Hometrust Care Limited

Nether Place Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Nether Place Nursing Home is a care home providing personal care and nursing for up to 32 older people and people living with dementia. At the time of our inspection there were 22 people using the service.

Nether Place Nursing Home accommodates people across 2 separate wings, each of which has separate adapted facilities. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were at risk due to shortfalls in safety across the service. Risks linked to nursing staff had not been robustly assessed to keep people safe. Staffing levels were not always sufficient to meet people's needs or for the size of the service. Staff had not always received training to enable them to support people effectively and carry out their roles.

People were at risk as fire safety was not managed safely; staff did not always know how to respond in the event of a fire. The provider was working to make improvements to fire safety.

Systems were not always in place to ensure people received their medicines properly and safely. Medicines were not always being administered to people as directed, this was addressed during the inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. We have made a recommendation about the recording of Deprivation of Liberty Safeguards (DoLS) conditions.

People were at risk of harm because of a lack of oversight of the service by the provider. The service had been without a registered manager for over 6 months. The provider did not have effective systems in place to monitor quality and safety at the service and had not identified the issues we found during the inspection. The provider had started to make improvements following our inspection, these changes had yet to be embedded.

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

Rating at last inspection
The last rating for this service was good (published 13 December 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. 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 Nether Place Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing and good governance. We issued a warning notice for the breach of good governance. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Nether Place 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 Health and Social Care Act 2008.

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
The inspection was carried out by one inspector.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager was in post, we have referred to them as 'the manager' throughout this inspection report.

Notice of inspection
This inspection was unannounced on the first day and announced on the second day.

Inspection activity started on 25 January and ended on 23 February. We visited the service on 25 and 31 January.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
This inspection was carried out by conducting a site visit and speaking to relatives and staff remotely. We spoke with 3 people who used the service and 4 relatives about their experiences of the care provided. We spoke with 10 staff including the nominated individual, compliance manager, manager, deputy manager, nurses, care staff and a domestic. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 4 people's care records. We looked at multiple medicines records. We reviewed 3 staff recruitment records. A range of records relating to the management of the service, including staff training records, accident and incident records, quality assurance checks, health and safety records and a sample of the provider's policies and procedures were also reviewed. We received feedback from 2 health and social care professionals who work alongside the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
- Systems were not always in place to ensure risks linked to staff were effectively managed.
- The provider had not recorded robust risk assessments to ensure nursing staff had the skills, experience and competence to support people safely and oversee their clinical needs.
- Checks were not routinely carried out by the manager or provider to ensure nurses continued to be registered with the Nursing and Midwifery Council and if there were any conditions on their practice. Nurses are required to be registered with the Nursing and Midwifery Council to practice.

We found no evidence people had been harmed. However, the provider had failed to ensure staff providing care and treatment had the qualifications, competence, skills and experience to do this safely. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider did not always ensure staffing levels were sufficient to support people to stay safe.
- All of the staff we spoke with said staffing was not sufficient for the number of people living there and the layout of the building.
- The provider's dependency tool was not always completed accurately or regularly following new admissions to ensure staffing levels were reviewed and adapted to meet people's needs.
- Staff had not always received training to enable them to carry out their roles. For example, at the time of our inspection visits none of the 8 care staff had received training in behaviours that challenge the service despite the service specialising in dementia care and having a dedicated unit for this.
- Staff were not always recruited following a robust and safe recruitment process. One staff member had been recruited without the risks associated with them working vulnerable adults being fully assessed or mitigated.

We found no evidence people had been harmed. However, the provider had failed to ensure there were sufficient numbers of skilled and experienced staff to support people safely and effectively. This placed people at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's family members and friends we spoke with gave mixed feedback on staffing levels at the service. One relative said, "Staff do seem to be rushing around a bit sometimes. The nurses are really brilliant with [family member], it's just that they seem very stretched." Another relative told us, "I was worried about staffing, it is much improved now."

● Nursing staff had completed refresher training to support them in carrying out their roles.
● Although staff had not received formal training in managing behaviours that challenge, staff were knowledgeable about the needs of any people with behaviours that challenged the service, such as possible triggers and ways to support them. One professional said, "I have observed staff dealing and managing very difficult and challenging situations while still maintaining their professionalism at all times."
● Appropriate recruitment checks had been carried out for staff that had been more recently recruited.

Assessing risk, safety monitoring and management
● People were at risk as fire safety was not well managed.
● Staff did not always know how to respond in the event of a fire and had not always attended regular fire drills to prepare them for how to respond in this situation. At the time of our visit the last recorded fire drill took place on 16 August 2022 and was attended by one staff member.
● Staffing levels at night were not always sufficient to enable safe evacuation arrangements to take place. For example, at night there were 2 staff on shift for 22 service users across 4 fire zones in the home.
● Checks to ensure fire equipment was available and in working order at the service had not been recorded since 1 December 2022.

We found no evidence people had been harmed. However, the provider had failed to assess and reduce risks to people's health and safety. This placed people at risk of harm. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was addressing actions identified following a visit from the local fire service to improve fire safety in the service.
● Following our feedback, the provider was in the process of reviewing staff fire training and staffing arrangements overnight to address the issues we found.

At our last inspection we recommended the provider change bedroom door locks to enable them to be opened externally in the event of an emergency. The provider had made improvements.

● On day 2 of the inspection we observed the temperature in the lounge was cold, all the people sat in this area were wrapped in blankets. The provider advised plans were in place to install new radiators to improve the heating in the lounge.
● Care plans and risk assessments were used to good effect to guide staff in how to manage people's health conditions and needs, for example, diabetes.

Using medicines safely
● Systems were not in place to support the safe and proper management of medicines.
● Medicines were not being administered as prescribed. For example, some medicines were given to people at mealtimes when the directions specified the medicine should be given before food.
● 'As and when required' protocols were not always in place to support the use of these occasional medicines.
● Staff administering medicines had not always received training or had their competence to provide this support assessed in-line with best practice. For example, care staff were applying creams to people despite not having received training or having had their competence assessed.
● Quality assurance checks were not in place or being carried out to monitor the use of medicines.

We found no evidence people had been harmed. However, the provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was an additional breach of

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following day 1 of our inspection, the provider made changes to medicines systems, including medicines administration arrangements. We observed medicines being administered as prescribed on day 2 of the inspection.
● The provider had further work planned to support the safe and proper use of medicines.

Systems and processes to safeguard people from the risk of abuse

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● People's care records did not always show how any conditions given as part of their DoLS authorisation were being met.

We recommend that the provider ensures records are maintained in relation to any DoLS conditions.

● People were supported by staff who understood their safeguarding responsibilities.
● The provider raised safeguarding concerns following incidents within the service.
● People, their family and friends told us they felt safe with the support provided at the service. One person said, "I feel safe here and can get help if I need it."

Preventing and controlling infection
● Whilst we observed the service was clean during our inspection, we were not assured there were sufficient staff to ensure cleanliness and effective infection prevention and control was maintained across the service at all times. One domestic was responsible for cleaning and laundry throughout the service. The nominated individual advised recruitment checks were in progress to appoint a new domestic.
● The provider's infection prevention and control policies had not been reviewed and updated to reflect current guidance.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.

Visiting in care homes
● People were able to enjoy visits from family members and friends.
● People's family and friends spoke positively about visiting arrangements at the service and communication by the provider about these.

Learning lessons when things go wrong

● Systems were not always in place to ensure lessons learnt were shared and communicated across the staff team.
● Staff understood and followed the provider's processes in the event people experienced an accident or incident.
● Accidents and incidents were recorded to help ensure all appropriate steps were taken to keep people safe. The provider was developing and improving these records.
● The provider had started to look at patterns and themes linked to falls to identify any wider learning and areas where safety could be improved across the service.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance and management systems were not always reliable or effective to ensure people received high quality care.
- The service had been without a registered manager since 21 July 2022. The compliance manager and manager were not always maintaining effective oversight of the service.
- Quality assurance checks were not routinely taking place by the manager or provider. Where audits had been carried out, action plans had not been followed up to address any areas identified for improvement.
- The manager and provider had not identified the issues we found, including with fire safety, staffing levels, staff recruitment, staff risk assessments, medicines, DoLS conditions and the provider's policies.
- The provider had not shared learning or identified areas for improvement following a previous inspection at another of their services where similar issues had been found.
- The provider's policies were not always appropriate or being followed to support good practice in the service. For example, the provider's medicines policies did not follow best practice guidance.

We found no evidence people had been harmed. However, the provider had failed to have effective systems in place to assess, monitor and improve the quality of the service. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had developed an audit schedule, to support quality assurance within the service. This had yet to be introduced.
- A new manager started following our inspection visit and had yet to register with CQC.
- Following our inspection, the nominated individual told us they were reviewing the provider's policies and procedures.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Whilst the provider understood the principles of person-centred care, their systems and ways of working did not ensure people received high quality care.
- Staff were committed to providing people with person-centred care and promoting their independence. One person told us, "We're well looked after, the staff are lovely." One relative said, "The efforts of the staff to do the right thing [for person] have been the best thing here."

● Staff worked effectively to achieve good outcomes for people. For example, for one person, staff encouraged the person to walk with support to improve their mobility. The person took pride in this achievement.

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
● Nurses and the provider understood their responsibility to apologise when issues occurred with people's care.
● Relatives were kept informed of any incidents involving their family members. One relative said, "I am told if anything has gone wrong."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's representatives were involved in planning and reviewing people's care to meet their needs and preferences. One relative said, "They [staff] listen to me as [person's] voice. I am always kept up to date with [person's] care."
● People and their representatives knew the managers and nominated individual and felt able to contact them should they need to.
● Staff were able to give feedback on the service. One nurse told us, "We will give feedback if we have anything to say. If something isn't going to work or be of benefit to people I have to say."

Working in partnership with others
● Staff worked effectively in partnership with other professionals. This led to positive outcomes for people's care and support.
● Professionals gave positive feedback on their experience of working with staff at the service. One health professional said, "Each and every visit I have made to the service has been welcomed and the staff and management were very eager to learn from me."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess risks to the health and safety of service users, including staff and fire safety risks and do all that was reasonably practicable to mitigate these. The provider had failed to ensure staff providing care to service users had the qualifications, competence, skills and experience to do so safely. The provider had failed to ensure the safe and proper management of medicines. (1)(2)(a)(b)(c)(d)(g)

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 there were sufficient numbers of skilled and experienced staff to support people. (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 17 HSCA RA Regulations 2014 Good governance The provider had failed to have systems and processes established to assess, monitor and improve the quality and safety of the service. (1)(2)(a)

The enforcement action we took:

Warning notice issued.