Huddersfield Nursing Homes Limited

Newsome Nursing Home

Inspection report

1-3 Tunnacliffe Road
Newsome
Huddersfield
West Yorkshire
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06 December 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Newsome Nursing Home took place on 29 November and 6 December 2016 and was unannounced on both days. The home had previously been inspected in June 2015 and was found to be requiring improvement in all areas with breaches of regulations in dignity and respect, safeguarding service users from harm, nutrition and good governance. We checked during this inspection whether improvements had been made.

Newsome Nursing Home is a registered nursing home in a quiet residential area of Huddersfield. The home provides accommodation for up to 46 people with residential, nursing and dementia care needs. The home consists of linked houses, Newsome Court and Newsome Lodge. Five bedrooms of Newsome Court are provided to support the care of people living with dementia. Accommodation in both houses is provided over three floors which can be accessed using passenger lifts. There are secure gardens which provide a private leisure area for people. There were 33 people in the home on the days we inspected, four of whom were living in Newsome Court.

There was a registered manager in post although they were on leave on the first day of the inspection. We did speak with them on the second day. 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 therse had been considerable changes to the home since our last inspection, most notably in the attitude of staff which helped to promote a welcoming and positive atmosphere within the home.

People told us they felt safe and we were confident staff knew how to acknowledge and respond to any concerns around potential abuse or neglect.

Although risk assessments were in place they were not always detailed enough and did not always get updated following an incident. Combined with a lack of robust equipment audits this meant risks to people were not always minimised to reduce the likelihood of harm. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as not all risks had been identified meaning people were being placed at the potential risk of harm through faulty equipment. The registered manager implemented an immediate plan to address these concerns and we saw evidence of this following the inspection.

Staffing levels were appropriate to the needs of the people in the service and we saw people being responded to promptly and with care. Medicines were stored in line with requirements and the home had effective policies and procedures in place for staff to follow which we observed in their practice.

People told us they enjoyed the food and there was plenty of it. We observed people being offered drinks

throughout both days and supported with their nutritional needs as required. External health and social care support was requested when required and we saw evidence of other professionals' views being integrated into the care plans.

The registered manager understood the requirements of the Mental Capacity Act 2005 well and we saw evidence of appropriate authorisations in place where people's liberty was deprived.

Staff had a pleasant and friendly manner with people, and it was evident they knew people well. They promoted people's dignity and privacy at all times. There was ongoing interaction throughout both days in terms of activities and conversation with people, assisted by the activities co-ordinator who amended their plans according to people's wellbeing and preferences.

Care records were detailed and person-centred, reflecting people's needs and choices. There was good cross reference between risk assessments and other documentation to enable staff to access all key information quickly. We found care records were updated in a timely manner.

Complaints were handled in depth and thorough investigations conducted where necessary.
The registered manager was fully aware of all key events in the home and was able to relay all recent changes. We found the audit system was not robust enough to identify some of the concerns we noted in relation to equipment but had confidence this would be taken forward and urgent improvements made. This was evidenced following the inspection where photographic and documentary evidence detailed the changes made.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found equipment checks and risk assessments were not always completed to protect people and the registered manager took immediate steps to rectify this.

People told us they felt and we found staff had a sound knowledge of how to identify and report any signs of abuse or neglect.

Staffing levels met the needs of people in the home as staff responded promptly to call bells and had access to staff during the day.

Medicine storage, administration and recording and infection control procedures were robust.

Is the service effective?

Good

The service was effective.

Staff had access to regular supervision and ongoing training.

The home was operating in line with the requirements of the Mental Capacity Act and its associated Deprivation of Liberty Safeguards.

People were supported with their nutritional and hydration needs as required, and supported to access external health and social care support when needed.

Is the service caring?

Good

The service was caring.

Interactions between people and staff were positive and friendly.

People were involved in a review of their care needs where they wished to be and their privacy and dignity was promoted by all staff we observed.

Is the service responsive?

Good

The service was responsive.

A wide range of internal and external activities was on offer to people which reflected people's preferences and needs. It was evident staff knew people well.

Care records had been integrated onto the electronic system which provided current details of people's care needs.

Complaints were handled in a timely and thorough manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home had a positive and welcoming atmosphere and people told us they were happy.

Meetings with people in the home and staff were held and people's views were heard.

Audit checks were not robust enough to identify problems, especially with equipment, and the registered provider acknowledged this. The registered manager implemented an action plan immediately following our inspection to address these concerns.

Newsome 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 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 29 November and 6 December 2016 and was unannounced on both days. The inspection team consisted of two adult social care inspectors.

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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service.

We spoke with seven people using the service and four of their relatives. We spoke with 13 staff including three care workers, one senior carer/team leader, three supervised practice nurses, one nurse, the staff member responsible for maintenance, one member of the domestic staff, the activity co-ordinator, the regional manager and the registered manager.

We looked at eight care records including risk assessments, seven staff records, supervision records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

One person said "The staff are all marvellous. Nothing is too much trouble and they always come when I need them. I prefer to stay in my room. I have my buzzer but I try not to use it. The staff are all busy seeing to the others who need it." Another said "I do feel safe living here."

Staff were able to identify signs of abuse. One member of staff said "I would raise any safeguarding concern with the manager if I had any. I am aware to look out for bruising, changes in people's behaviour or what people said to me. I think people get good care here as the home is safe and there is a good team. We all work together." Another member of staff told us "I report any safeguarding concerns such as incidents between residents, bruises and if people raise any concerns." They would alert the manager and also report to the safeguarding team. A further staff member said "All staff keep people safe". We also spoke with a relative who had been involved with the home for a number of years and they told us "I have never seen anything which concerned me."

The registered manager reported safeguarding concerns appropriately and we saw evidence of thorough investigations with risk assessments in place following incidents where necessary. The registered manager had a close relationship with the local authority and liaised with them ensuring people's needs were reassessed where it became evident the home was no longer suitable.

We observed safe moving and handling practice with the procedure being explained in full to people. We saw one person on return from the hairdressers being asked if they wished to transfer to a more comfortable chair and then told how this was going to be achieved. At each stage the person was supported appropriately and their dignity respected through the use of a screen to shield the view from other people in the lounge and a blanket placed over their legs. They were continually asked if they were comfortable and reassurance given.

Risk assessments showed the hazard, risk and action to be taken to minimise this. In one person's records there were risk assessments relating to mobility, falls, personal care, skin integrity and bed rails. Each risk was graded as high, medium or low with actions noted to reduce this to the lowest possible likelihood of harm. People's moving and handling assessments included reference to their communication abilities, physical frailty and behaviour along with their history of falls. They outlined the necessary equipment and guidance staff were to follow although the methodology was not always recorded in full.

During our check of people in bed at 6pm on the first day of inspection we were concerned about one person in bed where there seemed to be a large gap between the bottom bed side bumper and the mattress. The person was very close to this side of the bed and a pillow had been wedged in the gap to prevent their leg from becoming trapped. We spoke with the nurse on duty who said they should have a wedge cushion but they did not know why they didn't have one. On the second day of inspection this had been provided and the maintenance man had checked the positon of the bed rails.

We looked at bed rails risk assessment and saw noted "Ensure at all times that cot rail is locked into place,

you will hear a click when this is done. Ensure rails are compatible with the mattress/bed and are the correct height". However, we saw there was no specific guidance for staff as to how to do this. The maintenance staff member told us how they adapted the bed rails with an additional rail to make them taller when there was a risk the person could roll over the rails.

In one care record we saw one person was at risk of entrapment as they were quite agile in bed, as they were able to turn themselves around completely. One incident was recorded for 4 November 2016 where this person had 'been shuffling around their bed, had removed their bed bumpers and had trapped their left arm between the bed side rail and mattress. Although this did not result in a significant injury there was no evidence of an immediate re-assessment of the risk to this person of having bed rails in place. The only information noted was "staff to be observant when [name] is agitated." There had been a previous incident for this person in March 2016 where staff had freed this person's leg, which had become trapped between the left side bed rail and the bed, by the use of a slide sheet to move them to safety. However, again there was no reference to any reassessment of need.

This person had bed rails which did not attach to the end of the bed but finished some way short. We spoke with the staff member responsible for maintenance who advised us they had adjusted the bed rails to restrict the gap at each end to limit the future risk of harm so there was a smaller gap at each end. They told us "the bed rails come as a standard two bars kit and if a further bar is needed I add an extra bar and then fix it using the two fixing bars provided." However, they also noted the additional bars came in a shorter length, hence the gap we observed.

We discussed our concerns with the registered manager about this on the second day of the inspection and they said some of this information had been lost in the transition to the electronic record system. They showed us their previous paper risk assessment which provided all the necessary information and agreed to re-implement these until such time the electronic system could accommodate these changes. This was completed promptly after completion of the inspection and they acknowledged they had needed to address this in more detail.

We noted the window restrictors in place did not comply with current HSE guidance and advised the registered provider this needed to be remedied with immediate effect. In one room on the first floor the attached restrictor had broken and needed urgent attention as the window opened fully. All window restrictors were immediately replaced following the inspection which reduced the likelihood of serious injury or harm.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people's safety was not being considered in full detail. We did acknowledge the immediate improvements following our inspection and saw the registered manager had plans in place to implement regular and thorough checks to minimise the risk of future harm.

Accidents were logged on people's care records and analysed on a monthly basis detailing who had had which accident, the time and possible cause and what remedial action had been taken. Where specific incidents had occurred details of the event and action taken both immediately and further on was cross referenced to other care plans and amended support guidance for staff.

People told us they saw the same staff and the staff team was stable. We spoke with staff about their working hours. One told us "I work regular shifts although they can be long days." However, they also said there were enough staff and "we communicate well with each other. We have handover records which tell each shift what has happened the shift before." We saw these records contained detailed information about

the care people had received, their ongoing needs and overview of their situation. Another staff member said "I work 13 hour days but I'm happy to work a lot."

Staffing rotas showed most care staff worked combined shifts of early and late during the day and had responsibility for overseeing the care of specific people during their shift. The registered manager told us key tasks were assigned to staff at the start of each shift and break times allocated so people were never left unattended. We checked the staffing rotas and found staff had regular breaks in between working and where there were shortfalls in number s these were filled by agency staff.

We heard one person shouting for help in their room and staff attended promptly. One person who preferred to remain in their room told us "I have my buzzer and staff usually come quickly when I press it. There may be more of a delay at mealtimes but I understand that. Staff always apologise if they take a longer time to answer it." Another person said "I always have my buzzer and staff will always come."

We checked recruitment files and saw staff had been interviewed and evidence of their answers were in their files. References had been obtained from previous employers and identity checks had been carried out. This was especially important for staff who had been recruited from abroad where the usual checks were not able to be carried out immediately. However, checks had been obtained from their relevant police authorities showing whether there were any concerns prior to employment commencing. The registered manager did ensure that DBS (disclosure and barring checks) did take place as soon as possible after employment for these members of staff. The registered provider had an active recruitment link with sponsored nursing staff from other countries who sought practical experience in the UK in order to gain their PIN to enable them to work in the UK. They explained that this was their attempt to deal with the shortage of nurses within the UK.

We observed medication being administered to people. Staff took time with people, sitting with them ensuring they were taking their tablets safely and had swallowed them. In between administration the staff used sanitising hand gel to minimise the risk of infection. One staff member said "When I was new I was shown how to do this [medication] but now I do it by myself. If I get stuck I ask the nurse on duty."

There were two medicine trolleys in the home which were stored in the treatment room where regular checks of the room and fridge temperatures were recorded. Controlled drugs were stored in line with legal requirements and people prescribed PRN (as required) medication had appropriate protocols in place to advise staff as to when the medicine should be given. Medicines were only administered by team leaders and qualified nurses following specific training and were stored correctly with dates of opening noted on creams and liquids. We saw evidence of annual medicine competency checks for all necessary staff.

Staff had access to personal protective equipment such as gloves and aprons when assisting people with personal care tasks. These were stored in the bathrooms to aid ease of access. We spoke with the domestic staff who advised us there was a plentiful supply of cleaning materials and they understood the importance of safe storage of hazardous chemicals as required under COSHH (Care of Substances Hazardous to Health) guidelines. They were also able to explain the requirements for reducing the risk of infections by the use of specific cleaning equipment.

Good

Is the service effective?

Our findings

One person said "The food is nice and there is always something to eat. I was helped to understand the importance of being hydrated when I moved in and staff encouraged me to drink more for good health." Another person told us "My breakfast is beautiful, it always is. It's the best." A further person said "My dinner was nice – very tasty."

People were offered a choice of breakfast and meal choices for later in the day were displayed on a large notice board in both houses along with the day, date and weather to help orientate people. The cook came into both lounges to update the board with the menu choices and chatted, explaining the options to people. Staff also told us people always had a choice of food and were able to tell us about people's preferences and dietary needs. This information was displayed in the kitchen which included a four weekly menu, and people's daily menu choices were noted alongside this.

We observed people in their rooms being supported where needed with their breakfasts and staff speaking to people, offering them more drinks. In the communal lounges people were asked regularly if they wanted a drink or a snack. One person said "I am always asked my choice of food. The meals are nice and hot, and I can always have more if I want it."

During lunchtime in the unit for people living with dementia we observed people being given pre-plated, covered food from the trolley. We saw people seemed to be enjoying their dinner and lunchtime was a sociable and happy time for people. Staff were very attentive to people's needs, offering drinks and desserts. Where encouragement to eat was needed, people were offered this. In the lounge in the main house we observed people being supported with eating and drinking as needed. One person started playing with their spoon and a member of staff patiently came and guided them how to use it so they could eat by themselves.

We noted that not all food and fluid charts were recorded in a timely manner or in sufficient detail. One noted "ate all dinner" but didn't specify what this had been and another said "half of main meal". This would prove difficult for staff to determine what a person's actual nutritional intake had been and we spoke with the registered manager about this who agreed to take further immediate action to remind staff of the importance of detail. We saw this had been a topic of supervision previously. People were weighed in line with their needs and weights recorded on their care records with any changes being identified quickly and action taken where necessary.

All staff had received an induction and shadowing experience before commencing work on their own. Induction training included safeguarding, infection control, moving and handling, food hygiene, dementia care, health and safety and dignity and respect, amongst others. Each topic had a workbook with completed and marked answers, as well as evidence of oversight by the registered manager, and further discussions where learning needed to be further embedded. A checklist was signed by both employee and the registered manager to evidence it was completed in full.

Staff had access to regular supervision and training. One person said "I am confident staff know what they

are doing and will look into any issues if I had them." One staff member told us "Supervision is every couple of months and training is regular. However, I do sometimes have to come in on my day off to complete training." Individual supervision records evidenced discussion between employee and manager, and any necessary action learning points. The registered manager was very clear staff had three opportunities to improve if issues with their practice were noted and each stage was recorded, with action taken if there was no improvement.

The registered manager advised there was a minimum of four supervisions a year for all staff, one of which was face to face, two group supervisions and an appraisal. Over the year staff had received group supervisions in infection control, pressure care, distraction techniques, fire, topical medication, and skin care among other topics. Attendance sheets were completed and a register of attendees monitored.

Staff also had received appraisals which were focused on their own achievements and developmental needs. There was evidence of staff engagement in the process by a record of their comments and views. Feedback was given by the registered manager on their performance in relation to job knowledge, time keeping, empathy, communication skills and team working among other areas. Where further development was required training was offered and encouraged.

One member of staff told us "I have done plenty of training and we receive regular updates on moving and handling and also safeguarding. I have also completed medicines training and I understood the importance of being careful when administering medication." We saw the training matrix and found staff had received regular updates in all key areas such as safeguarding, moving and handling and dementia awareness.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people lacked capacity we saw the home had obtained the relevant documentation to support the decision-making process for people such as evidence of lasting power of attorney.

One staff member said "I understand people may not be able to make decisions, for example they might be confused, but it is always their choice. They always have the choices. I can't force people to do what they don't want to do." Capacity assessments had been completed in relation to specific decisions such as medication administration and bed rails although the subsequent best interest decisions did not detail sufficiently how the decisions had been made in line with the MCA Code of Practice. The registered provider agreed to look into this further.

There were appropriate DoLS in place for people whose liberty was being limited, with renewals in place where this had been required. We noted some people had sensor mats in place which assisted staff to ensure their safety by alerting them to their movements. We checked people's care records to see if the appropriate restrictions had been authorised and saw they had. We found any conditions attached to the DoLS had been incorporated into people's care records. This meant the service was ensuring they followed

the requirements of the DoLS by ensuring regular reviews of people's needs to ensure they were not restricted longer than necessary.

Care records showed people had access to external health and social care services as needed such as chiropody or a GP and any input was then incorporated into their care plans. One person told us "They always get the GP in quickly if needed."

Improvements to the environment were ongoing and during our time in the home we saw flooring being replaced, a bath hoist being repaired and a bath being repaired due to having a large crack in it which was very sharp. The house supporting people living with a diagnosis of dementia was designed to help assist people with orientation by having brightly painted front doors to their bedrooms. There were also a number of objects around for people to use such as CDs, keyboard, games and a memory box on the wall. The storage of equipment was much improved from the previous inspection as communal areas were free from clutter.

Good

Is the service caring?

Our findings

One person said "Staff are very nice." Another person told us "The staff are so good, all wonderful, like family." A further person said "Staff are friendly and respectful."

One staff member said "I treat people as if they were my parents or members of my family."

We heard a number of people being spoken to by different staff members about their recent trip to the hairdressers. One person was told "You look lovely. You've been coiffured!! The person responded with a big smile as their verbal communication was limited. One person said "Staff are all very friendly – I feel they know me well."

Interactions between all staff and people in the home were positive. People were very happy and friendly, and we observed much spontaneous chatter and singing. During the first day we saw people engaging in conversation with each other, and people were supported by staff where communication was more difficult due to memory impairment. One staff member put some music on and people started to sing and laugh together. The atmosphere was friendly and pleasant. It was evident all staff knew people well as the discussions focused on the individual. People were informed the hairdresser was working and were encouraged to see them if they wished. One person told us "I've no complaints about this place. The girls are nice here. They've never shown any signs of impatience."

Our observations found staff were patient and attentive. People were able to watch the TV, discussing the game show with staff or read newspapers as they wished. People were supported with their personal care needs as required discreetly and in a timely manner when in a communal area. We also overheard many kind and caring interventions with people in their own rooms.

We observed staff members knocking on people's doors before asking if it was acceptable to enter. It was evident staff knew people well and greeted them as individuals. We saw one person trying to eat their dinner whilst laid flat on their back and despite the best attempts at encouragement by staff, who explained the risks attached, they refused to sit up. We checked this person's care records and found this was frequent behaviour and staff were to support as we had observed.

One person told us "I have been involved in a review of my care needs." Some people had advocates to support them in making decisions where they had lost the ability to do so.

We saw people's end of life wishes were noted in their care records, however there was limited recording around people's cultural and spiritual needs. The registered manager agreed to discuss this is more detail with people.

Good

Is the service responsive?

Our findings

One person, who preferred to stay in their room, said "It's very good here. I get everything I need; I've only to ask. I'm very comfortable and relaxed". Another person told us "I have a bath three times a week on days I choose. I also choose when I go to bed. It's generally around 8pm as this is when I get tired." A further person told us "I am looking forward to going to the hairdressers." One relative told us "I can visit any time; there are no restrictions."

Staff demonstrated an in-depth knowledge around people's wellbeing. One person had been asleep late into the morning and left their breakfast uneaten but staff were aware the person had been 'off their food' and were keeping a close eye on them. One person said "I feel able to ask if I want anything."

The activities co-ordinator brought the Christmas tree into the lounge area and chatted with people, while decorating the tree, about Christmas festivities. During lunchtime two staff discussed ideas for Christmas activities and possible outings to the local town with people. The activities co-ordinator stressed they preferred to be spontaneous and asses people's moods on the day, and then offered choices which corresponded with this. On the second day of inspection we observed one person decorating some wine glasses in readiness for some fundraising in conjunction with the activity co-ordinator. Again, there was positive conversation and it was evident they knew each other well.

The home had issued a newsletter in September 2016 outlining all the recent activities that had been undertaken and referring to future ones. These included parties for Easter, Halloween, the Queen's 90th birthday, trips to the local shops and outings for coffee, entertainers wo visited the home and a play which was performed in the home.

Staff were aware of the care records. One staff member said "there are two types of care plan – one the care staff fill in and one with more detail, which are all on the computer. All staff are able to use the system. Position, food and fluid charts are separate." This staff member also disclosed how they had learnt from a supervision session about the importance of correct record keeping as evidence that care had been delivered correctly. This showed the registered manager was identifying where there were issues and addressing them appropriately.

We looked at care records which were on an electronic system which all staff had access to via laptops. People had an overview care record which provided an outline of people's key support needs in relation to mobility, personal care, behaviour, decision-making ability, medication, infection, skin integrity and communication. Where people had more specialist needs these were also noted. From these overview needs a care plan was created providing specific information to staff as to how best support an individual through a description of the condition, the objective to be achieved and the actions needed for staff to support effectively. These were written focusing on the individual and their particular needs ensuring staff understood what made the person tick.

For example in one care record it was noted 'may become distressed during personal care' and so staff were

encouraged to use the 'leave and return' technique to ensure any anxiety was minimised. In another record it was noted a person struggled to retain information so it was logged 'when staff communicate they should be mindful and ensure they structure sentences simply, repeating in different ways where necessary, to facilitate understanding. Staff to initiate conversations.'

Daily care notes were updated regularly and reflected care we observed being given. Records were evaluated on a monthly basis and showed each person's individual needs. Most people had a detailed life history which helped staff to support them effectively by understanding their work and life experiences. We noted care was delivered in line with people's care plans such as one person preferred their curtains closed during the day when in their room and this was observed.

We checked people in bed at 6pm in the main house on the first day of inspection and saw repositioning charts had not been completed since 3pm for some people who had been in bed since that time. We spoke with the team leader and advised of our concerns. On the second day of inspection we checked the charts for the preceding week and found all entries had been completed as required, showing the communication had been shared and action taken.

One person said "I would like to see some of my missing clothes returned but I haven't complained although I do know how to." Another person told us "I know how to complain. I see the manager on a regular basis and I would tell them of any concerns." One relative said they had confidence the registered manager would deal with any complaints well, and another relative told us "I would approach the manager if I had a complaint."

The registered manager advised us of four complaints since June 2015. Records showed the description of the issues, immediate action taken, any interim action and preventative action and whether the complaint was resolved. There was also evidence each complainant had received a written response. This showed the registered manager was aware of their responsibilities to look into each circumstance and respond promptly.

Requires Improvement

Is the service well-led?

Our findings

One person said "I am happy here. No one would choose to be in a home would they? But as I'm here it's not so bad." Another person told us "I've been here three years and it's lovely. I've got the best room in the valley." A further person said "This place is very good. There are good carers and good food."

One relative said "I'm very happy with the care as my relation is happy. Staff are friendly and the food is good." Another relative told us "I'm very happy with the care my relation receives. They are always well dressed and appear to have had their needs met." A further relative said "I see the manager often and find all the staff very good. The place is always very clean. It is always friendly and welcoming." We observed a homely atmosphere throughout our time in the home.

People were asked their views as to the care provided at Newsome Nursing Home. The latest survey had been completed in July 2016 and analysed in August 2016 with a 39% return rate. An action plan had been created from this and was checked on a monthly basis to see if actions were being completed. We saw a 'family meeting' had been held on 21 September 2016 which outlined recent changes and improvements to the home, and relayed the key themes from the survey. We saw where issues had been raised before, such as a lack of name badges for staff, these had been implemented.

One staff member said "The managers are very supportive." Staff meetings were held on an irregular basis. The most recent had been in September 2016 where rotas, annual leave and training had been discussed. Staff views were considered as one suggestion had been the development of a 'carer of the month' scheme but staff were not keen to differentiate in this way. Although meetings were irregular, we did note that regular group supervisions were held which meant staff had the opportunity to develop their practice and discuss any concerns.

We found evidence of weekly meetings between the registered manager and the regional manager, and monthly management meetings which included the registered providers. These involved updates regarding people's care needs, staffing changes and any performance management or disciplinary issues, a check on the environment and spot checks of staff's knowledge on particular topics.

The home had a series of audits in place. One staff member told us they had responsibility for checking mattresses and pressure cushions, and they showed us the monthly check records which included a checklist of what to assess. They demonstrated an in-depth understanding of the requirements. Medication audits were completed on a monthly basis although there was a three month gap between April – June 2016. There was a clear audit trail as to where issues had been identified, what action had been taken such as an email to the recruitment agency where an agency worker was implicated. An action plan was drawn up as a result and shared with all nursing staff. Records were also kept of staff competency checks. Care plan audits had also taken place on an ad hoc basis with evidence of action being taken where problems were noted. When this had been completed it was signed to verify the issue was resolved. This meant the registered manager was aware of the importance of regular checking for quality assurance purposes and any issues followed up promptly.

We saw maintenance checks including PAT records (portable appliance testing), infection control, hoists and slings and legionella. The lift, moving equipment such as hoists and slings had all been checked under the LOLER guidance. However, there were no regular interim checks. The registered manager advised concerns were brought to her attention by staff such as if slings appeared worn or damaged. We noted the lifts had been checked on 7 November 2016 and some parts needed replacement. Although noted in the health and safety minutes as 'recommended' there was no evidence of any follow up action. Gas, emergency lighting and fire equipment had all been checked as necessary.

We noted no night inspections had been completed since November 2015 and the registered manager advised us they were aware of this. They completed one on 19 December 2016 following our inspection and found no concerns sharing with staff feedback from our recent inspection. This showed the registered manager was ensuring all staff had the opportunity to discuss their experiences and monitoring of support at night-time ensured safe delivery of care for people in the home.

We did speak with the registered provider and manager about the lack of equipment audits in place for items such as bath seats, commodes and wheelchairs. We had noted in one bathroom on the first floor one hydraulic bath seat had no brake to hold the seat steady and combined with a limited gap between the arm rests and the bathroom wall, posed a significant trap hazard. The registered manager agreed to put this bathroom out of use until this had been addressed. This was also the case for the top floor bathroom where the back rest of the seat was cracked posing a potential risk of skin being caught. A replacement seat was ordered following our inspection. We saw remedial action being taken following a recent incident where a bath seat had lifted off the floor despite having been LOLER checked on 11 November 2016 and although no serious injury had occurred, the potential for significant harm had been high

The registered provider acknowledged there were no systems for regular checking in place but agreed to remedy this immediately by supporting a staff member to undertake this role. They did stress following our first day of inspection they had ordered further equipment, bumpers and sought guidance around best practice guidelines which we saw evidence of.

The registered manager was able to discuss all the recent changes and improvements in the home, clearly demonstrating their in-depth awareness of each person's needs and where they were on their care pathway. Appropriate referrals had been made to other agencies and learning had taken place from key events which were evident in changes to practice observed during the inspection. They cited key achievements as obtaining the gold Healthy Eating Choices Award from Kirklees, an improved staff culture and better infection control practice. The registered manager felt they led by example and was very hands-on in their management style so they could keep abreast of everyday issues within the home. They said they were always keen to learn from others visiting the home such as social workers, commissioners and community psychiatric nurses to ensure the care for people was the best possible.

Following the inspection feedback the registered manager responded promptly to our concerns and immediately took action with the window restrictors and bed rail checks and audits. They sent us evidence of more in-depth bed rails assessments in line with requirements. We discussed the importance of recording decisions where no further action was required to evidence the issues had been thought about. This was in reference to our concerns about the bed rails of one person where certain actions had not been taken as the risks would have been too great and the registered manager verbalised those to us. However, they were not recorded and they agreed to evidence this moving forward.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people from poor equipment had not been identified as checks were not regular or robust enough.