Huddersfield Nursing Homes Limited

Newsome Nursing Home

Inspection report

1-3 Tunnacliffe Road
Newsome
Huddersfield
West Yorkshire
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29 June 2021
11 August 2021

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23 September 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Newsome Nursing Home is a residential care home providing personal and nursing care for up to 46 people, including people living with dementia. At the time of inspection there were 28 people living at the service.

People's experience of using this service and what we found
Health and safety risks at the service were not always assessed, monitored and managed effectively. Parts of the environment were in need of refurbishment and placed people at increased risk of harm.

Care records did not always contain enough detail to enable staff to support people safely. The provider did not fully take into account people's dependency needs and there were not always enough staff to meet people's needs in a timely way.

Systems in place to monitor the service had not been effective in identifying and addressing areas requiring improvement. Lessons learned from accidents and incidents were not identified and were not used to make improvements to the service.

Staff did not always use respectful terminology when talking to people. We made a recommendation that the provider takes action to address and monitor staff interactions with people to ensure that this is consistently respectful.

The service had not acted upon feedback obtained from people and relatives to inform improvements in quality and safety.

Infection prevention and control (IPC) processes and procedures were in place however some aspects relating to IPC required improvement.

People were safeguarded from the risk of abuse. The service worked in partnership with other agencies to support people and people felt that staff knew them well.

Staff received appropriate training and support in order to fulfil their role.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 24 January 2020). This service has been rated requires improvement for the last four consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvements to the service had not been made and there are multiple breaches

of regulation.

Why we inspected
The inspection was prompted in part due to concerns received about the environment, health and safety and culture at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Newsome Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Newsome Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 29 June 2021 and concluded on 11 August 2021. We visited the home on 29 June 2021.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch Kirklees. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in

England. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who use the service and six relatives about their experience of the care provided. We spoke with twelve staff members including the registered manager, nurses, carers, maintenance and housekeeping staff.

We reviewed a range of records. This included one person's care records, multiple medication records and health and safety records. We looked at two staff files in relation to recruitment, induction and supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at three people's care records. We reviewed a range of records relating to the management of the service, including policies, procedures, training data, health and safety and quality assurance records. The evidence review was concluded on 11 August 2021.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure systems were robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have reported our findings in these areas under the well-led section of this report.

- The provider did not always ensure robust assessment, monitoring and management of health and safety risks at the service.
- Care plans and risk assessments did not always contain enough information to support people safely. For example, one person's risk assessment lacked detail regarding seizure care. The records for one person who had a feeding tube and required regular support with a build-up of mouth secretions, lacked detail. On two occasions the person was found to have secretions around the mouth. After our feedback the provider took action to address this.
- Sufficient checks for legionella risks were not in place at the time of inspection. The provider has since sent a report from an external contractor regarding legionella safety. The report identified several outstanding actions to ensure risks relating to legionella are mitigated.
- Fire safety checks were carried out however we found one person's personal emergency evacuation plan (PEEP) was not in place. One person's PEEP had the incorrect room number documented. This meant people were at increased risk of harm in the event of a fire. Since our feedback the provider took action to address this.
- The environment was in need of refurbishment. Floor coverings and light fittings were in a state of disrepair. We found one corridor did not have adequate lighting. This placed people at increased risk of falls. The provider had a refurbishment plan in place however the action plan was not clear regarding what work had been done and what was still to do.
- One member of staff was supporting seven people in a separate part of the home. The staff member said they used a buzzer to alert colleagues if they needed additional help however, they were unable to locate the buzzer. This placed people at increased risk of harm in the event of an emergency.

The provider had failed to ensure premises were safely maintained and had not fully assessed the health and safety of service users. This placed people at increased risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not always enough staff to meet people's needs in a timely manner. There were occasions where people's call buzzers were ringing between eight and 20 minutes before staff were able to attend.
● At the previous inspection the provider used a dependency tool to calculate the staffing levels in line with the dependency of people living at the home. The tool accounted for people's care needs and did not consider people's nursing needs. This remained the case at this inspection. The provider has since taken action to address this.
● People and staff told us that there were not always enough staff. Feedback included; "They do their best with staffing but it's not so good at weekends," "Staff don't have enough time to care for people properly as they are often rushing," and "Staffing levels are not always good but agency staff do support."
● Two people told us there was not enough to do and they felt bored. Staff were task focussed and had little time to engage in meaningful conversation with people. The registered manager said that the service was recruiting activities staff and when time allowed a staff member was assigned to facilitate activities.

The provider had failed to ensure there were sufficient staff to meet people's needs in a safe and timely manner. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Procedures were in place to support safe recruitment and induction to the service.

Preventing and controlling infection
● The service was visibly clean, and systems and processes were in place to prevent and manage the risk of COVID-19. Regular cleaning was in place. There were, however, some areas of infection prevention and control requiring improvements.
● Two staff were observed wearing a mask under their chin during a break. The masks were not then changed. This had been previously documented by the registered manager for one person and reinforced in communication with staff however improvements were still required.
● There was a dirty suction pump and tube in one person's room and some people had bars of soap in use in their rooms, posing an infection control risk. Action was subsequently taken by the provider to address this.

Using medicines safely
● Overall, medicines were managed, stored and administered safely. Records showed people received their medications as prescribed.
● Eye drops and ear drops were found in one person's room. The registered manager stated that this was at the request of the person. Action was taken to address this.
● Staff received training and regular competency checks to ensure safe medicines management.
● People felt supported when taking their medicines. One person told us, "They give me my tablets and if I need anything for pain, I tell them."

Systems and processes to safeguard people from the risk of abuse
● There were policies and procedures in place to safeguard people from the risk of abuse. Staff were trained in safeguarding and knew how to protect people.
● People and relatives felt the service was safe. Feedback included; "They look after me," and "[name] is safe there. [name] has been doing really well."
● The service was reporting safeguarding incidents to the relevant authorities.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to ensure governance systems were sufficiently robust and failed to ensure people's safety was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service has been rated requires improvement for the previous four inspections. The action plan from the last inspection had not been implemented and this inspection identified repeated concerns around health and safety assessment and management oversight. Governance systems and processes were not effective in assessing, monitoring and improving the service.
● The systems in place had failed to identify concerns found at this inspection in relation to personal emergency evacuation plans (PEEPs), inadequate lighting, infection prevention and control and terminology used by staff.
● Audits in place were not always robust and lacked detail regarding action planning, progress and completion.
● Accidents, incidents, complaints and safeguarding concerns were analysed however lessons learned were not identified, shared with staff, and used to improve practice.
● People and relatives had the opportunity to provide feedback via a survey which was last completed in June 2020. The results were collated however there was no evidence of actions taken or improvements made following this.
● The previous inspection identified the dependency tool system was ineffective. This was still in use at this inspection. The previous inspection also identified concerns regarding monitoring of moving and handling equipment. Monitoring was in place at this inspection however it did not always evidence that equipment was accounted for. Three slings had been identified as "not found" and therefore had not been assessed as fit for use.

Governance systems and processes were not effective in identifying, monitoring and addressing the quality of the service, placing people at increased risk of harm. This was a continued breach of regulation 17 (Good

governance) of the Health and Social Care Act 2008 (Regulated Activities).

Following the inspection, the provider has taken action to address issues found in relation to PEEPs and the dependency tool. The provider also confirmed that the slings were not in operation at the service however they did not know the whereabouts of this equipment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● Staff did not always use respectful terminology when speaking to and about people. One staff member described a person's behaviour as "playing up" and asked a person if they needed "a wee-wee" to support them with the toilet. Another staff member referred to people as "feeds" when discussing supporting them with their meals. We discussed this with the registered manager.

We recommend that the provider takes action to address and monitor staff interactions with people to ensure that this is respectful at all times.

● People and relatives felt staff knew people well. Feedback included, "I'm happy here," "Nursing staff know [name] well. They put things in place to help [name]" and "Staff definitely know [name] well. They worked with [name] and now she can get up and walk about."

● Staff had regular training, supervision and staff meetings. Staff felt supported by the registered manager. Feedback included; "The home is well run and the teamwork is good," "I am supported to do my job," and "My competence is regularly checked by the registered manager."

● The service worked effectively in partnership with other agencies to support people. Staff communicated well with other professionals. For example, where people were at high risk of pressure ulcers, community professionals supported them and discussed their plans of care with staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;

●The registered manager was open and honest when accidents and incidents occurred. They understood and acted upon the duty of candour. One relative told us, "They inform me if anything happens, like when [name] had a fall."

● Information was shared appropriately with the local authority safeguarding team and CQC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of staff were in place to meet people's needs. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess and mitigate the risks to the health and safety of service users. The provider had failed to ensure that premises were safe to use for their intended purpose. Regulation 12 (2) (a) (b) (d)

The enforcement action we took:

Serve warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems and processes that were effective in assessing, monitoring and improving the quality and safety of the service. The provider had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of service users. The provider had failed to seek feedback from service users for the purposes of evaluating and improving the service. Regulation 17 (1) (2) (a) (b) (e)

The enforcement action we took:

Serve warning notice