S K Care Homes Ltd

Holmfield Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Holmfield Court is a residential care home providing personal care to 21 people aged 65 and over, most of whom were living with dementia. The service can support up to 25 people.

People's experience of using this service and what we found
We found multiple concerns at this inspection. The impact of the concerns was that people did not receive safe care and treatment. People's needs were not fully met, and people were not always treated with dignity and respect.

Following the inspection, the provider has made the decision to close the service. Where a service is rated inadequate overall it would usually be placed into special measures. This is a process which ensures the service is monitored closely. Because the provider has made the decision to close the service on this occasion it will not be placed into special measures.

The provider had failed to protect people from avoidable harm. Risks in the environment had not been managed and staff followed poor infection control processes. In addition, staff and the manager did not recognise or respond appropriately to abuse.

People's care needs were not routinely reviewed following accidents and visits from healthcare professionals. Therefore, staff were not aware of and did not apply all the control measures in place to reduce risks to people.

Staff were directed to complete tasks, rather than focus on people's wellbeing and holistic needs. People were not supported to avoid social isolation and engaged in little or no activity. One person told us, "I just accept things. Things are not desperately unhappy or happy."

The management of the service was ineffective; roles and responsibilities were unclear. The manager told us they were unhappy with the provider's quality systems; however, we saw no evidence to demonstrate this had been raised or that any action had been taken to address their concerns.

People were not supported to have maximum choice and control of their lives and staff did not treat them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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 15 January 2019) and there were multiple breaches of regulation. 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 had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified seven breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 at this inspection. The breaches relate to person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse or improper treatment, premises and equipment and good governance.

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
Following the inspection, the provider has made the decision to close the service.

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 effective?

The service was not effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Holmfield Court

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.

Inspection team
The first day of the inspection was carried out by three inspectors and one Expert by Experience. The second day of the inspection was carried out by one inspector. 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
Holmfield Court 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 did not have a manager registered with the Care Quality Commission. A registered manager 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.

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 also contacted Healthwatch. 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 the information the provider sent us in the provider information return. This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and five relatives about their experience of the care provided. We spoke with eight members of staff including the nominated individual, manager, regional managers, assistant manager, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and received feedback from the provider and local authority.

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 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; Preventing and controlling infection

At our last inspection the provider had failed to ensure the premises were properly maintained and that the equipment used to deliver care was clean and suitable for the intended purpose. This was a breach of Regulation 15 (Premises and equipment) 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 15.

● The provider had failed to act to address damage to a ceiling within the home. The manager alerted the provider to a developing crack in the ceiling along one of the corridors in the home. However, the provider failed to act until a plasterboard ceiling partially collapsed in a person's bedroom several weeks later.
● Areas of the home had not been properly maintained which put people at risk of harm. For example, a wooden board had been secured across the top of one person's bath; the handles of both taps had been removed which left two sharp points. The side panel of the bath was also coming away and the extractor fan sounded noisily when the bathroom was in use.
● Checks to ensure the safe working of equipment had not been completed since April 2019. The manager told us these checks should be completed every month but the person responsible for carrying out these checks had been working at another of the provider's services.

The provider had failed to ensure that the premises and equipment used to deliver care were properly maintained and suitable for the intended purpose. This was a continued breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is also a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the risks associated with equipment that was not maintained safely.

● People were not protected from avoidable harm. The provider had failed to safely manage risks associated with building work being carried out within the home. For example, vulnerable people, living with dementia had access to workmen's tools and equipment and two bedrooms deemed to be at risk of a plasterboard ceiling collapsing.
● Information about risks to people were not always passed on to staff. Therefore, staff were not aware of all the control measures that were needed to prevent harm. For example; staff did not know the correct

amount of thickener to add to one person's fluids to reduce the risk choking and aspiration when drinking.
● Restrictions that were in place had not always been assessed appropriately; for some people these had not always been lawfully obtained through best interest decisions involving appropriate health professionals.
● The manager did not investigate accidents to understand what could be done to prevent the same incidents from happening again.
● Staff did not always follow good infection control practices to help prevent the spread of healthcare related infections. For example, individual and communal bathrooms did not always have liquid soap and disposable hand towels. One person's bed had been made but the bed linen was soiled.

The lack of systems to fully understand risk and do all that is reasonably practicable to reduce the likelihood of harm was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff did not recognise or respond appropriately to abuse. Incidents of unexplained bruising and neglect were not reported as safeguarding concerns.
● The manager did not follow local safeguarding systems and was not familiar with the provider's policy for safeguarding vulnerable adults.

The provider failed to safeguard people who used services from abuse or improper treatment while receiving care. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not always available to support people.
● The manager reviewed staffing levels in accordance with people's needs. However, staff were not deployed effectively. For example; the manager assigned one agency staff member to care for everyone in the home whilst all other staff members attended a meeting. A relative told us, "There are not always enough staff. I was told that they don't use agency staff, but they do."
● The provider had safe recruitment process in place.

We recommend the provider revisits staffing levels and the deployment of staff within the service, taking into account current best practice guidelines.

Using medicines safely
● People received their medicines as prescribed.
● Staff managed medicines safely and kept accurate medicines records.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

At our last inspection we recommended the provider reviewed the provision of training for staff related to MCA and DoLS. Not enough improvement had been made at this inspection.

● The manager did not have a clear record of which people using the service were subject to a DoLS. Therefore, they could not be sure staff were following any authorised restrictions correctly and ensuring people's rights were met.
● The service did not seek consent to care and treatment in line with legislation and guidance. It was not always clear how decisions around people's care had been made and/or agreed, as this information was not captured or included in people's care records.

The provider did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Adapting service, design, decoration to meet people's needs
● People did not receive appropriate person centred-care and treatment. Where people required support

from healthcare professionals this was arranged. However, the guidance provided was not always recorded in people's care records. The provider had failed to follow up on advice given for one person and there was a risk their treatment would be delayed.
●Staff did not have the information they needed to fully meet people's needs. For example, people's care plans and risk assessments were not routinely updated following incidents of falls or visits from healthcare professionals.
● The home had not been adapted for people living with dementia. People spent the most part of their day sat in the communal lounge and in the corridor; there were no areas of interest for people and little meaningful activity.
● Access to the garden was restricted and the garden was not secure. Therefore, people could not access the outside unless escorted and supervised by staff. A relative told us, ""I've never seen it (the garden) used. There are no signs that they go in the garden and I don't see much interaction."

People did not receive person-centred care reflective of their needs and/or preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff completed an induction before they started working at the service. They undertook training in a range of subjects relevant to their roles, including specialist dementia training.
● Not all staff had received supervision and appraisal to review their practice or behaviours and focus on professional development. The manager had put a system in place to ensure all staff received opportunity for supervision within the month.

Supporting people to eat and drink enough to maintain a balanced diet
● People were provided with enough to eat and drink. However, we received mixed feedback from staff and people about the food. Comments included, "It's not exceptional but I've no complaints", "It's alright" and "There could be more choice. There is no summer menu".
● The dining room was newly decorated, and tables were laid with clean cloths, place mats, glassware and condiments. The food was as stated on the menu, with choices.
● Jugs of juice were available in communal areas for people to help themselves to.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure people were treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) 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 10.

● People were not always afforded privacy and dignity when being supported with personal care. For example, a window in a communal bathroom did not have a blind or curtain which left people exposed and compromised.
● People and relatives told us clothes often went missing and people were not consistently supported with personal care. We observed people not wearing tights or socks; people with dirty finger nails, stained clothing and unkempt hair.

The provider had failed to ensure people were always treated with dignity and respect. This was a continued breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
● Staff were focused on completing tasks rather than people's wellbeing. The provider specified a minimum of three people had to be bathed or showered each day and there was a list in place for staff to follow and record this. This was not person-centred and demonstrated the service operated a task-based bathing routine, rather than accommodating people's own bathing choices and preferences.
● Staff had all received training in equality and diversity. There were policies in place to help ensure staff were considering people's individualised needs in the delivery of care but we found people did not always receive individualised care in practice.

People did not receive individualised person-centred care. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoke to people with kindness. People told us, "The staff are all nice and kind" and "I think the staff

are kind."

Supporting people to express their views and be involved in making decisions about their care
● People and their relatives were involved in writing care plans.
● Some people were less able to express their choices and we observed staff supporting them with decisions; they spent time explaining options to assist them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive care in a way they preferred. People's care plans contained information about their likes and dislikes. However, staff did not always follow this guidance. For example, staff encouraged one person who did not enjoy music to participate in a music related activity; no alternative was provided.
- Staff did not respond to changes in people's care and support needs. People's needs were not regularly reviewed, and care plans were not up to date and did not sufficiently guide staff.
- People did not have enough support to avoid social isolation. People were sat for long periods of time engaged in little or no activity and staff did not spend meaningful time with people. A staff member told us, "There is no dementia focused activity or stimulation."
- People and relatives told us the same musical entertainer visited the service twice a week; this did not cater to everyone's interests or preferences. A relative told us, "I've only seen (Name of musical entertainer) here, I've not seen anyone else. That weekly [activities] list; I've not seen any of it".

People did not receive appropriate person-centred care reflective of their needs and/or preferences and records were not appropriately reviewed and updated. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and also a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

- Complaints were managed inconsistently, and lessons were not learnt to ensure any necessary improvements were made to the service.

We recommend the provider considers current guidance for receiving and acting on complaints and takes action to update their practice accordingly.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had their communication needs assessed and included in care plans, which staff were aware of

and followed.

End of life care and support

● Staff worked closely with other healthcare professionals to ensure people were supported to be comfortable and free from pain at the end of their life.

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 inadequate. At this inspection this key question has remained the same. 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; 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; Continuous learning and improving care

At our last inspection the provider had failed to suitably assess, monitor and improve the safety and quality of the service. 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 and the provider was still in breach of Regulation 17.

● The service was not well-led, and the management of the service was poor and ineffective. The registered manager had left the service in February 2019. A temporary manager had been appointed, however they told us they were not well-supported by the provider.
● Systems for identifying, capturing and managing organisational risks and issues were ineffective. This led to the new and continued breaches identified in this report. The manager told us the provider's audits were not practical to work with and they did not have the freedom to make improvements.
● The provider had failed to act when safety and quality issues had been brought to their attention by CQC. The last four comprehensive inspections at the service have been rated as 'requires improvement', with a repeated cycle of breaches. This placed people at continued risk of harm and in receipt of poor-quality care.
● The provider did not analyse complaints, accidents and/or incidents to consider wider learning or to make improvements to the service.
● Communication about people's needs and risks and how to manage these was inconsistent.

Failure to establish and operate systems and processes effectively placed people at risk of harm and in receipt of poor-quality care. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager wanted people to receive a good quality service but was unable to provide the leadership to drive sustained improvements.
● Staff showed genuine care and compassion for people using the service. However, the provider failed to

equip staff with the resources necessary to effectively care for people living with dementia.

● People, relatives and staff were positive about the manager. They told us the manager was motivated to make improvements in the service. For example, a staff member told us "They (Name of manager) kept pushing [the provider] and they got the dining room done."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The manager had engaged with people and their relatives through meetings and we saw minutes from the last meeting in April 2019. However, there were no records of actions taken forward from this meeting or evidence that these actions had been fulfilled in practice. There was no evidence that feedback from people and relatives in these meetings was used to make improvements to the service.

This is a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.