Holmdale House IOW Ltd

Holmdale House

Inspection report

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Date of inspection visit: 24 February 2015
Date of publication: 08/07/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We undertook this focused inspection on 24 February 2015 and it was unannounced. This was to check that the provider and registered manager had followed the requirements of the warning notices issued to them on 5 January 2015 and to confirm that they now met legal requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Holmdale House on our website at www.cqc.org.uk

Following an inspection on 12 & 16 December 2014 we issued three warning notices telling the provider and registered manager they must improve the service provision in these areas by 26 January 2015. The warning notices related to medicines management, safeguarding people who used the service and the failure to ensure that people had their care and welfare needs met. We found the provider had not taken adequate action to meet the warning notices and become compliant with the regulations.

Holmdale House provides accommodation for up to 31 people who require support with their personal care. The home mainly provides support for older people and people living with dementia. There were 10 people living at the home at the time of our inspection.

The home had a registered manager in place. 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.

Summary of findings

Medicines were not managed correctly. Where people were unable to say if they had pain there was no system or procedures to identify pain or ensure pain relief medicine was administered. Therefore people did not receive pain relief medicine when they require it. Medication audits had not identified the failure to administer topical creams as prescribed or the incorrect use of topical creams. Essential safety precautions were not followed in respect of the storage of oxygen. People were at risk due to these failings.

People were not protected from the risk of abuse and neglect. Staff did not recognise some aspects of their care practises as being abusive. People were at risk of developing injuries which may have been preventable and action was not taken promptly to ensure people received correct safe care.

Healthcare advice was not always sought or followed when required. Care records did not always show when medical advice had been sought or what the advice or guidance from medical practitioners had been. Care and support was not planned or delivered in a way that met people's individual needs or responded to their changing needs.

People's legal rights were not ensured. The principles of the Mental Capacity Act 2005 were not being followed and Deprivation of Liberty Safeguards (DoLS) not implemented effectively. People's wishes in respect of how they should be cared for were either not known or ignored.

Staff did not receive the training they required to give them the necessary skills to meet people's needs safely.

We found the provider had failed to take adequate action and are planning further enforcement action. You can find further information about this at the end of the report.

Summary of findings

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.

Systems were not in place to ensure people received pain relief as required. Medical gases (oxygen) were not stored safely. Topical creams were not always applied or the most suitable cream used.

Staff and the registered manager did not appear to recognise some aspects of their care practises as being abusive. People were at risk of developing injuries which may have been preventable and action was not being taken promptly to ensure people received correct safe care.

Is the service effective?

Inadequate

The service was not effective

Healthcare advice was not always sought or followed when required. Adequate supplies of equipment essential to meet people's needs were not available. People were not receiving the mental and physical stimulation and activities they required.

The principles of the Mental Capacity Act 2005 were not being followed. People were at risk of being unlawfully deprived of their liberty and their legal rights were not maintained.

Staff had not received all the necessary training to enable them to have the skills and knowledge to meet people's needs.

Is the service well-led?

Inadequate

The service was not well led.

The home was not well led and the provider and registered manager have not ensured people's needs were met and they were safe. Action had not been taken to comply with the three warning notices issued in January 2015.

Incidents and accidents were not investigated to ensure learning was used to prevent further occurrences or make improvements to ensure the safety of people.

Staff did not feel valued and supported by the registered manager.

Holmdale House

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 24 February 2015 and was unannounced. The inspection team consisted of an inspector and a specialist advisor in the care of frail older people and in particular those living with dementia.

The team inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well led. This is because the service was not meeting legal requirements.

Before the inspection, we considered all the information we had received from the provider and information from the local authority safeguarding team who were undertaking an investigation at the home. We used this information when planning and undertaking the inspection. We reviewed information we already held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with four people using the service, one family member and a social care professional. We also spoke with the registered provider, the registered manager and four care staff. We looked at records including care plans and associated records for six people; staff training and supervision records; one staff recruitment file; records of accidents and incidents; policies and procedures; and quality assurance records. We observed care and support being delivered in communal areas including the lounge and the dining room over the lunch time period.

Inadequate

Is the service safe?

Our findings

At our inspection in December 2014, we found the way medicines were managed was unsafe. We issued a warning notice telling the provider and registered manager they must ensure medicines were managed safely by 26 January 2015. At our focused inspection on 24 February 2015 although we found some improvements had been made, the management of medicines was not safe.

The warning notice relating to medicines management specifically highlighted the need for pain assessments to be undertaken. These would enable staff to determine if people living with dementia required pain relief medication when it was prescribed on an 'as required' basis. A standardised pain assessment tool had not been introduced nor were there individual 'as required' medication care plans. The registered manager stated "I am thinking about introducing the Abbey Pain Assessment Tool in the home but we have not done so yet". They could not explain why they had not already introduced this. This meant systems were not in place to assess pain in people unable to state they were in pain. People were at risk of not getting pain relief medicine when they require it leaving them in unnecessary pain.

Medically prescribed oxygen was not stored safely. In the nurses office there was a single cylinder of oxygen. This had administration tubes attached to it but was not secured in any way. Essential safety precautions were not followed as there was no hazard notice on the door of the office to warn of the presence of the oxygen. The registered manager stated the oxygen belonged to a person who no longer lived in the home. Oxygen is a medical gas and is prescribed and dispensed for an individual and should have either been sent with the person to their new accommodation or returned to the pharmacy. Three staff told us the cylinder had been knocked over several times. One said "it's been there (in the office) for weeks. It's a nuisance it keeps getting knocked over during handover, there is not enough room". A second care staff said "it's been there for a while; I have no idea where it is meant to go or what is meant to happen with it but it is in the way". Staff were at risk from injury and the failure to follow safe storage procedures placed everyone in the home at risk.

The medicines audit record identified that there had been ten errors during February 2015. Most of these had been identified during the monitoring visits completed by the local authority safeguarding team. These included non-completion of Medication Administration Records (MAR), and tablets being found on people's chairs or in bedrooms.

People were not always having prescribed topical creams administered. Information was available in bedrooms to direct care staff about prescribed topical creams and enable them to record the administration. Records of administration showed that prescribed topical creams were not always being applied as prescribed. Not all creams being used were included on the topical creams administration records. One person had a cream in their bedroom which was not included on either their MAR chart or room topical cream record. The cream was inappropriate for the purposes stated in their care plan. When we asked the registered manager, who had not known the cream was used, they immediately stated "that's not a suitable cream for that". Staff therefore did not understand the different uses of topical creams and had used an inappropriate cream. Medication audits had not identified the failure to administer topical creams as prescribed or the incorrect use of topical creams.

Staff had not receiving the training they required to give them the necessary skills to administer medicines safely. Staff told us they had undertaken very basic medicines administration training which had lasted approximately 20 minutes. Those who had not previously completed medicines training said they did not feel competent to administer medicines following the training.

The above concerns were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlates to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were now given their medicines at regular intervals which meant they were no longer at risk of overdose. Systems to manage stock levels now meant people had access to medicines in a timely way and that excessive stocks were no longer being held.

During the inspection in December 2014 we found people were not safeguarded from abuse. We issued a warning notice telling the provider and registered manager they must ensure people were safe by 26 January 2015.

At our focused inspection on 24 February 2015 we found people were still not protected from the risk of abuse. Staff

Is the service safe?

did not appear to recognise some aspects of their care practises as being abusive. For example, two people were sitting in wheelchairs at breakfast tables in the dining room when we arrived at 08.40 am. One person sat for one hour and forty minutes before they were moved to the lounge. The other person became distressed about fifteen minutes before they were moved at 10.25. This meant they had sat for one and three quarter hours in a wheelchair which should only be used for moving people around the home and not for prolonged use.

People were at risk of developing injuries which may have been preventable and action was not taken promptly to ensure people received correct safe care. Care plans, risk assessments and daily records showed people were not cared for in a safe way. These included instances where people had developed moisture lesions, bruising or sores. A moisture lesion is a reactive response of the skin to chronic exposure to urine and/or faecal matter. The skin becomes red, broken and painful. The presence of moisture damage is associated with incontinence and/or pads that are left on a person for too long. One person's daily notes detailed they had developed a moisture lesion. Two nights later it was identified on the staff handover sheet that there were no incontinence products of the correct size for the person. This meant the person had to wear the wrong size product which did not protect their skin from moisture contact. The person had suffered an avoidable injury as systems had not ensured the risk was appropriately managed.

Unexplained injuries had not been investigated. One person's body map included a scratch on their arm measuring 5cms x 0.2cms. There was no indication that this had been reported to the registered manager or that it had been investigated. The registered manager was unable to explain or describe any investigation into the injury. Similar concerns were identified in other care plans. The failure to have systems in place to investigate injuries means action cannot be taken to prevent or reduce the risk of future harm.

One person's care plan stated "carers to ensure my call bell is always within my reach". However the staff handover sheet stated "not to be given call bell". The registered manager stated "this is an oversight, she cannot have a call bell as she might be in danger from the cord". There had been no investigation of the use of other call bell systems which would not have required a cord and the person remained unable to summon assistance if they required it.

The above concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlates to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding training from an external training provider the week prior to our inspection. Staff were aware of their responsibilities in respect of reporting safeguarding concerns to the manager or external organisations. We spoke with two people who told us they felt safe at the home. They said staff were kind and caring and were prompt to answer their call bells meaning their needs would be responded to promptly.

Inadequate

Is the service effective?

Our findings

During the inspection in December 2014 we found the principles of the mental capacity Act 2005 were not being followed, staff had not received induction or other training and were not receiving supervision. We also found people had not received all the health and personal care they required. People were therefore not receiving effective care. We issued a warning notice telling the provider and registered manager they must ensure people received the care they required by 26 January 2015.

We spoke with one visitor who was happy with the care that was provided to their relative. We also spoke with two people who did not raise any concerns about the way they were cared for. However, we found action had not been taken to meet the warning notices.

During the focused inspection in February 2015 we found people continued to receive ineffective care which was not planned or delivered in a way that met people's individual or changing needs. The registered manager had rewritten four of the care plans however, these did not provide staff with all the necessary information about the person and how their needs should be met. Other care plans had not been reviewed and were not representative of the person's current health and personal care needs. One plan had not been reviewed since July 2014 and did not contain any information about the person's nutritional, skin care or mental health needs.

Care records did not always show when medical advice had been sought or what the advice or guidance from medical practitioners had been. One record showed that a GP had requested a blood test. There was no further information about this to show if this had been completed. Staff and the registered manager were unsure. They subsequently spoke with the GP who said they had decided not to do the investigations. However, the systems in the home had not identified and followed up the initial records stating a blood test was required. Medical advice was not always followed. A GP had visited the home two weeks prior to our inspection and advised that a person "elevated their legs". This was not done during the day of our visit.

Staff did not have guidance to follow to help reduce the discomfort, pain and distress associated with urinary tract infections (UTIs). Two people had urinary tract infections (UTI) but neither had a UTI care plan. There were also no processes to reduce the risk of people developing subsequent UTI's by monitoring the effectiveness of prescribed treatment. One person was receiving a second course of antibiotics for a urine infection within two weeks. There was no evidence that a urine test was completed following the completion of the first course of antibiotics to determine if the infection had been resolved. The person would have remained in discomfort and at risk of complications such as kidney damage for an additional two weeks.

One person had not been eating well. Their care plan and risk assessments had not been updated to reflect the change in their eating and drinking and the support they required. Staff were trying to encourage the person to drink. Food and fluid intake was being recorded. However, these were not being added up daily so staff were not able to easily see how little the person was drinking and take effective action.

Risk assessments were either not completed or were inadequate. Four of the six care plans contained an assessment of the person's risk of developing a pressure related injury. The failure to ensure people had up to date and consistent care plans and risk assessments meant people may not receive the care they require to meet their health and personal care needed. All older people are at risk and an assessment should have been completed for everyone to determine the level of risk and action to be taken to reduce this. Other risk assessments had also not been reviewed. One stated "review every two months" but had not been reviewed since July 2014.

We observed staff assisting people to move using moving and handling equipment. Staff said that they used the same equipment for all people as they did not have individual equipment. This meant people were not only placed at risk of infection but that the equipment used may not be suitable for their body shape and size.

People did not receive care as detailed in their care plans or how they liked to be cared for were not met. One care plan stated 'I like to get up after 08.00am', also 'likes to lie in in the morning and get up when I please'. The handover sheet for the day of our inspection recorded that the person had been woken at 6.15am. Daily records of care also recorded that the person was woken early on most

Is the service effective?

mornings throughout February 2015. The handover sheet also detailed that other people were woken at 06.15 am although their care plans stated 'I like to get up at my leisure'.

People were at risk of deterioration in their mental and physical health as they were not receiving the mental and physical stimulation and activities they required. In one person's daily notes there were several instances recorded when the person was described as "low in mood". A GP had visited and suggested staff increase activities and make an "about me book" so staff can use this to talk to the person. There was no information in the person's care plan about their life history and no evidence that the GP's suggestions had been acted upon. The activities record showed that the person had eight activities in the first 24 days in February 2015. Some recorded activities included watching a film on television. Staff told us some external activity providers were no longer contracted to attend the home as the provider had cancelled the arrangement for these. Records showed activities previously provided by external activity providers had not occurred.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlates to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection in December 2014 we found people's legal rights were not protected. We issued a warning notice telling the provider and registered manager they must ensure people's legal rights were protected by 26 January 2015.

At this inspection in February 2015 we found people's legal rights were not protected. Care records showed that Mental Capacity Act (MCA) 2005 principles were not followed. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. People were not supported to make decisions and their legal rights were not being upheld.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. In one care record we found three references during February 2015 that the person was expressing a wish to go home and on one occasion had attempted to leave the home via the rear garden. Other information in the care plan indicated the person lacked capacity to make some decisions and therefore a mental capacity assessment should have been completed and DoLS applied for. There was no information about this in their care plan. The registered manager stated that an application had been submitted but did not provide evidence of this. The local authority, who assess DoLS, subsequently told us that no application had been received for this person. This meant people were being unlawfully deprived of their liberty.

The above issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlates to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Following an inspection in December 2014 we issued three warning notices telling the provider they must improve the service by 26 January 2015. The warning notices related to medicines management, safeguarding people who used the service and the failure to ensure that people had their care and welfare needs met. We found the provider had not taken adequate action to meet the warning notices and become compliant with regulations.

There were inadequate systems in place to ensure the home was well led and able to ensure people's needs were met and they were safe. The provider for Holmdale House is registered as a limited company and registered with the Care Quality Commission (CQC) in January 2014.

Systems were not in place to ensure that all necessary equipment and supplies were available. We identified that five people had not had access to the correct continence supplies as these had "run out". Proactive systems were not in place to monitor the level of stocks to ensure that adequate supplies were held to enable people's needs to be met. The consequence of the lack of continence supplies was that people did not receive the dignified care they required or deserved.

There was inadequate quality monitoring of the care people received. We spoke with the registered manager about the handover sheet and records in daily notes which referred to most people being woken up and some dressed at 06.15am. One record included the notes 06.15am asked if wanted to wake up'. It was recorded the person said no. Another record stated 18.15 'asked if wanted to go to bed'- replied yes'. There was nothing in the person's care plan indicating they either needed or wanted to get up or go to bed that early in the evening. Daily records also included terms used such as 'strip wash' which are disrespectful. The registered manager and provider are responsible for the quality of care people receive. Daily records were not being reviewed by them to ensure people were being offered safe, effective care which was responsive to their individual needs and wishes. The registered persons have failed to ensure the culture of the organisation, and subsequently the words staff used, were respectful and protected people's dignity.

There was a lack of governance systems for monitoring the quality of service provided. The provider had not identified the concerns identified during the inspection. There was a lack of audits, other than medication audits and reviews with no learning from events or evidence that improvements were being made. There was no record or analysis of accidents or incidents and no action was being identified and taken to reduce incidents and harm to people.

People, relatives and staff were not kept informed about the safeguarding or CQC concerns. A relative told us they did not know what was happening. They said they had heard rumours but nothing from the provider or registered manager. They added that staff also did not seem to be kept up to date about the current situation in the home as they could not answer their questions.

The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correlates to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three staff spoke with us individually and all said the registered manager did not provide support for them and often spoke to them and/or shouted at them in a manner that belittled them. One said "you should hear the way she talks to us in front of visitors, the residents and other staff, we always get the blame here, she takes no responsibility for anything". We observed an incident between the registered manager and a member of care staff who were shouting at each other in the dining room. Three people using the service and two other care staff were also present. The episode lasted several minutes and was audible from outside the dining room. The provider and registered manager have failed to ensure the service is well led for the benefit of people.