Berkeley Health Care Limited

Newlands Nursing Care Centre

Inspection report

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Date of inspection visit:
19 April 2016
20 April 2016

Date of publication:
08 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 April 2016 and was unannounced. Newlands Nursing Care Centre forms part of and is within a care village. People who live in the care village can be cared for here on a temporary basis or transfer permanently to the care centre when needed. People from outside of the care village are also admitted to Newlands for short-term or long-term care. The service can accommodate 25 older people and at the time of the inspection there were 17 people. The service provides nursing care with nurses on site at all times.

The service had a registered manager in position. 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.

During this inspection we found one area of regulation not fully met in relation to the records kept about people's care and treatment. You can see what action we told the provider to take at the back of the full version of the report. People received support which was tailored to their individual needs and care was delivered with kindness and compassion. People's end of life care was well planned and their families involved and supported. However, care plans did not always provide staff with accurate and sufficient information about people's care and treatment. The risk to people from this was reduced because care staff received exceptional support and guidance from senior nursing staff. Senior nursing staff were very hands on in the delivery of people's care and worked alongside care staff so the appropriate care was delivered. However, care plans must accurately reflect and record what care people need and how their care and treatment is to be provided. Shortfalls in accurate and relevant care records can potentially put people at risk of receiving unsafe and inappropriate care.

We also recommended that the service seek appropriate advice with regard to the principles of the Mental Capacity Act 2005 and how better to reflect these were being followed in people's care records. We observed people's care being delivered with their consent, although a desire to protect people from risk had resulted in a decision being taken for one person, which they objected to and which they had not provided consent for. Staff were aware of the need to protect those who were unable to make decisions about their care and treatment independently. However, the process of recording their considerations under the appropriate legislation for another person and the practice of assessing everyone's general capacity on admission required review and improvement.

People's risks were identified and managed and they were kept safe from harm because staff knew how to report any concerns they may have. There were enough staff to meet people's needs and robust recruitment practices protected people from those who may be unsuitable. People received their medicines safely and were provided with explanations about these when they asked. Staff had been trained and were well supported. Staff competencies were reviewed and assessed but this process was not recorded. Staff training was on-going.

People were helped to maintain and a healthy diet and when there were concerns about this appropriate monitoring and support was provided. People had a choice of food and drink and there were well appointed restaurants to eat in and to entertain friends and family. People had opportunities to take part in social activities and they were supported to go out. Newlands did not provide transport which was adapted to accommodate wheelchair users however, we were told transport which was adapted could be hired. Arrangements were in place for people to raise a complaint and to have these responded to.

The service was managed well despite the registered manager not being present in the home as much as people would like. Some people told us this hampered communication but people also told us the registered manager was very approachable. Following the inspection the provider informed us the time spent in the home by the registered manager had increased. The views of people, their relatives and staff were sought and a summary of their feedback made available to each group to read. Quality auditing processes were in place to assess, monitor and identify shortfalls although the improvements required in care planning records had not been identified. When we fed our findings back to the management staff they told us ways to improve this would be found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected against risks that may affect their health and well-being. Environmental risks were also monitored, identified and managed.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

Arrangements were in place to make sure people received their medicines appropriately and safely.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Is the service effective?

Requires Improvement

The service was effective.

People's consent was sought before their care and treatment was provided. Staff were aware of the Mental Capacity Act (2005) and on the whole considered its principles when delivering people's care. However, this was not well reflected in some people's care records.

People received care and treatment from staff who had been trained to provide this and who received very good practical support.

People received appropriate support to maintain nutritional well-being. People dining experiences and food choices were very good.

Staff ensured people's health care needs were met and helped people where needed to attend their appointments.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff where possible. Care was tailored to people's individual needs.

People's dignity and privacy was maintained at all times.

Is the service responsive?

Requires Improvement

The service was responsive but sometimes there was a lack or accurate care planning.

Care plans lacked relevant detail and were not always relevant. However risks from this were lowered because staff received close support and guidance on how to meet people's needs from very involved nursing staff.

People had opportunities to socialise and partake in activities, although ad-hoc trips out (apart from being pushed to the local shops) were limited for people dependent on a wheelchair.

There were arrangements in place for people to raise their complaints although areas of dissatisfaction were not always recorded.

Is the service well-led?

Good

The service was well-led despite the registered manager not being on site as often as people would have liked.

Quality monitoring arrangements were in place but they had not picked up the shortfalls identified in the inspection.

There was a good sense of team work from staff who were committed to running the best service they could.

There were opportunities for people to express their thoughts and suggestions.

Newlands Nursing Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 April 2016 and was unannounced. One inspector carried out this inspection. The last inspection of this service, by the Care Quality Commission, was completed on 21 October 2013. The service was found to be fully compliant in the areas inspected. A report of that inspection was seen to be available for people to read in the reception area.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This form 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. We also reviewed the statutory notifications we had received from the provider. A statutory notification is information about important events which the service is required to send to us by law. We reviewed information local commissioners had shared with us.

During the inspection we spoke with six people and three relatives. We also spoke with the registered manager and ten members of staff. We reviewed four people's care records as well as three people's medicine administration records. We reviewed the recruitment records of four members of staff. We reviewed various records relating to the management of the service. These included the staffing rosters, staff training records, the service's Statement of Purpose (a document which outlines what services Newlands provides and to whom), complaints file, minutes of various staff meetings and a selection of quality monitoring audits. We also reviewed four of the provider's policies and procedures. We attended two heads of department meetings.

We asked the provider to forward to us information on training for staff which had already been booked

which they did.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "Oh yes, I feel perfectly safe here". People trusted the staff to make appropriate arrangements to maintain their safety. One relative said, "I'm very confident that [name] is kept safe and well looked after".

People were protected from the risk of abuse. The service had a safeguarding policy with procedures in place. The policy we read had a review date of 2013 recorded however, following the inspection the provider confirmed this had been reviewed in 2015. The provider's safeguarding policy referred to Gloucestershire County Council's multi-agency policy and protocols. The service followed these protocols and ensured for example, that all appropriate agencies were made aware of any safeguarding concerns. This enabled other professionals with the responsibility for safeguarding people to also be fully informed. This included the local county council's safeguarding team, the Care Quality Commission and police. Staff told us they had received relevant safeguarding training. They were able to tell us what abuse was and who they would report concerns to. The subject was also discussed in staffs' one to one support sessions. One member of staff said, "I would report any safeguarding issues I had straight away".

Appropriate recruitment procedures were in place and had been adhered to in order to protect people from those who may not be suitable to care for them. All the recruitment files inspected showed checks had been carried out before the staff started work. These had included a clearance from the Disclosure and Barring Service (DBS). A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and unexplained gaps in employment explored.

There were enough suitable staff to meet people's needs and to keep them safe. We spoke with four members of staff about the numbers of care staff available to meet people's needs. Three out of the four agreed there were enough care staff on duty. One person said, "You do sometimes have to wait a little while when you call your call bell". This person also told us when they had fallen "four or five staff were here in no time". Another person said, "What I like about here is the staff do not rush you".

Risks to people were identified and managed. This related to individual care and health risks as well as risks relating to the environment. People's care records contained risk assessments which stated what the actual or potential risk was to a person. The assessment, along with a care plan, then gave staff guidance on how the risk would be managed. Health risks included risks relating to loss of appetite and weight, swallowing problems and the development of pressure ulcers. Accidents relating to falls for example were monitored and senior staff looked for trends and patterns to help them ensure appropriate measures were in place to avoid a further fall.

People's medicines were administered safely, stored appropriately and the whole medicines system regularly monitored. We observed staff following appropriate procedures when administering people's medicines. They made sure the right medicine was given to the right person at the right time. People

received the support they needed to take their medicines. Staff who administered medicines maintained their competency in this task by updating their knowledge and by having their practices monitored.

Arrangements were in place to keep the environment and equipment safe. This included a well managed cycle of maintenance checks and servicing by appropriate contractors. For example, work had been carried out following a planned electrical check. This involved further insulation to some electrical cables in order to prevent a potential fire. Gas appliances had been checked and on-going maintenance of these was in place to ensure safe use. For example, staff checked and cleaned the gas tumble dryer filters every 12 hours to prevent a build-up of dust and fibres. This also formed part of the measures taken to prevent a potential fire. Contractors were due to check all gas appliances in the kitchen soon. Regular action was taken to keep the water system free from the risk of Legionella growth. For example, water temperatures were regularly checked at different outlets. Arrangements were in place to maintain a regular flow of water in areas that were not in regular use. Contractors had checked and serviced the hot water system boilers in December 2015 and records stated "In good working order". All fire safety precautions were in place. The fire detection system and fire fighting equipment were checked regularly by the maintenance person and by a specialist contractor. The last fire alarm drill had been completed a couple of weeks prior to the inspection and records stated a "good" response from staff. Staff had received appropriate training in relation to fire safety and evacuation processes.

People lived in a clean environment where precautions were in place to prevent the spread of infection and reduce potential cross contamination. Cleaning staff were seen to be carrying out their tasks. One new member of the team told us the cleaning schedules had been explained to them. They were also aware of what cleaning equipment to use in specific areas of the home in order to avoid cross contamination. Care staff also took appropriate precautions to prevent cross contamination and the spread of potential infection. They were observed to wear plastic gloves and aprons when delivering care which they changed between visiting different people. The kitchen staff ensured high standards of food safety and cleanliness. The kitchen had been awarded a rating of "five" by the Food Standards Agency. This is the top rating awarded and means the kitchen was found to have 'very good' hygiene standards (www.food.gov.uk). Arrangements were in place to segregate various items of laundry and to make sure it was washed adequately and correctly.

Requires Improvement

Is the service effective?

Our findings

Care records did not always demonstrate that a person's consent had been sought and provided for the decisions contained in their care and treatment plans. One person's care records did not demonstrate that the principles of the Mental Capacity Act 2005 (MCA) had been followed. One generic practice, carried out on admission to the care home, did not follow the principles of the MCA. Despite these findings, when discussing the principles of the MCA with the staff they demonstrated understanding of these and where they were unsure they told us they took appropriate advice.

One person had experienced previous falls and had been assessed as still being at risk of falling. To help staff manage this risk specific equipment had been installed in the form of an alarmed floor mat. When the person stood staff were alerted and they could arrive in a timely manner to provide the level of support needed to prevent a fall. It's use was not intended to restrict or control the person in any way and the person was free to move around as they wished. An entry in a care plan in September 2015 referred to its use. We could find no recorded reference to the person having given consent for this equipment so we discussed its use with them. They told us they fully understood why it was in use however, they also told us they were "a private person and they objected to the interference" and continual monitoring of their movements. In this case the person considered themselves to be monitored. We fed this back to the staff and the fact we could see no original consent for its use. They told us they would reassess the situation. Following this inspection the provider forwarded to us a review of care, carried out with the person. This review recorded the use of the equipment as part of the person's falls prevention management. The review was signed by the person indicating their agreement with the care they received. This review however had been completed four months after the care plan entry. The specific equipment in use could potentially be used to control and monitor a person's movements so it would be important to seek a person's consent for its use.

Staff were aware of the principles of the Mental Capacity Act (MCA) 2005 because they discussed these with us and when they were in doubt they sought advice from the county council's MCA practitioner team. The 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 make particular decisions, any made on their behalf, must be in their best interests and as least restrictive as possible.

The MCA assumes a person has capacity unless, for various reasons (explained in the MCA Code of Practice) there may be concern the person may not have capacity. If a person's capacity is to be assessed it must be assessed in relation to a specific decision to be made, not to determine a person's overall level of capacity. We saw mental capacity assessments which were general capacity assessments, not decision specific and which were completed on admission to the care home. The practice of assessing a person's general capacity is not in line with the principles of the MCA. This is because people's capacity may be different and also alter depending on the decision that has to be made. Following the inspection the provider confirmed the document we saw was used to assess people's general capacity. They told us all 'residents' undergo a general capacity assessment on admission and unless otherwise indicated they are then presumed to have capacity. The practice of assessing a person's capacity when there is no concern they may lack this is also

not in line with the principles of the MCA.

In one person's case however, their care records recorded they lived with dementia. In early 2015 the records recorded that despite this the person was able to make decisions and give consent in relation to their care and treatment. A change in health and abilities in 2016 required the person's care to be altered. The person was described as being "very confused". There was no reference in the records that the person's consent had been provided for the changes and decisions made regarding their altered care and treatment. One member of staff told us the person's mental capacity needed to be assessed but this had not been completed by the time of the inspection. Decisions had therefore been made in relation to this person's care and treatment for which they had not given consent. There had also been concern about the person's capacity but this had not been assessed in relation to the decisions made about their care and treatment. The records did not therefore demonstrate that the principles of the MCA had been followed. Unless the MCA principles are acted on people who lack mental capacity to make informed decisions about their care and treatment are at risk of having decisions made on their behalf that may not be in their best interests. They are also at risk of not being involved in decisions they could possibly still make independently.

We recommended that the service seek further advice, from an appropriate source, on the principles of the Mental Capacity Act 2005 in relation to the findings above and how best to demonstrate these are followed.

Since the inspection the provider has told us a new document has been introduced which allows staff to record a mental capacity assessment in relation to a record specific decision. The use of this will be followed up in future inspections.

One senior member of staff told us what they had considered in relation to Deprivation of Liberty Safeguard (DoLS). 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). Staff had appropriately completed DoLS applications when they thought a person was deprived of their liberty. The applications submitted to the county council (the supervisory body) had not been assessed as needing authorisations under DoLS. This practice ensures people are not deprived of their liberty unlawfully.

People did receive support to make day to day decisions. Staff were also aware of who required more support to do this and they provided the appropriate level of support. We also observed care staff seeking people's agreement before they provided care and treatment. An example of this involved a person's decision making in relation to their medicine and then their consent for the medicine to be administered. One member of staff provided answers to the person's questions about their medicine and explained how the medicine worked. The person was consequently able to make an informed decision about their medicine and give consent for its use.

People were cared for by staff who had been trained and who were supported to meet their needs. One relative told us they felt the staff were often "spot on" in knowing what care their relative needed. Staff confirmed they had completed training which was helpful and relevant to their role. Most of this training involved the completion of computer based training modules but some face to face training had been provided. Newly employed staff were supported to become aware of the provider's policies and procedures during their induction training. Induction training included basic training which the provider considered necessary for staff to complete to be able to perform their duties safely. It also consisted of shadowing more experienced staff and their competencies being assessed and cleared before they worked alone. Basic training for all staff included, fire safety, health and safety, safeguarding people, Mental Capacity Act and Deprivation of Liberty Safeguards and safe moving and handling. The registered manager told us they

considered the overall experience and skills of the team when recruiting staff. They therefore aimed to ensure a good balance of inexperienced and experienced staff.

The Provider Information Return (PIR) told us the registered manager planned to introduce the care certificate in the next 12 months. The care certificate is a nationally recognised framework of training and support which new care staff can receive. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed. Following this inspection the provider forwarded evidence to us which showed that the care certificate had been introduced and one new member of staff had been supported to complete this.

On-going training needs were identified during one to one support meetings and when senior staff worked alongside the staff. The registered manager told us several areas of training were booked and due to take place over the next four months. These would offer an update for some staff and provide new knowledge for others. These included, first aid, accountability and documentation, dignity issues, end of life care, falls risks and management, syringe driver management for nurses and pressure ulcer prevention and the management of related wounds. Senior staff told us they worked closely with the care staff and we observed this in practice. We were told that staff competencies were therefore being continually reviewed and assessed. Following this inspection the provider forwarded information to us which supported this practice.

People's nutritional risks were monitored and where needed action was taken to reduce these. Appetites were monitored as well as people's weight. Any concerns about these were recorded and discussed with the person's GP. We spoke with kitchen staff who were fully aware of who needed dietary support. Dietary support came in the form of fortified foods to promote a higher calorie intake. For example, additional biscuits, cake and added cream, butter or powdered milk to everyday foods and sauces. Chefs were also aware of specialised diets, allergens and food textures. For example, pureed or soft textures for people with swallowing problems.

People told us they had a good choice of food and their particular likes and dislikes were known. We observed people having informal chats with the kitchen staff and making particular requests for the day. People's dining experiences were very good and two very well appointed restaurants provided comfortable surroundings where people could eat alone or with company if preferred. The restaurants were open to all the Newlands community as well as friends and family who could be entertained. People who needed it received discreet support with their eating and drinking. We observed one member of staff giving a person, who was in bed, very gentle encouragement to decide what they would like to eat. The member of staff said, "I will organise anything you fancy". Another member of staff was observed helping another person to eat their food in a very caring and respectful way. Another person was very independent but the dining experience was important to them. They told us they enjoyed making suggestions to the chef which they in-turn had listened to and acted on. In-between meals we saw other beverages being delivered to people by support staff. A new chef was to start work soon and a date had been booked for people to meet him.

People had good access to health care professionals and specialists when needed. Many were helped to attend specific appointments by family members and other people were either supported by staff or were seen in the home. Senior nursing staff told us they had a very good working relationship in place with the local GPs. One local GP surgery provided designated visits on set days and, like surrounding GP surgeries, would also visit if needed in-between. A senior member of staff told us they were able to get advice at any time from the GP surgeries. People also had access to a chiropodist (foot care) who visited regularly. Optical and hearing appointments could be organised for people who could not attend an external appointment. Due to geographical distances to a hospital and wanting to avoid a hospital admission, in one person's case, staff worked with the NHS Rapid Response team. This team had visited three times a day for 3 days to

administer intravenous (via the person's veins) medicines.

Good

Is the service caring?

Our findings

People told us the staff were caring and compassionate. When talking about how they found the staff who looked after them one person said "so very caring". One relative's comments included. "so caring", "lots of compassion" and they spoke of staff "going that extra mile". We observed extremely kind and compassionate support being provided to people. All staff showed genuine interest in people's well-being when they spoke with them. We observed staff being respectful towards people. People who required extra support or time to be understood were afforded this.

People looked relaxed around the staff who looked after them. Staff showed affection towards people when it was needed, such as a reassuring arm around their shoulder which was well received. Staff knew the people they were looking after well and they were aware of their personal preferences, likes and dislikes and aimed to meet these. People's needs were responded to quickly when they were confused or distressed. We observed two such situations, one when someone needed reassurance about their plans for the day and another when a person became disorientated. Both were managed by staff in a gentle and caring way.

When able to do so people were involved in making decisions about their care and planning how their care would be delivered. Two people confirmed they knew what their documented care plans contained and they had been involved in reviewing these. One relative confirmed their involvement on behalf of their relative. They said, "Yes, I have been very much involved with the care planning and the reviewing of [name] care". Some care plans included people's preferences and choices. In particular people's care plans relating to their personal care were very personalised. In two people's personal care plans it stated their preferred staff gender for delivering this care. A third such care plan recorded that the person did not mind. One section in one person's care file was headed "Things that I would like to do". This referred to things and people the person was doing and seeing whilst living in their own home and which they wanted support with to maintain once living at Newlands.

People were given explanations and information to help them make decisions about their care and treatment. One person had been given options and helped to make a choice with regard to their pain control. This person said, "[Staff name] has talked to me about this and we have a plan. We are going to try [type of medicine] out and see how it goes". The member of staff told us they had explained how the medicine worked and they would monitor the effectiveness of this with the person involved. People's care records recorded the involvement of their relatives in relation to discussions about their care and treatment and when they had been informed about something in particular. Some relatives were consulted with on a regular basis about their relative's care. This was only done when it was the person's wish that this happen or where the relative was the legal representative. Staff informed us that some people did not want their care or treatment discussed with their family. When this wish was expressed it was respected. One person we spoke with told us they preferred issues about their care to be kept private.

People's privacy and dignity was maintained at all times. We observed staff knocking on bedroom doors and waiting for an answer before entering. Doors were always closed before care was delivered. We observed non-care staff being very aware of when personal care was taking place and they did not enter a bedroom

during this time. Necessary conversations about people's care needs were carried out in private.

A senior member of staff described to us how the service met people's end of life care needs. Staff aimed to explore people's wishes and preferences for this part of their care whilst they were able to discuss these. Another reason for exploring these in advance was to make sure staff and family were clear about what these were and could work together at the appropriate time to meet these. Changes in people's health were monitored carefully and senior nursing staff were experienced in recognising the end stages of life. They worked closely with local GPs at this point to make sure all medical and nursing arrangements were in place. This included making sure appropriate medicines were in place, so they could be used to keep the dying person comfortable. A senior member of staff told us staff were "totally committed to ensuring a peaceful time for the person and their family". When talking about the management of a person's end of life care needs they said, "the person is always at the centre of this". They told us "staff feel rewarded when they can see a person's end of life care was good". They spoke of the staff group being very "stable" and of supporting each other at these times. The registered manager spoke of using reflective discussions after a person had died so staff could explore safely what went well, what they would have liked to improve and how they felt.

Requires Improvement

Is the service responsive?

Our findings

The service was responsive to people's needs although care plans sometimes did not sufficiently explain what a person's needs were and what care needed to be given. Some information in people's care plans did not correspond with additional recorded assessments and information. This gave conflicting information and unclear guidance for staff and other health care professionals. One person's care file contained information about their continence needs. There were various assessments, reviews and documents about this. The information in the relevant care plan did not fully relate to this information so we had to ask a member of staff to clarify exactly how this area of care was being managed. The care plan did not reflect the care that was actually being given and which was meeting this person's needs.

Staff aimed to review care plans on a monthly basis. We were told that a review would also take place earlier if something had altered, such as a person's abilities, care or treatment. This had not happened in one person's case following a fall. The person's mobility care plan was very generic and stated for example, to ensure all areas were clear of obstacles and to ensure the person wore safe footwear. A comment had been added at a later date which said, "Sometimes uses a Zimmer [walking] frame". The following month the person had a fall. This was responded to appropriately by ensuring the person was medically checked. The falls risk assessment and the care plan however were not reviewed. No new risk strategies or guidance for staff to prevent a further fall had been recorded. In other care plans we could see that care plan reviews had been completed but an alteration to the actual care plan had also not always followed.

Other record keeping issues included statements which had not been accurately recorded. For example, in one person's review of their communication care plan a month prior to the inspection a comment said, "requires to have eyes syringed". We were told this was meant to have said "requires to have ears syringed". In another person's care plan review, when talking about a person's skin a comment said, "it's improving & deteriorating". These inaccurate recordings are simple mistakes but potentially confusing for staff. We fed back our findings to the registered manager with regard to people's care plans and record keeping generally. They told us they would look at ways of improving this.

A lack of up to date and accurate information in people's care plans potentially puts people at risk of receiving inappropriate and unsafe care. This is a breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

In the case of Newlands the care of people was so carefully directed and monitored by the senior nursing team that this risk was reduced. People's care plans for personal care were also personalised and stated their preferred staff gender for delivering this care. Despite this we observed staff responding to people's care needs in a personalised way. One person said, "I find it excellent here". A relative told us how well the registered manager and staff had responded to the changing care needs of their relative. They said, "They have been utterly brilliant".

People's needs were assessed prior to admission. This process helped the staff identify if the service could meet someone's needs and whether any particular arrangements needed to be made beforehand. For

example, the need for specialised pressure relief equipment or the involvement of specialist health care professionals. The registered manager told us staff were always informed about a new admission. They said, "If they [staff] can visualise the person before admission then that works well". This process involved people and their relatives and was an opportunity for them to express their likes, dislikes, preferences, choices and discuss their expectations. The registered manager said, "People and their relatives come with very high expectations and we need to ensure we can meet those. We want to ensure people get what they want when they want it".

People's complaints were taken seriously and responded to with subsequent actions taken to resolve the issues raised. The provider had a complaints policy which they have subsequently confirmed was reviewed in September 2015. People were made aware of how to make a complaint and received information on this when they were admitted. There was also information about how to make a complaint along with advice on advocacy in the reception area. Complaints could be raised in writing, by email or verbally. The complaints procedure told people who they should refer their complaints to. The provider's details were given as well as the address of the local ombudsman. People were also signposted to raise a complaint with the Care Quality Commission (CQC). Although CQC is responsible for ensuring the provider adheres to the relevant regulations of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014 in relation to complaints, it does not hold statutory powers to investigate individual complaints. We fed this back to the management team. People told us they had not had reason to complain although one relative had raised dissatisfaction over how problems with the lift had been managed and communicated. Records relating to this were not contained in the service's complaints file. The provider has subsequently explained that this was because the complaint had been received at the company's head office. The registered manager however told us they had also responded verbally to the person which they admitted they had not recorded. This complaint had nevertheless been fully responded to. Another person's complaint relating to the laundry had been recorded in the service's complaint file and discussion about improvements to this had been held in a subsequent staff meeting.

Many people were supported by their family and friends when it came to their social needs and social activities. Family and friends could visit at any time and join people for coffee or a meal. There were staff other than care staff to help support people with various social activities. People were able to socialise in the communal areas which were also used by the whole of the Newlands community. These included a coffee shop and bar which was licenced and where alcoholic beverages were sold. Leading out from this was a large terrace where we observed people enjoying the sun and enjoying a coffee. The grounds included extensive and well-manicured gardens which people told us they took a stroll in when it suited them.

The majority of activities in the care home were on set days and included the showing of films, craft and flowering arranging groups, and discussion groups; sometimes led by visiting speakers. On a regular basis an external person came in and led an exercise group which included chair exercises. This was paid for by the provider. Just prior to the inspection a group of people from the care home had paid for tickets and attended the Opera in Cheltenham. For this trip the Newlands people carrier had been used. This transport did not accommodate wheelchair users. People in wheelchairs or people who were unable to independently access a vehicle needed alternative transport which the registered manager told us could be hired through external companies. There had not been an organised trip out involving transport for people in wheelchairs for some time. The registered manager told us people had changed their minds at the last minute for the last planned trip. When asked about the organised social activities no-one made comment about there being a lack of opportunity. Staff told us they supported people in wheelchairs and others to visit the local shops and the local community as a whole.

Good

Is the service well-led?

Our findings

The service was well-led and people considered the registered manager to be approachable but people did not feel she was present enough in the home. One person said, "She is not here nearly enough" another person said, "I feel she needs to be in the home more regularly". A relative said, "She is approachable but not here enough". The registered manager explained her role which has also been clarified since the inspection. At Newlands the role of "general manager" encompasses the role of registered manager of the care service including management and resale of the properties in the care village. They are also operations director for another of the provider's care villages. At the time of the inspection the registered manager explained they should be working three days at Newlands but this was not always working out. Minutes of a staff meeting dated in April 2016 recorded staff had been reminded about when the registered manager was present at Newlands. For example, in one week this was one day at Newlands and the rest of the week at other services owned by the provider. Staff however confirmed she was always contactable by telephone if needed. Newlands also had a full time clinical lead who was a registered nurse. Their responsibilities involved a lead responsibility for all care/nursing issues as well as the checking/monitoring of all staff competencies.

The registered manager explained their main challenge was delivering what the care village at Newlands wanted of her. The Provider Information Return (PIR) told us this was to be resolved in the next 12 months through the recruitment of a new manager for the Newlands site. The registered manager explained that to date they had had little success in this. The reason given was people in the Newlands community had expressed a wish for this person to be a registered nurse but their skills also needed to include experience in property sales and this combination was difficult to find.

We were told the Directors visited the service approximately twice a month when people and staff could speak with them. A representative of the provider visited once monthly to support the registered manager and sign off completed audit actions. Managers held meetings with different staff groups of which we saw the minutes of. We attended two daily heads of department meetings where information was shared and collective plans made for the day and week ahead. For example, if maintenance work was to be completed in a certain area of the home the housekeeping team knew when this would start and finish and could plan the required cleaning accordingly. Information about planned visits and preparation for admissions was passed on in these meetings. These meetings were also used by the registered manager to pass on important information from the provider and to communicate their expectations. The registered manager said "We work as a team".

The registered manager explained that all staff were valued and an individual recognition system was in place called "Employee of the Month". A monthly prize was awarded to the winner of this. The registered manager said anyone could nominate a member of staff and small but important contributions to the "whole team approach" were recognised. For example, one member of staff in one team had "kept things ticking over" for one month without making any obvious personal reference to this but it had been noted and they had won "Employee of the Month". The registered manager told us a lot of work had been done over the last couple of years in empowering staff and supporting them to feel proud of their achievements. A staff survey completed in 2015 had been passed out to all 30 employees. Ten staff completed the survey and

nine staff confirmed they felt valued.

The quality and performance of the service was monitored through auditing processes and by gathering feedback from people, their relatives and visitors. We reviewed various audits which were completed by the management team. These included audits of the infection control systems, care plans, staff personnel documents, medicines system and various health and safety checks. The actions were subsequently checked by a provider representative during their monthly visit. The improvements in record keeping identified during this inspection were not formally recognised in the audits and neither were the recording shortfalls around the Mental Capacity Act 2005 (MCA). The registered manager explained that staff had received different guidance in relation to the MCA from different local authorities and CQC inspection teams. We explained that a consistent way of recording what had been considered and completed under the MCA needed to be established throughout the provider's group. The registered manager subsequently forwarded information to us which showed that they were exploring ways of improving record keeping in relation to care planning.

The views of people were gathered and the results of a 'resident and relative survey from 2015 were on display in the reception area. People had opportunities to express their views on an informal basis when they visited, by email or during a monthly 'resident and relative' meeting held with the Directors. A new chef was due to start soon and a date had been booked for people to meet with him and express what they would like to see altered or improved. People told us they would like communication by the management team on changes and planned improvements to improve. They felt the lack of the registered manager's presence on site currently contributed towards this. Since this inspection the provider has confirmed that the registered manager is present at Newlands four days a week.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and relevant care plans were not always maintained in order to provide guidance to staff about peoples care and treatment. Regulation 17 (1) (2) (c).