Newford Ltd

Newford Nursing Home

Inspection report

Newford Crescent
Milton
Stoke On Trent
Staffordshire
ST2 7EQ

Tel: 01782545547
Website: newfordnursinghome.co.uk

Date of inspection visit:
26 April 2016

Date of publication:
19 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We completed an unannounced inspection at Newford Nursing Home on 26 April 2016. At the last inspection on 31 December 2013 the provider was meeting the required standards.

Newford Nursing Home is registered to provide accommodation with personal care and nursing for up to 41 people. People who use the service may have physical disabilities and/or mental health needs such as dementia. At the time of the inspection the service supported 38 people.

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

We found medicines were not managed in a safe way and improvements were needed to ensure people were protected from the risk of harm.

The registered manager was not fully aware of their responsibilities to notify us (CQC) of any Deprivation of Liberty Safeguards (DoLS) that had been authorised for people who used the service.

People told us they felt safe with the care provided by staff. However, the registered manager had not always reported alleged abuse appropriately.

People's risks had been assessed, but we found improvements were needed to ensure these were monitored and managed to protect people from the risk of harm.

Improvements were needed to ensure that people were supported consistently in line with their eating and drinking assessments. Mealtime choices were not always promoted in a way that helped people who had difficulty communicating their needs.

Improvements were needed to ensure that staff provided care in a way that protected people's privacy and dignity.

Improvements were needed to ensure that people were able to access hobbies and interests that were important to them.

People were not always supported in a way that met their communication needs which meant people did not always receive support in line with their preferences.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was unable to be identified and rectified by the registered manager and

provider.

There were enough suitably qualified staff available to keep people safe and the provider had effective recruitment procedures in place.

People were supported by staff who had received training, which gave staff the knowledge and skills to provide appropriate care that met people's needs.

People consented to their care and the provider followed the requirements of the Mental Capacity Act 2005 (MCA) where people lacked the capacity to make certain decisions about their care. Staff understood their responsibilities and followed the requirements of the MCA and Deprivation of Liberty Safeguards (DoLS) when they provided support.

People were supported to access other health professionals to maintain their health and wellbeing.

People were supported by staff that were caring and compassionate. Choices on how people wanted their care and support provided were promoted, listened to and acted on.

People and their relatives were involved in the planning and review of their care.

The provider had a complaints policy available and people knew how to complain and who they needed to complain to.

People were given the opportunity to feedback on the quality of their care and actions were in place to make improvements.

People and staff told us the registered manager was approachable and staff felt supported in their role.

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 consistently safe.

Medicines were not managed in a safe way.

People's risks had been assessed, but we found improvements were needed to ensure these were monitored and managed to protect people from the risk of harm.

Improvements were needed to ensure the registered manager reported alleged abuse appropriately.

There were enough suitably qualified staff available to keep people safe and the provider had effective recruitment procedures in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure that people were supported consistently in line with their eating and drinking assessments. Mealtime choices were not always promoted in a way that helped people who had difficulty communicating their needs.

People were supported by staff who had received appropriate training.

Requirements of the Mental Capacity Act 2005 (MCA) where people lacked the capacity to make certain decisions about their care were followed.

People were supported to access other health professionals to maintain their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Improvements were needed to ensure that staff provided care in a way that protected people's privacy and dignity.

People were supported by staff that were caring and compassionate.

Choices on how people wanted their care and support provided were promoted, listened to and acted on.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed to ensure that people were able to access hobbies and interests that were important to them.

People were not always supported in a way that met their communication needs or their preferences.

People and their relatives were involved in the planning and review of their care.

The provider had a complaints policy available and people knew how to complain and who they needed to complain to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager was not fully aware of their responsibilities to notify us (CQC) of any Deprivation of Liberty Safeguards (DoLS) that had been authorised for people who used the service.

Systems that were in place to assess, monitor and improve the quality of care were not always effective.

People were given the opportunity to feedback on the quality of their care and actions were in place to make improvements.

People and staff told us the registered manager was approachable and staff felt supported in their role.

Newford Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 26 April 2016, and was unannounced. The inspection team consisted of three inspectors and an expert by experience. The expert by experience carried out interviews with people who used the service or their relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We reviewed information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries, safeguarding concerns and deaths that had occurred at the service.

We spoke with 10 people who used the service, three relatives, five staff, the registered manager and the provider. We viewed six records about people's care and seven people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records, staff recruitment and training records.

Some people who used the service were unable to speak with us due to communication difficulties. We 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.

Requires Improvement

Is the service safe?

Our findings

We found that improvements were needed to the way medicines were monitored and managed. We saw that where people needed 'as required' medicines there were no protocols in place to give staff guidance as to when people may need these medicines. For example, one person who often became confused was prescribed pain medicine but there were no protocols in place to guide staff on how to recognise the person was in pain. We spoke with the nurse on duty who was able to tell us how they recognised signs of pain for this person. However, the service used agency nurses when there was a shortfall in staffing due to sickness or holiday cover, which meant they would not be aware when they needed to administer an 'as required' medicine.

We completed a small audit of the medicines held by the home against the medicines recorded on the Medicine Administration Records (MARs). We found that some of the medicines in stock did not match the amount recorded on the MARs, which meant we could not be assured that people had received their medicines as prescribed. For example; we saw that three out of four people's medicine for their blood did not match the amount we counted. We also saw that the amount of one person's diabetic medicine did not match the amounts recorded on the MARs. We were told by the registered manager that they were unable to assure us that people had received their medicines because the balance of stock had not been carried forward.

We checked the stock levels of nutritional supplements that people had been prescribed because they were at risk of malnutrition. The amount of supplements in stock did not balance with the MARs. We saw that one person who had not received their nutritional supplements had lost weight in the last two months, although this had stabilised at the time of the inspection. We asked the registered manager how they could assure us that people were receiving their prescribed supplements to keep them healthy. We were told, "I can't as they've [the medicine stock numbers] not been carried forward". This meant that we could not be assured that people were receiving their medicines as prescribed.

The above evidence shows people were not always supported in a safe way because appropriate actions were not taken to manage medicines safely. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe when being supported by staff. One person said, "I'm treated very well". Another person said, "The staff are very good. I feel comfortable with staff". A relative said, "I feel that my relative is safe here". We saw that people were happy and appeared comfortable when staff provided support. Staff explained their actions if they were concerned that a person was at risk of harm and the possible signs that people may display if they were unhappy and where abuse may be suspected.

People's risks had been assessed, but we found that they were not consistently managed to protect people from the risk of harm. For example; the records we viewed for one person stated they should only be provided with an open cup and not a straw or spouted beaker for their drinks. We saw this person in their room with a spouted beaker which contained their morning cup of tea. Staff we spoke with were aware that

this person should not be given any drinks in a spouted beaker, but were unable to explain why this person had not received the appropriate equipment to keep them safe. We discussed this with the registered manager who told us they would speak with staff and ensure that this person's plan was followed in future.

We saw records of accidents that had occurred at the service. The registered manager had reviewed the accidents on a monthly basis. We saw that actions had been taken, which included a review of the person's risk assessments and care plan. For example, one person had suffered a number of falls at the service and sensors had been but in place to alert staff when this person was attempting to mobilise. This person's mobility plan had also been updated and gave staff guidance of the appropriate equipment to use to support this person safely.

People gave varied experiences of staff availability within the service, which included, "I sometimes have to wait ", and "There are plenty of staff". A relative said, "Staff come quickly if a call bell is pressed". We saw that there were enough staff available to meet people's needs in a timely way and call bells were answered swiftly by staff. Staff we spoke with felt there were enough staff available and plans were in place to cover shortfalls in staffing numbers. The registered manager had a system in place to assess the staffing levels against the dependency needs of people. We saw changes had been made to staffing levels when needed, which ensured there were enough staff available to keep people safe. We saw records that showed the provider had safe recruitment procedures in place. Staff who were employed at the service had undergone checks to ensure that they were of a good character and suitable to provide support to people who used the service.

Requires Improvement

Is the service effective?

Our findings

People gave us varied views of their mealtime experiences. Most people were happy with the quality of the food, but some people told us that they didn't always have a choice of meals. On the day of the inspection we observed breakfast and lunch and people were given choices and staff listened to what people wanted. We saw support plans were in place that detailed the individual support people needed. For example, some people were unable to eat independently and we saw staff supported people to eat sufficient amounts to maintain a healthy weight. However, we saw one person who needed encouragement by staff to drink sufficient amounts throughout the day was unable to reach their drink in their room. We asked the person what they did if they wanted a drink, they said, "I can't reach, so I don't bother. If I was desperate I'd ring the bell I suppose". We saw that this person was a high risk of developing pressure sores. It is important that sufficient amounts of fluid are available to maintain a healthy skin condition. At the time of the inspection this person's skin was intact. This meant that improvements were needed to ensure that this person was able to access sufficient amounts of drinks when they needed to and to ensure that they maintained a healthy skin condition.

People told us they were able to see health professionals when they needed to. One person said, "I can see a doctor if I'm unwell. I have also seen someone about my hearing aids and I'm waiting for them now". The records we viewed showed that people had accessed health professionals such as; the doctor, dietician, consultants and social workers. We also saw that the registered manager had sought advice from health professionals which ensured people's health and wellbeing was maintained.

People told us that they consented to their care and staff asked their permission before they provided support. We observed staff talking with people in a patient manner and gained consent from people when they carried out support. Some people were unable to understand some decisions about their care and staff understood their responsibilities under the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw mental capacity assessments had been carried out when people lacked capacity to make certain decisions, which contained details of how staff needed to support people in their best interests.

We saw there were Deprivation of Liberty Safeguards (DoLS) in place, which had been authorised after an assessment had been carried out, which included input from other professionals. DoLS are for people who cannot make a decision about the way they are being treated or cared for and where other people need to make this decision for them in their best interests. Staff were aware of the restrictions in place and we saw staff supported the people to keep them safe from harm in line with their individual DoLS.

Staff explained how they supported people with behaviour that may challenge and they knew people's individual triggers that caused their anxieties. One staff member said, "We know the signs if someone is becoming anxious. The best way is to give people time and go back when they are ready or sometimes we

can try another member of staff instead". The records we viewed confirmed the staff understood how to support individual people with behaviours that may challenge in a way that met their needs.

Staff told us they received an induction when they were first employed at the service. One staff member said, "The induction was good, I had training and I shadowed another member of staff for a week before I provided support on my own". Staff also told us that the training was regularly refreshed and updated and they had opportunities to undertake specific training. The records we viewed confirmed staff had received training to help them carry out their role effectively. Staff received supervision from the registered manager on a regular basis. One member of staff said, "Supervision is good. I get observed carrying out procedures and the registered manager would remind me if I'm not doing things right".

Requires Improvement

Is the service caring?

Our findings

We found that people's dignity was not always considered. For example, one person was administered eye drops at the dining room table whilst they were having their breakfast and lunch with other people who used the service. The nurse on duty did not ask this person if they wanted their eye drops to be administered in a private area, therefore, this did not promote their dignity. We saw another person being transferred from a chair to a wheelchair by the use of a hoist. This person's dignity was not protected during the transfer as the sling that was used was an open sling and the person's underwear was on display. This meant that people were not always supported in a way that gave them privacy and protected their dignity.

People told us staff gave them choices in the way they received their care. One person said, "I choose different things, such as, what clothes I want to wear, what I want to do and where I want to sit. Staff never make me do something I don't want to". Another person said, "I choose when I get up and go to bed. I like to be up very early and staff never have a problem with that". People told us and we saw that people were dressed individually and were given choices in the clothes that they preferred to wear. We saw people were given choices by staff and staff showed patience and listened to people's wishes. During lunch we saw that people were given choices of drinks and a number of people asked for something different than what had been offered by staff. Staff listened to people and provided the drinks they had requested. We saw that this made people happy and people felt comfortable asking staff for various things that met their preferences.

People told us they were happy with the way the staff supported them and staff were kind and caring. One person said, "They are very nice and kind. They work hard". Another person said, "They [staff] are kind and gentle". Relatives told us that the staff always treated people in a kind way and they were happy with the way staff cared for their relative. One relative said, "Staff are always helpful. They have a nice friendly manner without being patronising towards my relative". People and relatives also told us there were no restrictions on visitors and they were able to see their family and friends at any time. We saw staff interacted with people in a caring and compassionate way. Staff gave people time and listened to what people said. We saw staff speaking with people face to face and placed their hand on people in a caring manner when they gave reassurance to people.

Requires Improvement

Is the service responsive?

Our findings

Some people and relatives told us there were activities available that they enjoyed, such as; bingo, quizzes, listening to music and an external entertainer visited the service. We saw records that showed people had been involved in various activities, which included church services, one to one activities, gardening, reminiscence discussions and pet therapy sessions. The records showed whether people had enjoyed the activities on offer and how people had reacted, for example; one person had said, "It made my day seeing the dog". However, the only activity available on the day of the inspection was hairdressing and we saw that people were sat in the lounges with very little to keep them occupied other than the television. We did not see that there were personalised activities for people to keep them occupied or to maintain their emotional wellbeing. One person told us that they did not like the activities on offer as the only thing that was on offer was "playing games", which they were not interested in participating in. This meant that improvements were needed to ensure that all of the people who used the service had access to hobbies and interests that were important to them.

Some people had limited communication and we saw that they were not always supported effectively to make personalised choices at lunch. For example; one person was showing signs of confusion and found it difficult to choose their lunch when staff asked them what they wanted. Staff did not use any other methods to help this person choose a meal, such as, pictorial aids or showing the person the two meals available. We saw this person did not eat their lunch and they told us it was because they didn't like what they had chosen. This meant that staff were not responsive to this person's communication needs, therefore their preferences were not taken into account.

We saw that people and their relatives had been involved in the planning of their care. The records we viewed showed that people's plans of care were detailed and contained what was important to them and how they liked to be supported. We saw that people's life histories had been recorded, to enable staff to have discussions about peoples' past lives before they used the service. The registered manager had carried out regular reviews of people's care, which included consulting relative's and other professionals which enabled a clear view of any changes in people's needs. We also saw that people's plans of care had been updated when there had been incidents such as falls or concerns raised by staff regarding a change in people's dependency levels.

People and their relatives told us they knew how to complain if they needed to and they were comfortable raising concerns. One person said, "I can speak to the manager if I had any concerns". The provider had a complaints policy in place and we saw there was a system in place to log any complaints by the registered manager. The complaints we viewed had been acted on and a response sent to the complainant. This meant that the registered manager acted on complaints received to improve the quality of the service provided.

Requires Improvement

Is the service well-led?

Our findings

The provider has a duty to notify us (CQC) of any incidents that had happened at the service, which enables us to monitor the service. For example; expected and unexpected deaths, serious injuries, Deprivation of Liberty Safeguards (DoLS) and alleged abuse. We found that the registered manager had not notified us of any DoLS that had been authorised for people who used the service. For example; during the inspection we saw that people who used the service had DoLS in place that had been authorised but our records showed that there were no people who used the service who were subject to an authorised DoLS. The registered manager told us that they had not fully understood their responsibilities to notify us, but they would ensure that this would be undertaken in the future. We will continue to monitor to ensure that DoLS are reported appropriately as required by law.

The provider had not notified the commission of incidents as required. This is a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009.

We found that some of the monitoring systems in place to ensure that people received appropriate care and support were not always effective. For example; we were unable to sufficiently check people's medicines and assess whether there was the correct amount in stock as the system in place was not effective. The medicine audits showed that concerns had been identified by the registered manager that the amounts of stock did not balance with the records between the period of 25 January 2016 and 20 March 2016. There were no details of the action taken to prevent a reoccurrence and protect people from unsafe care and treatment. This meant that people were at risk because there were ineffective systems in place to assess and monitor and mitigate the risks to people.

We found that some incidents had not been considered or reported as abuse by the registered manager. For example; we saw that on two occasions a person had become physically aggressive towards two other people that used the service. We asked the registered manager if they had considered reporting this to the local safeguarding authority, who told us that they did not realise that they needed to report alleged abuse when there had been no injuries sustained. They said, "I haven't reported these incidents, but I will in the future". This meant people were at risk of unsafe care because staff and the registered manager did not fully understand their responsibilities to keep people safe from harm.

We found that the registered manager and provider did not have a clear overview of the issues that we had identified at the inspection. For example; we found that staff were not always supporting people in a dignified way, staff were not always following people's risk assessments to ensure they were protected from the risk of harm and people were not always supported effectively to ensure they had sufficient amount of drink available to them. The registered manager did not have a system in place to monitor staff practice across the service to ensure people were receiving their care as planned. The provider told us that they had recently employed an external consultant to assess the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, but they had not received a report of actions from the consultant at the time of the inspection.

The above evidence shows that the provider did not have effective systems in place to monitor and manage the quality of the service provided to protect people from the risk of harm. This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and we saw that feedback was gained about the quality of their care. One person said, "I attended a meeting a few weeks ago". Another person said, "We can ask questions. They [the registered manager] ask us if there is any more they can do for us". A relative told us they had completed a questionnaire that asked them about their relatives care. We saw records that showed a questionnaire had been circulated to people and their relatives to gain feedback ion people's experiences. We saw where there had been concerns raised these had been acted on by the registered manager. For example; a person had stated that their laundry had gone missing; we saw that the registered manager had spoken with domestic staff to ensure this did not occur again.

People and their relatives told us the registered manager was approachable and they felt comfortable raising any concerns with them. One relative said, "I can speak to the manager if I have any concerns". Staff told us that they could approach the registered manager if they needed to. One staff member said, "The manager is very supportive, we have regular supervisions and I get to discuss any issues I might have, we also have training to check that we know what we are doing and keep us and the residents safe". We saw staff were comfortable approaching the registered manager and the provider on the day of the inspection. We found the atmosphere within the home was friendly between staff and people, relatives and the senior management team.

Staff were positive about their role and told us that they enjoyed supporting people. One staff member said, "I love working here, I wish I'd decided to work here sooner". Another member of staff said, "It is important to keep the residents safe and content. It's good to see people happy". The provider told us that they were committed to providing a good standard of care and the values of the service were on display in the reception area of the service. The provider matched the values of the service alongside the Care Quality Commission's way of inspecting. The provider told us that they would ensure that they would put actions in place to make improvements to meet the required standards of care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission without delay of the incidents which occurred at the service in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. Regulation 18 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with unsafe management of medicines. Regulation 12 ((1) (2) (g)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider did not have effective systems in place to monitor and manage the quality of the service provided to protect people from the risk of harm.
Treatment of disease, disorder or injury	

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.