Newlyn Court Limited

# Newlyn Court

## Inspection report

Merstone Close
Bilston
Wolverhampton
West Midlands
WV14 0LR

Tel: 01902408111

Date of inspection visit:
13 April 2016

Date of publication:
14 July 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

Our inspection took place on 13 April 2016 and was unannounced. We last inspected the service on 15 and 21 April 2015. The service was rated as requires improvement after that inspection but there were no breaches of regulations.

Newlyn Court is registered to provide care and accommodation for up to 80 older persons, some of whom may be living with dementia or have poor mental health. There were 65 people living at the service when we carried out our inspection.

The service 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.

People felt safe and staff were aware of how to protect them from the risk of harm and escalate any concerns. Risks to individual people were identified and minimised. Visitors were not always confident there was sufficient staff. We saw occasions where staff were busy, meaning people had to wait for assistance. People received their medicine when needed and in a safe way. The provider checked prospective staff to ensure they were safe to work with people.

People were supported by staff who had the appropriate skills and knowledge to meet their needs. People's health was promoted through timely access to a range of healthcare professionals. People had limited choices of food or drink, as they were not always given access to available options. People did have enough food and drink though, and it was presented in a way that met their specialist dietary requirements. People's mental capacity was assessed; however assessments and best interest decisions were not specific about the decisions people may need support with.

People did not always receive consistent kind and compassionate care. People received care that was often task orientated and staff did not always listen to, or respond to people at the point care was delivered. Staff understood people's needs and cared for people in a manner that respected people's privacy and dignity. People were supported to maintain their independence.

People were involved in the planning of the care and support they received. People were involved in appropriate pastimes which reflected their preferences and gave them enjoyment. The provider took action in respect of people's complaints but did not pro-actively encourage complaints or record outcomes from complaints to help capture learning or improvements the service may have made.

There was still scope for improvement in respect of some aspects of the service in respect of ensuring people received consistent person centred care. The registered manager expressed a wish to improve so the service was providing high quality care and was able to tell us of plans they had to help them achieve this.

Staff told us they were well supported and able to approach managers, who listened to them. There were systems in place to monitor and provide an oversight of risks to people and the service, so these risks could be minimised.

## 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

People felt safe and staff knew how to protect them from the risk of harm. There were systems in place to monitor risk and these identified and reduced risks. People were not confident the service always had sufficient staff, and people waited for assistance at times. People had their medicines when needed. Staff were vetted to ensure they were safe to work at the service.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People were supported to have enough food and drink and specialist dietary requirements were being met. However, food choices were limited, people were not always offered a choice of food or drink and their preferences were not always accounted for. People's mental capacity was assessed; however assessments did not provide information about the specific decisions that people were not able to make for themselves. People were supported and cared for by staff who had the skills and knowledge to meet people's needs. People were supported to maintain their health because they had good access to a range of healthcare professionals.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring

Peoples were not always listened to and there was inconsistency in the delivery of kind and compassionate care. People were not always afforded choices but were encouraged to be independent and were supported by staff who respected people's privacy and dignity.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive

People were involved in the care and support they received but a person centred approach to care by staff was not consistently

provided. Systems were being developed to ensure staff were knowledgeable about people's needs and preferences. People had involvement in pastimes appropriate to their abilities, preferences and gave them enjoyment. People's complaints were responded to, but outcomes were not always recorded

## Is the service well-led?

**Requires Improvement** 

The service was not consistently well led.

People views were sought and changes were made in response to these. The service was developing community links and looking to work with other specialist agencies. There was still scope for improvement in some areas of the service, for example ensuring that staff had a consistent caring approach, that staff deployment was improved, and complaints systems assisted good governance. Staff told us they were well supported and able to approach managers, who listened to them.

# Newlyn Court

**Detailed findings**

## Background to this inspection

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

The inspection took place on 13 April 2016 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist advisor who was a practising nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. Before the inspection, the provider completed 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. We also reviewed statutory notifications of incidents that the provider had sent us since the last inspection. Notifications are events that the provider is required to tell us about in respect of certain types of incidents that may occur like serious injuries to people who live at the service. In addition we sought the views of local commissioners about the service prior to our inspection. We considered this information when we planned our inspection.

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

We spoke with five people who used the service and seven visitors. We also spoke with the registered manager, assistant manager, two nurses, three care workers, the cook and one activities co-ordinator. We observed how staff interacted with the people who used the service throughout the inspection.

We looked at seven people's care records to see if these records were accurate, up to date and supported what we were told and saw during the inspection. We also looked at records relating to the management of the service. These included minutes of meetings with people, training records, complaints records, stakeholder survey records and the provider's self-audit records.

Requires Improvement

# Is the service safe?

## Our findings

Visitors we spoke with were not confident there were sufficient staff one telling us, "I don't think there are enough staff", a second, "There aren't many staff in the afternoon". A third visitor said, "We have seen people in the outer lounge waiting to go to the toilet for half an hour because there are no staff". A fourth visitor said, "A lot of people need two members of staff to help them so there is no one in the lounge then". While visitors did not feel people were at risk, they all felt there were occasions where more staff would be beneficial. We saw staff were visible around the home and that they responded quickly to requests for assistance from people, with the exception of lunchtime. During lunch we saw some people requested assistance and had to wait as staff were busy assisting other people. During the afternoon we saw two people on bed rest upstairs, who did not have the ability to use call bells. Although, we saw these people were checked by staff at least two hourly to be repositioned, staff were not able to tell us how these people would summon assistance between these checks if they were in discomfort or needed assistance. Staff could not demonstrate they carried out more regular well-being checks to see if people were safe, for example with documented checks. Management said they were aware and told us a staff member was allocated to cover this area, and staff we spoke with confirmed this. We spent time in this area in the afternoon and did not see this allocated member of staff around however.

Staff we spoke with said the provider did use bank and agency staff to maintain staffing levels and felt there had been some improvement in staffing levels recently. One staff member said, "There is enough [staff] and we can always use agency and we ask for specific people". The registered manager told us they had voluntarily restricted admissions to the service due to the dependency levels of people living at the service. They also told us staff vacancies had been filled and they were only using agency staff to fill vacant night staff posts for which they were using the same bank workers. They did tell us agency staff were used to fulfil people's needs where they had one to one support however, which may have reflected comment we heard from a visitor that, "There is a lot of agency staff". This was indicative that the confidence of relatives and visitors in staffing levels could be better. While we saw there were sufficient staff available to ensure people were safe, there were occasions where staff deployment could be improved throughout the service, for example people were seen to wait up to 30 minutes for staff to respond to their requests at lunchtime.

Two people we spoke with said they felt safe at the service and were cared for in a safe way. One person said, "They are looking after me here". Visitors to the service said people were safe. One visitor told us their relative "Is safe, I have never felt [the person] is unsafe". A second said "[The person] is safer, bottom line she is safer than at home" and a third that, "[The person] is safe enough". This indicated that people felt safe at Newlyn Court.

Staff demonstrated a good awareness of their responsibilities in respect of protecting people from harm or abuse. Staff were able to describe what abuse looked like, when they should escalate concerns and to whom. One staff member told us they felt people were safe and the reasons for this were that [staff], "Know the procedures for whistleblowing and understand the signs of abuse and what to do if they suspect it". Staff told us they had received training in local safeguarding procedures to support their knowledge. The registered manager also understood what they needed to do if they had concerns about abuse and we were

aware that any allegations brought to the attention of management had been promptly referred to the appropriate external bodies. This showed that staff knew how to protect people by raising any concerns about their safety.

The provider had taken steps to ensure people's medicines were managed safely and people received medicines as prescribed. One visitor told us the person, "Has been taking [their] medicines", another that, "We are kept in the loop and we are aware of what medication [the person] is on". A third visitor told us the person, "Can get painkillers when [they] want. They [staff] always ask 'do you want any painkillers'." We saw nurses administering medicines and these were given to people in a way that was safe, with the support people needed to take their medicines considered. Medicines were stored, managed safely and administered by staff who were trained, with their competence checked by the registered manager. People's Medicine Administration records (MAR) showed people received their medicines as prescribed. This included medicines that people had 'as required' where we saw there was clear guidance for staff to follow as to when these medicines should be given. However, we found records of application of people's prescribed creams indicated these were not always applied. We found positive outcomes found in respect of people's skin care which indicated creams were administered, but not consistently recorded. The registered manager assured us systems would be introduced to ensure these were recorded.

We found that systems were in place to ensure that the right staff were recruited to keep people safe. We spoke with staff that had been recently employed and they confirmed that checks, for example Disclosure and Barring checks (DBS), were carried out before staff began work at the service. DBS checks include criminal record and barring list checks for persons whose role is to provide any form of care or supervision. The provider had carried out checks to ensure all nurses employed had current registration with the NMC (Nursery and Midwifery Council), which is the regulatory public institution of nurses in the UK.

We saw risks to people had been identified, assessed and recorded in their care records. A relative told us, "We know [the person] was risk assessed. [The person] has a bed rail and crash mat. They told me the bed lowers which is safer for [the person] if [they] fall out and there is an alarm on the bed that goes off if [they] fall out of bed". We saw people's records accurately reflected risks to people and how these risks were appropriately managed and minimised. Staff we spoke with understood what these risks were and we also saw they had signed records to evidence that they had read and understood the risk assessments and management plans. For example we saw that when people were at risk of developing broken skin we saw these risks were assessed and plans were in place to ensure risks were minimised. We saw people were repositioned in accordance with their plans, with the result no person had developed broken skin areas. We saw some people presented behaviours that may challenge staff. Staff were well informed as to why people may become anxious. They knew what steps to take to ensure situations that create anxiety did not arise, or how to respond to them if they did to calm a person's anxiety.

Requires Improvement

# Is the service effective?

## Our findings

People told us the food was not always enjoyable. One person told us, "I Wouldn't say I like it, I eat it". People were not always offered choices in what they had to eat and drink. One relative told us, "Food is the issue, especially at teatime. [Person] likes certain things; couldn't they say what do you want? There is no choice at teatime." Another relative told us, "[Person] can't eat tuna; [person] gets given it at teatime. [Person] will say they won't eat it. Some will change it. Some will just leave it". During this inspection, we saw the drinks trolleys had a number of drinks options for people, however we observed that people were not being offered a choice. We asked staff why people were not being offered a choice of drink and they told us they knew what people wanted. We also observed lunchtime and saw people were offered a choice of two meals. Staff told us that if people did not like the choice of food they would be offered an alternative choice. However, we saw two people who did not eat their meal were not offered an alternative choice by staff. Staff did not always support people in making decisions about what they would like to eat or drink.

We looked at how staff supported people with their food and drink at lunchtime. For example, we observed some staff tried to hurry people to eat when they were assisting them to eat their meals. We saw one member of staff putting a spoonful of food to the mouth of a person who still had a mouthful of food. We also saw there were limited interactions between people and staff during mealtimes. For example, we observed one member of staff assisting a person with a drink. There was no interaction with the person throughout this activity. Some people were observed having to wait lengthy periods for their meals. For example, we observed a person who asked for staff assistance 3 times and was not responded to by staff. The person started eating with their fingers. Another person had finished their meal and had asked for pudding. We observed a 30 minute wait for pudding to be served to this person. People did not always receive appropriate support at mealtimes.

We looked at peoples care records and saw people had individualised eating and drinking plans, for example, a soft diet was available for those who required it and we saw the staff took advice from the dietician. We saw staff followed plans that had been put in place from a speech and language therapist in relation to supporting people to eat and drink by using aids, cleaning their mouth between food, offering a pureed diet and sitting people upright to eat. We saw people were kept hydrated and we saw people had hydration charts which showed they were exceeding the target amounts of fluid required. This showed that people received sufficient food and drink and were supported to eat and drink in accordance with their eating and drinking plans.

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 people 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 the provider had completed assessments of people's capacity in accordance with the MCA and we saw decisions had been made in the best interests of people. However, MCA assessments and best interest decisions were vague and non-decision specific. For example, the assessments did not record the specific decisions that people were not able to make for themselves.

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 saw the registered manager had made appropriate applications to deprive people of their liberty where they felt this was in their best interests to keep them safe and had a process to track when DOLS applications needed to be reviewed. Staff had not received formal training on MCA/DOLs. One staff member told us, "The manager deals with it all". Staff had a general understanding of the principles of the MCA, however, during our inspection we saw staff did not always ask people for their consent before providing care and support. For example, some staff would ask people if they were happy for support to be provided, whilst other staff members would not. This showed that staff did not consistently seek people's consent to care.

We looked at staff training records and saw some training had not been kept up to date; however the registered manager and the training coordinator confirmed there were plans in place to address this. Staff were confident in their abilities to carry out their roles and told us they had access to personal and professional development opportunities such as training and one to one sessions with their line manager. One staff member told us, "Training needs are met very well for us all'. Another staff member told us, "The manager is looking for lots of courses for us". Another staff member told us, "The training I received on induction has been out of this world, I've been really impressed". This showed people were supported by staff who were receiving training in order to support them to carry out their role effectively and that the registered manager was keen to ensure all staff were kept up to date with training.

People were supported to maintain their health and the service had access to a range of healthcare professionals for ongoing support such as GP's, Dentists, Chiropody, Speech and Language Therapy, Opticians. One relative told us, "The doctor comes in Fridays". During our inspection we saw the dentist was visiting the home. We saw peoples care records showed evidence of a range of input from other healthcare professionals. The assistant manager told us the service was trying to build further links with other external agencies to enable a good range of specialist services to be accessed where required. This provider had good links with healthcare professionals in order to support people to maintain good health.

Requires Improvement

# Is the service caring?

## Our findings

We observed inconsistency in the delivery of caring and compassionate care. Relatives we spoke with had mixed views in relation to the quality of the care being delivered. One relative told us, "I'm seeing more concern today but that's how it should be all the time". Another relative told us, "There are good days and bad days". Another relative told us how they had come to visit their relative one day and found them to be scruffy. They told us, "One time we came in and they had put clothes on [person] that were too short and too small, they were too tight for [person] and halfway up [persons] legs. [person] has a wardrobe full of clothes. I told them that [person] looked very scruffy. Since then it's been a lot better on but maybe this is because we visit on a specific day". Another relative told us, "One day I came in and [person] had mess on their hand. It may have been a day that [person refused personal care, but [person] still shouldn't have had mess on their hand".

We saw that staff did not always consider peoples well-being and did not always treat them compassionately when providing care and support. For example, relatives told us that people were not always listened to and their requests for support and assistance were not always acted on. One relative told us, "Some will listen to [person], some will just walk away". Another relative told us, "[Person] asked them to close the windows as they were cold but it wasn't done". Another relative told us, "[Person] needs to be moved more, [person] is always in a chair I have seen [them] slumped over and [relative]and I have had to move [them]. I wished they moved [them] a bit more". During our visit we observed a person trying to reach over the side of an armchair to get a tissue. We observed a staff member walk past the person twice without providing assistance. We also saw a person wanting to talk to a staff member. Two staff members walked past the person without interacting. We saw another two members of staff talking between themselves whilst supporting a person with a drink, there was no interaction with the person during this task. This showed that staff did not always listen or interact positively with people.

However, some relatives thought staff were caring and friendly. One relative told us, "The staff are friendly". Another relative told us, "There are some good ones". Another relative told us "It's very good, they look after them. We feel we have peace of mind". We saw some examples of caring interactions, for example a staff member noted a person's food had been left uncovered for some time before they were able to eat it. The member of staff checked it was still warm before assisting the person with eating their meal. We observed a person with poor eyesight being assured they would be able to enjoy the afternoon entertainment of an animal encounter as although they were unable to see well they were assured that they could touch them. The person was reassured by the comments from the staff. We observed a member of staff asking a person if they would like the curtains drawing as they noticed the sun was in their eyes. We also observed a staff member discreetly cleaning a person's face after a meal. However, staff were not always consistent in their caring and compassionate approach towards people living at the home. Staff had little time to sit and chat to people, and we saw that interactions with people were often focused on the task in hand rather than being kind and compassionate. During this inspection we observed some positive examples of caring interactions between people and staff, however this was inconsistent .

There was inconsistency in how people were involved in making choices about their care. Staff told us that

they tried to involve people in planning and making decisions about their care as much as possible. One staff member told us, 'We always ask them what they want and tell them what we are doing'. Staff told us they always offered people choices in relation to the care and support they received. One staff member told us people had the choice as to what time they got up in the morning. We saw that some people were having breakfast later in the morning. Another staff member told us that sometimes people needed support to make decisions about their care and therefore they would support them to make decisions by offering them choices. For example, one staff member told us how they would ask people what they would like to wear and may offer a range of choices of clothes so that they could be involved in making decisions. . Staff told us they respected people's right to choice. For example, One staff member told us, "If they [people] refuse something it is their choice, we try to encourage but we never force people to do anything". This showed that staff understood the importance of offering people choices, however people were not always afforded choices in the care and support they were provided. For example, We saw that in one of the lounges the television was on, however people were not afforded the choice as to what program they wanted to watch. One person told us, "I watch television but this isn't my favourite program, I need to watch my program". We also saw a person asking a member of staff for a cup of tea, the staff member provided the person with a glass of juice and told them that the tea would be served later. We observed a person being moved with the use of a hoist. Once the transfer was completed the person was told where they needed to sit and was not offered a choice. Staff understood the importance of offering people choices, however people were not always afforded choices in the care and support they were provided.

People were encouraged to do what they could for themselves. One staff member told us that, "We try to keep people as independent as possible". Another staff member told us, "We try to get them [people] to do what they can". We observed a person being assisted to mobilise from a wheelchair to a chair, the person was able to mobilise independently with the encouragement of the staff. This showed that people were encouraged to be independent.

People were supported by staff who respected people's privacy and promoted peoples dignity. Staff told us how they demonstrated respect for people's privacy and dignity by knocking on doors before entering bedrooms, closing doors and covering people during personal care. One staff member told us, "When I am delivering care I always ask them if I can do something, I ask them what they would like and how they would like it done and tell them what I am doing".

Staff told us and we saw there was an open visiting policy. There were no restrictions on visit times for friends and relatives and the registered manager told us how relatives were invited to attend day trips and be involved in the care of their relatives during visiting.

Requires Improvement

# Is the service responsive?

## Our findings

The registered manager saw people's care plans were essential to providing good person centred care. They told us about improvements they were making to people's care plans so they would be more concise and easier to understand. We saw the provider was using a new format for care plans that was clearer and easier to follow, for example it was easier to track how people's care was planned. We saw people had detailed and informative care plans which staff understood, with staff able to tell us about people's care needs and preferences as to how they liked their care to be delivered. However, throughout our inspection we observed occasions where the care people received was not consistently person centred. For example, we saw people were on occasion ignored, and their expressed preferences were not listened to. Staff did not always respond to people in a person centred way and many interactions were focused on a task rather than engaging with people as individuals. We also observed occasions when the support people received did not meet their individual needs. For example, staff were not supporting people at an appropriate pace when assisting them with their meals. This contrasted with other occasions where we saw some staff were very attentive and followed what we saw documented as people's preferences.

Nurses we spoke with told us they encouraged staff to read care plans, and said they were responsible for promoting people's, or representatives involvement so as to ensure care plans reflected people's current needs. Some of the relatives we spoke with confirmed this involvement and we saw people's records contained a relative's communication sheet to record any comments in relation to their relative's care. One visitor told us the care their relative received was appropriate and said of staff, "They are doing the job; they [the person] have improved since being here". We saw the staff were completing people's life histories, with the involvement of their relatives to provide information about people's past, that may be relevant to their current preferences. One relative said however they did not always feel involved though telling us, "I don't get told things, I don't get informed". This showed that while people's care plans were improved the care people received was not consistently person centred.

We looked at people's records in respect of how their needs were identified at the point of admission. We saw the registered manager or nurses gathered information about a person's needs before they moved to the service, for example through meeting with people, their representatives and gathering further information from services they were currently using. The registered manager told us this helped them make decisions about the service's ability to meet the person's needs. They told us where they felt the person's needs were too complex for them to meet they would advise the person or their representatives that they were not able to accommodate them. This showed there were systems to consider the ability of the service to respond to people's needs prior to their using the service.

We spoke with people's visitors and they told us about people's preferences, but some said it was sometimes difficult for them to participate in the hobbies and pastimes that they used to like.
Visitors told us people were encouraged by staff to have involvement in pastimes though. One visitor said, "[The person] has been to most of the [activities], they do enjoy it. They need things to keep them stimulated and they have that here". Another that, "I have been here in the evenings. It is quite good. They have music. There is plenty of entertaining". A third relative said, "We had a little party with [the person's] two daughters,

with cakes and wine" another that, "People from the church come in and visit". People's diversity was considered for example peoples religious beliefs were respected and people had the opportunity to have a visiting chaplain of their faith or attend church should they wish. An activities coordinator was employed at the service and they told us about group sessions they advertised (as we saw in the service's reception area) so that relatives were able to attend. We saw that there were also planned trips out into the community, with comment that a narrow boat trip was to be arranged. The activities organiser recognised not everyone wanted involvement in group activities and they told us they ensured people received one to one time to undertake pastimes they liked such as reading, chatting and having their finger nails painted. This was recognised by staff to be important for those people who were cared for in bed and were unable to join in with the group activities. Staff told us they tried to ensure people's interests were encouraged, for example they said one person liked to dance but was particularly frail. Staff said that in order to support this person to dance two staff assisted the person when dancing. We saw the activities co-ordinator supported people with appropriate activities in a 'sensory' room where they put lights and music on while talking to them and giving them a hand massage. We also saw there was a visiting animal encounter for people in the afternoon, where people were able to touch and interact with some unusual creatures, such as giant snails. This showed the provider worked to support people to main or participate with appropriate activities or interests.

The registered manager told us about a number of ways they sought people's views. These included comment sheets (seen to be available in the home's reception) and questionnaires that were sent out annually. One relative told us, "We have filled in some questionnaires". Some visitors said they had not, but acknowledged other family members may have done. A third visitor told us about the service's newsletter and said, "I picked up the newsletter at the front desk". The activities co-ordinator also told us they were trying to develop more involvement through meetings.

The registered manager said there had been no formal complaints about the service in the last 12 months but said if concerns were received they would be investigated and resolved. We saw the service had a complaints procedure on display, although information within this was not indicative that complaints would be welcomed as a means to improve the service people received. It stated in the provider's complaints procedure that, 'We hope that rather than having complaints about our service you will have cause to compliment staff' as the latter would be a means of improving staff morale. One relative also told us, "I was complaining a lot about certain things". They told us they had they had raised a verbal complaint, but we found there was no record of this. The relative did say though, "The issues that I have raised have been resolved". We also saw another record of discussion with a relative was indicative of some potential concerns, although these had not been looked at as a complaint. The relatives concerns we saw had been addressed with verbal feedback given to them. Another relative told us of some minor concerns and said, "It gets sorted out quite quickly. They will endeavour to sort it out". This showed that while people's concerns were addressed, the importance of acknowledging complaints was not always recognised as a formal tool for service improvement.

Requires Improvement

# Is the service well-led?

## Our findings

The service had a long standing registered manager who was familiar with the service and had a good understanding of the service and their responsibilities. They had recognised the need for improvement after our previous inspection and we saw some positive changes had been progressed. However shortfalls in the service were still impacting on the quality of care people received, for example people had a poor dining experience and promotion of choices was inconsistent. We met an assistant manager who had been appointed to allow the registered manager more time to drive improvement in the service. For example the registered manager told us they were trained in dementia care mapping (DCM) and they would have more time now to observe and evaluate outcomes for people living with dementia. DCM is an established approach to achieving and embedding person-centred care for people with dementia. They also told us how they had signed up to, 'The social care commitment' and were looking to meet this by identified dates. The social care commitment is a national initiative to ensure people who need care and support within adult social care services receive high quality services. We saw the service had started to adapt the environment to make it more dementia friendly, for example there were focal points on the walls; however there were still improvements to be made. For example, we found systems to show that staff were deployed effectively were not always robust, and the care people received was not always caring and compassionate. In addition, while verbal complaints were responded to, the complaints systems was not used in a way that would identify how the service had responded to people's comments, this so the provider could use this to demonstrate how they used people's feedback to support good governance.

The majority of people we spoke were positive about the service and how it was run. One relative told us, "My overall sense is that it is fine" and "I think it is run fairly good considering how big it is".
Another relative said, "The management is okay. The home is okay". The majority of visitors we spoke with said staff listened to people and one relative said, "We think there is very good communication". Three relatives did feel communication could be better on occasion however, one commented they were not confident in approaching some staff. We saw the provider had received recent written comment from people through their surveys that was of a positive nature. One relative had stated, "I appreciate the care and attention all the staff are giving [the person] and the patience they show [them]'. Another had commented, 'Delighted with the care at Newlyn Court'.

The registered manager had a good understanding of their responsibilities in terms of the law, and told us how they ensured they kept themselves up to day with current developments, whether national or local, for example attending best practice days with the local Clinical Commission Group (CCG). We found the provider had met their legal obligations around submitting notifications to CQC and the local safeguarding authority. The provider was aware they were required to notify us and the local authority of certain significant events by law, and had done so. We also saw that the service's inspection rating was displayed as required by the law.

There were a number of systems in place to identify, assess and manage risks to the health, safety and welfare of the people using the service and others. We saw incidents, accidents, safeguarding and indicators of poor health were recorded and monitored for trends and patterns, to inform how risks were managed.

While we did find some areas where records could be improved, we found record keeping was better than we saw at our previous inspection in April 2015, with audits in been introduced by the registered manager to check people's records.

The activities co-ordinator told us they had tried to engage with relatives through meetings but take up had been very limited, but they were looking to combine meetings with a dementia café. The assistant manager also told us they had been working with another local service, holding a coffee morning where people from another service had attended. They also said they were developing links with specialist services in the community, for example the sickle cell society, which they saw as a valuable resource for specialist support when required. The assistant manager told us they were, "Trying to make as many links with the community as possible". This demonstrated the management were looking to develop links with the community, and other stakeholders that could provide support the service.

Staff expressed confidence in the way the service was managed and said they were well supported by managers. Staff were able to articulate a good understanding of their roles and responsibilities. They told us that the registered manager was visible and approachable and that relatives know who the manager was. One staff member said, "[The service] is managed well", another that the, "Manager and assistant manager are always contactable". Staff told us they felt well supported. One member of staff said the management were, "Very supportive, always had support" and "It's good to work here, communication is good between us and we work like a team". Staff confirmed they were able to have one to one sessions to reflect on their practice and nurses we spoke with said they were able to access support to revalidate their professional practice. This demonstrated staff were well supported by the management team.

Staff told us they felt able to raise concerns and while they all felt able to approach the registered manager they also said they would be able to contact the provider or external agencies and 'whistle blow' if needed. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, dishonest, or not correct within an organisation that is either private or public.