoring weight audits.

One person had been assessed as at risk of falling. Information gathered prior to admission stated they were cared for in bed and required bed rails to prevent a fall. A risk assessment on admission had been completed to assess the safety of using bed rails and had determined bed rails were safe to be used. We read three daily entries since 20 September 2018 stating the person had been attempting to climb out of bed. A care worker told us "(Name) can wiggle around in the bed and their head is one end and feet over the rail". This information had not been used to review the ongoing safety of using bed rails. The person had their bed set at a low setting and a crash mat at the side of the bed to reduce the risk of harm should they have fallen. We discussed this with the registered manager who arranged for an immediate review of the bed rails and falls risk assessment.

Medicines had not always been administered safely. Some people had medicine prescribed for as and when required (PRN). Protocols were in place but had not always been used to ensure consistent and appropriate administration of medicines. One person had been prescribed one or two paracetamols four times a day for pain relief. Staff had recorded how many tablets given but had not provided details of why, there effectiveness or the exact time given. This meant the person was at risk of receiving medicine inappropriately and outside of safe time parameters.

One person had been prescribed an inhaler PRN for times when they got breathless. A protocol was not in place to ensure consistent decisions for administering the medicine. The medicine had not been included on risk assessments when the person went out into the community. This meant they were at risk of not receiving medicines when required.

People were at risk of not having their topical creams administered safely. One person had two creams that read 'apply as directed'. The creams that were stored in people's rooms and applied by care workers did not always have body charts or instructions indicating where a cream needed to be applied or how often. Another person had a steroid cream on their medicine record which stated apply twice a day. The cream was not on the medicine trolley and the registered nurse told us it had been stopped but records had not

been changed to reflect this. We discussed our findings with the registered manager. They told us they would ensure topical cream charts were in place, PRN protocols reviewed and in place with PRN medicines recorded with the necessary detail. They also told us they would review no longer used medicines with the pharmacy.

Risks identified for people had not been monitored and reviewed in order to minimise the risks of avoidable harm. People were at risk as medicine administration was not always carried out in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

When people were at risk of skin damage specialist pressure relieving equipment was in place including air mattresses. These were checked daily to ensure they were working correctly and set at the right pressure.

When people had a risk of choking assessments had been carried out by a speech and language therapist (SALT). Staff were aware of people who required thickened drinks and soft textured diets.

People had Personal Emergency Evacuation Plans (PEEPs) which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People and their families spoke positively about the care and felt safe. One person told us "The staff are kind I've never been ill treated". Another said "There's always people about; that's the main thing. They check my windows every night and make sure they're locked". All staff had completed safeguarding training and understood their role in reporting any concerns including reporting poor practice. The registered manager understood their responsibility ensuring concerns would be raised appropriately with external agencies such as the local authority and CQC. People were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

Staff had been recruited safely including checks with the disclosure and barring service to ensure they were suitable to work with vulnerable adults. People told us there were enough staff to meet their needs and their call bells were answered in a reasonable time. A care worker told us "There are always enough staff on the rota which is quite good. We have bank and agency staff when needed".

People were protected from avoidable risks of infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand cleansing facilities were available around the building. All areas of the home were clean and odour free.

When things went wrong lessons were learnt. Accidents and incidents were used as an opportunity for learning and led to improvements. For example, one person became agitated and this had led to a high number of falls. Staff had worked with the community mental health team reviewing medicines and recording triggers to the persons behaviour. This had led to additional staff support for the person and a significant reduction in falls.

Requires Improvement

Is the service effective?

Our findings

People had their eating and drinking requirements assessed on admission to Newtown House. Information included associated risks, specialist diets, cultural and religious requirements and any likes and dislikes. Information collected formed part of people's care and support plans and had been shared with the catering team. However, information shared with the catering team had not been kept up to date which meant people did not always have an appropriate meal. One person's catering information stated vegetarian but their care records stated they also enjoyed fish. On the day of our inspection fish had been the meal of the day they had not been offered this choice.

People told us choice was limited. One person told us "You get a choice but not much of one. They will do something different if you ask". The daily lunch menu included one main meal option. We spoke with the chef who showed us a range of alternatives that were always available including jacket potatoes, salads or something specially requested. Some people lived with a dementia but no additional support such as pictures were used to help them understand and make choices. We discussed this with the registered manager. They told us they would arrange for the weekly menu to clearly show two main meal choices and list alternatives. They also said pictorial prompts would be sourced to assist people with making choices.

People had limited choice about where they could have their meals. There was one dining table in the lounge area which on the days of our inspection was used by one person being supported with their meal by a care worker. People who chose to eat with others in the lounge area sat in armchairs with chair tables. There were seven people in armchairs and this was the rooms full capacity. We discussed this with the registered manager. When we returned on the second day of our inspection they had spoken with directors of the service who agreed an empty bedroom on the ground floor could be altered to provide additional dining room space. They told us this would be in place by November 2018.

We observed people with dexterity or sensory problems experiencing difficulties such as navigating the distance from their plates when eating. We observed main meals and deserts being left on chair tables at the same time. Two people found this confusing and mixed the two dishes together. One desert option was hot and had become cold by the time some people had finished their main meal. Other people were having their meal in their bedrooms either with chair tables or whilst remaining in bed.

People told us the food was good with one person telling us "I particularly like the salmon or chicken meals". We observed meals which had been freshly cooked and were well balanced. Fresh drinks were available and being offered throughout the day. Bowls of fruit were available in the lounge area.

We recommended the service consider NICE guidance on dementia friendly care home environments or similar professional guidance when reviewing peoples eating and drinking needs and experiences.

People, their families and when appropriate health and social care professionals had been involved in pre-admission assessments which had been used to gather information about people's care needs and lifestyle choices. The assessments gathered information about a person's medical history and how they needed

support whilst reflecting their level of independence. The information had been used to create person centred care plans which had been developed in line with current legislative standards and good practice guidance. Were assessments had included equipment such as a pressure relieving mattress these had been in place prior to admission.

Staff had completed an induction and received on-going training and support that enabled them to carry out their roles effectively. Induction included for some staff the Care Certificate. The Care Certificate sets out common induction standards for social care staff. A care worker told us "It built my confidence shadowing a senior carer". Another care worker explained how they had benefited from dementia training. "It helped me understand (people) better. Sometimes (people) do things and you can't understand why and you have to be patient; it's important to understand the person". Nurses had completed clinical training and updates including palliative care and syringe driver competencies. Staff received supervision and an annual appraisal and had opportunities for professional development including national diplomas in health and social care.

The service worked with other organisations to ensure people had effective care. This included community mental health teams when people needed support with their dementia and palliative care nurses when people were receiving care at the end of their life. A nurse told us "(Name, a mental health nurse was always at the end of the phone. It gave us insight and helped us to understand more about (name). They knew the history". Each person had a 'grab sheet' which provided essential care information which would accompany them if they needed to move to another service such as a hospital admission.

People had been supported to access healthcare both in planned and emergency situations. Records showed us people had access to a range of health professionals including chiropodists, opticians and audiologists.

People were able to access all areas of the home including a secure garden. Areas in the home provided places to meet socially. Specialist bathrooms were available on each floor and following feedback from people had been decorated and had privacy curtains fitted around the bath. Dining space was limited and the registered manager told us this would be increasing in November 2018.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the service was working within the principles of the act. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. When conditions had been applied these had been met. When people had been assessed as not having capacity decisions had been made in the persons best interest and included families and health professionals. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of

decisions they could make on a persons' behalf. This meant people were having their rights upheld.

Good

Is the service caring?

Our findings

People and their families spoke positively about the whole staff team. One person told us "They look after me well. They are very patient. If you want help you ring the bell and they come straight away". Another said, "I like (staff name) they make me laugh". A relative explained "Sometimes (name) screams and gets upset and they (staff) are so good, so patient". A thank you tree had been put in the foyer with messages of thanks hanging from its branches. One was thanking the chef and read 'thank you for coming to the rugby with me'.

We observed a relaxed but professional relationship between people and the care team. We observed staff showing kindness, patience and understanding when helping people. We observed one person getting fidgety in their chair and unable to verbally express what they needed. Through simple questions staff established they were hot and helped remove their cardigan which led to smiles from the person. One person had been unwell and told us "I haven't felt like going downstairs (lounge) but the girls (staff) have looked after me very well".

Staff demonstrated a good understanding of people's past life's and family and friends important to them. A care worker told us "I enjoy listening to what people have been up to in their lives; some great characters which make you laugh".

People had their communication needs understood. One person had experienced temporary hearing problems and a note pad had been used to help communication. Another person had a piece of equipment that spoke the time, day and date. We saw that some people used sub-titles when watching TV. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example, talking with people at eye level and using hand gestures and facial expressions.

People were involved in decisions about their care and how they spent their day. One person told us "They don't get me doing anything I don't want to do". Another told us they had been unwell and said, "I haven't felt like going downstairs (lounge) but the girls (staff) have looked after me very well". We observed people making decisions about where and how they spent their time and staff respecting people's choices. A care worker explained "I ask people or show them what they might like to wear. Ask them if they want to get up or not, whether they want their TV on". People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had their privacy, dignity and independence respected. One person explained "Sometimes I like to help out. If carers are drying me I might say I would like to dry in that place". People had their dignity and privacy respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. People's clothes and personal space were clean and reflected a person's individuality. We spoke with a community mental health nurse who told us "Staff are very good at treating people with respect".

Information about people and staff was stored securely to ensure their right to confidentiality.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Care staff could demonstrate a good knowledge of the actions needed to meet people's care needs and how people communicated. Care plans described any religious and cultural needs and these were understood and respected by the staff team.

Care plans reflected any equipment or technology needed to support people. Examples included equipment which enabled people to alert staff if they needed assistance such as call bells in people's rooms and alarm alert mats when assessed as needed. Other equipment included specialist high/low rising beds, specialist baths and moving and transferring stand aids and hoists.

Staff were kept up to date with changes in peoples care needs through daily handover meetings at the start of each shift. A care worker told us "If anything happens such as an accident then all staff are made aware. Changes are discussed at handover or if we need to know immediately we're told by the nurse in charge". Daily notes had been completed which detailed the care people had received and any health or wellbeing concerns.

The service had met the requirements of the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

People had opportunities to join in group activities, spend one to one time with staff and access the local community. One person told us "If I'm told what's on and I like the sound of it I'll ask to go down. We have musical afternoons with a guitar and a bit of a sing along which I do like". A relative told us "(Relative) been out a few times recently. The New Forest to the museum and fish and chips at the seaside". We spoke with a visitor who visited Newtown House weekly and provided nail care and manicures for people. We observed staff sitting and playing puzzles with people or just having a chat. Other activities had included a film day. A care worker told us "(People) normally choose a musical, we close the curtains to create the atmosphere, have a bit of a sing a long".

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. A suggestion box was in reception for people, their families, visiting professionals and staff to use to share feedback and ideas. We looked at the complaints log and records showed us concerns had been investigated and actioned in a timely way. One person kept in touch with family abroad using the internet and complained the Wi-Fi was unreliable. A booster had been purchased to rectify the problem. Another person told us "I would soon speak up if I didn't like something. I would make a complaint if I needed to and (registered manager) would listen; I really think she would".

The home had been awarded a national accreditation for end of life care. The accreditation demonstrated a

standard of care that people can expect when they are near the end of their lives. It is designed to meet the physical, spiritual and emotional needs of people who are dying, with a focus on the management of symptoms, comfort, dignity, and respect. The deputy manager explained how the accreditation had impacted on practice. "We make sure there is always somebody there with the person in the last few hours of life if there is no family. Staff have put their names on a list of volunteers who are happy to be called in to sit with a person".

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted.

Requires Improvement

Is the service well-led?

Our findings

Systems and processes had not been effective in monitoring and reducing risks to people including the administration of medicines. Auditing processes had not been effective in highlighting areas found at our inspection that required improvement.

The registered manager told us the medicine audit tool had not included topical creams and protocols for medicines prescribed for as and when needed. They advised us that they would review the tool to include these areas. Throughout our inspection the registered manager was responsive when areas were identified that required improvement. They provided action plans during the second day of our inspection detailing how improvements would be made and by when. Actions included nurses being allocated key areas of risk to audit such as people's weight and dietary and fluid intake charts.

People, their families and the staff team spoke positively about the management of the home and described an open and transparent culture. One person said "The manager comes around and makes herself known and has a word. Feel you can talk with her. She tries to put things right for you". A care worker told us "I can put my opinion out to (registered manager) and they will listen. If they say they will follow something up you know they will".

Staff were clear about their roles and responsibilities and were focused on the importance of teamwork. A care worker told us "The nurses call us their eyes and ears. We report things to the nurses and they follow it up. Everybody will just chip in, including the deputy and registered manager". Staff told us they felt appreciated and part of a team. A nurse explained that management support was available at all times. "(Deputy and Registered Manager) are always on call out of hours".

The Manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. Engagement with people, their families and staff was achieved through a range of methods. These included both group and individual meetings and a quarterly newsletter. We read staff meeting minutes which included sharing information about new data protection laws and the mental capacity act. Minutes also included sharing positive feedback from community clinical professionals on end of life care staff had provided.

Quality assurance survey had been completed and had captured feedback from people and their families. One relative had suggested the bathrooms be decorated to provide a more relaxed experience and we saw this had happened. Another requested more information about activities and we saw that a timetable of activities was on display in the foyer.

The staff team worked with other organisations and professionals to ensure people received good care. These included 'Skills for Care' and the National Institute for Clinical Excellence to keep up to date with best practice guidance and support continuous learning. Links had also been made with a local university and Newtown House offered student nurse mentored placements. Information had been shared appropriately with other agencies such as the safeguarding teams and social care commissioners.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks identified for people had not been monitored and reviewed in order to minimise the risks of avoidable harm. People were at risk as medicine administration was not always carried out in a safe way.