Sidmouth Care Limited

Vale View Heights

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Holmesley Care Home is a residential care home providing personal and nursing care to 47 people aged 65 and over at the time of the inspection. The service can support up to 55 people. The service provides accommodation over two floors, with access provided by a passenger lift. There is office and training space on the third floor. Many bedrooms have en-suite facilities and patios leading to the mature gardens.

People's experience of using this service and what we found
Shortly after our second day of inspection, the home reported an outbreak of Covid-19. As the outbreak progressed most of the people living at the home tested positive for Covid-19; some people died both at the home and following admission to hospital. Many of the staff team were also affected. Effective measures to prevent the spread of infection were not put in place at the beginning of the outbreak. We received concerns highlighting poor leadership decisions in relation to the management of Covid-19. There is a current Police investigation into the circumstances of the outbreak of Covid-19. No conclusions have yet been drawn.

Once it became clear there was an outbreak of Covid-19, the provider worked closely and openly with the local authority and CQC to ensure people's safety. A Senior Infection Prevention Control Nurse visited Holmesley Care Home on 11 March 2021 to provide support and advice regarding management of the outbreak. They told us that they "found no major grounds for concern in current practice but was able to make some suggestions as to making things closer to best practice in challenging circumstances. Holmesley Care Home was not found to be an outlier in safe practice, at this stage, having addressed a number of significant issues in advance of the visit (isolation and PPE use).

People were at risk of neglect and abuse because systems were not in place, or not operated effectively, to identify concerns. Systems and processes were not robust enough to identify where things had gone wrong, so lessons could be learnt. People's needs were not always fully assessed, and poor record keeping meant the home was unable to demonstrate care delivery. However, people told us they felt safe, responded well to staff and looked relaxed and at ease with them.

There were widespread and significant shortfalls in the way the service was led. Systems and processes to monitor quality performance were either not in place or not effective, and the structure and responsibilities of the staff team were not always clear.

Some care plans frequently lacked specific detail and instructions, others contained good information. Daily records and charts were not sufficiently detailed to demonstrate what care had been provided or how that person's day had been. Some people's records indicated they had not been checked for long periods of time.

Staff had a lack of understanding of their roles and responsibility under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) procedures and decisions were being made for people outside of

the framework of the MCA.

Systems that had previously been in place to review risks to people such as falls, accidents and incidents had not been maintained.

There were process in place to monitor staffing levels and staff were recruited safely. Some staff told us they felt the atmosphere in the home was positive. One said there was a "good atmosphere", another told us they "instantly fell in love with the atmosphere."

The service worked well with other professionals. Whilst records relating to partnership working were not always correctly completed, visiting professionals were complimentary about the home and the registered manager. One said "Holmesley work in partnership with any cases I am managing and the [registered] manager's knowledge of residents likes, dislikes, family dynamics and this information is so important."

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

Rating at last inspection
This service was inspected but not rated (published 30 October 2020)

Why we inspected

We undertook this targeted inspection to follow up on specific concerns we had received about the service. These included concerns about low staffing levels, staff not treating people with dignity and respect, people not receiving care in a timely way (or at times that suited them), a lack of staff training and unsafe moving and handling practice. A decision was made for us to inspect and examine those risks.

During this inspection we found concerns about people not receiving care in a timely way (or at times that suit them) and people waiting long periods of time for assistance were partly founded. This was because records did not demonstrate that appropriate care had been provided. Concerns over a lack of staff training were founded, however, we were satisfied that staff had sufficient training in moving and handling and we did not identify any unsafe practice. Concerns about staff not treating people with dignity and respect were not founded at the time of the inspection. We did not find concerns around low staffing levels.

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.

On the first inspection visit we found concerns with infection prevention and control procedures, records relating to the delivery of care and people's needs and choices not being assessed in line with current legislation. Because of these shortfalls we widened the scope of the inspection to become a focused inspection which included the key questions of Safe, Effective and Well-led.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective 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.

This service had not previously been rated following the CQC comprehensive inspection process of rating all five domains. Therefore, for the purposes of this inspection, we have rated three key questions but have not

given an overall rating.

You can read the report from our last inspection, by selecting the 'all reports' link for Holmesley Care 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 safety of care, safeguarding, person-centred care, the need for consent and governance at this inspection. We took urgent action to impose conditions on the providers registration.

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.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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	**Inadequate**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service well-led? The service was not well led	**Inadequate**

Vale View Heights

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.

This was a targeted inspection to check on specific concerns we had about low staffing levels, staff not treating people with dignity and respect, people not receiving care in a timely way (or at times that suited them), people waiting long periods of time for assistance, a lack of staff training and unsafe moving and handling practice. We widened the scope of the inspection after the first day to become a focused inspection which included the key questions of safe, effective and well-led.
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 three inspectors over two days.

Holmesley Care 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
The first day of inspection was unannounced. The second day of the inspection was announced, so the service could send us information prior to our visit.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not

asked to complete a provider information return prior to this inspection. This is information we require provider's 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.

We used all of this information to plan our inspection.

During the inspection
On day one of the inspection we spoke with seven staff and six people. On day two we spoke with six staff and four people. We spoke with the registered manager and the provider's representative on both days. Following day one of our inspection we contacted seven professionals who work with the home and requested feedback. We received feedback from four professionals. We reviewed a number of records, including seven people's care plans and risk assessments, five people's care charts, three staff files, training records, records relating to the provider's oversight and documents relating to infection prevention and control.

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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed all of the information the registered manager and provider sent us. We had a meeting with the provider to discuss our findings and concerns.

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 good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were not protected from the spread of infection.
- Shortly after our second day of inspection, the home reported an outbreak of Covid-19. As the outbreak progressed most of the people living at the home tested positive for Covid-19; people died both at the home and following admission to hospital. Many of the staff team were also affected.
- Effective measures to prevent the spread of infection were not put in place at the beginning of the outbreak. For example, during the first seven days of the outbreak people who had tested negative for Covid-19 were being supported in the same communal space as people who had tested positive, putting them at risk of infection. All these people later tested positive for Covid-19.
- During the first day of inspection we observed seven staff wearing face masks incorrectly, or not at all, on multiple occasions within both office and communal space. This included members of the management team and domestic staff. We saw one staff member serving drinks to several people with their mask under their nose. This was not in line with current UK Government guidance.
- Staff told us there was a culture of people removing their masks or wearing them under their chin. For example, one staff member told us they saw staff with masks under their chin "all the time" and that one staff member had "refused point blank" to wear a mask at all.
- A relative had raised concerns regarding this practice through a relative's satisfaction survey in July 2020, they said "I have been alarmed by the way some members of staff are wearing PPE i.e wearing their face mask around their neck and touching the outside of it, is this due to lack of training?" The registered manager responded to this and reminded staff of the need to follow guidance.
- We raised our concerns regarding this with the registered manager during day one of our inspection. During verbal feedback they told us staff were "tired." The registered manager did not demonstrate a good understanding of why masks should not be moved under the chin and then reused.
- The registered manager wrote to us the following day to confirm they would address these concerns, including monitoring of mask wearing, a new mask wearing protocol for all staff to read and dealing with non-mask wearing as a disciplinary process. However they also wrote "whilst I am not excusing improper mask wearing, I do also believe that the risk to our residents (and team) from COVID-19 is now fundamentally and substantially reduced compared with March-December 2020."
- There were no separate handwashing facilities in the laundry, which increased the risk of spread of infection.
- We observed two cupboards containing cleaning chemicals to be unlocked and accessible. This potentially put people at risk of harm from hazardous substances.
- We have also signposted the provider to resources to develop their approach.

People were not protected from receiving unsafe care and treatment, from avoidable harm or 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.

●The provider reacted immediately during and after the inspection. They gave clear communication to management and staff regarding expectations around use of PPE. Once it became clear there was an outbreak of Covid-19, the provider worked closely and openly with the local authority and CQC to ensure people's safety.
●A Senior Infection Prevention Control Nurse visited Holmesley Care Home on 11 March 2021 to provide support and advice regarding management of the outbreak. They told us that they "found no major grounds for concern in current practice but was able to make some suggestions as to making things closer to best practice in challenging circumstances Holmesley was not found to be an outlier in safe practice, at this stage, having addressed a number of significant issues in advance of the visit (isolation and PPE use)."

●During our last inspection in September 2020 we raised concerns regarding the type of masks being used by staff when caring for a person who used aerosol generating equipment which increased the risk of infection. This had been addressed and the correct fit tested masks were being now used.
●When this equipment was being used, the bedroom door needed to be closed to minimise the risk of spread of infection. The person did not want their bedroom door closed as it made them feel claustrophobic. The home had found an innovative solution and sourced a clear plastic screen, secured by magnets, which meant both the need to minimise the risk of infection and the person's personal preference could be met.
●We observed a marked improvement in relation to mask wearing by all staff on day two of our inspection.
● People said their rooms were kept clean and none of the areas we visited had offensive odours. We saw staff cleaning rooms and carpets throughout our inspection. Systems were in place to ensure cleaning was carried out in line with current UK Government guidance including high touch points.

Assessing risk, safety monitoring and management
●Risks were not always appropriately assessed, and systems for monitoring and managing safety were not effective.
●People newly admitted to the home were not isolated in line with current UK Government guidance and no risk assessments were in place regarding this. We were concerned people's bedroom doors were held open and that this put them, and others, at risk from spread of infection. We raised our concerns with the registered manager on the first day of inspection. The registered manager did not feel closing the bedroom doors of people isolating was necessary, or "humane." We referred them to current guidance regarding admissions.
●Minutes from a head of department meeting held on 22 February 2021 stated: "comment from CQC – any new admissions we need to shut the door, [registered manager] explained we are not going to do it, it is not a prison, it is not human."
●Risk assessments were put in place following the first day of inspection, however they were not robust in demonstrating why the risks of the person isolating outweighed the need to prevent the spread of Covid-19.
●Some risk assessments failed to identify risks that people faced. For example, moving and handling risk assessments did not identify if the person was at risk, and if that risk was low, medium or high. One person's risk assessment had not been reviewed since June 2020.
●One person's mobility care plan identified that they had a history of falls. There was no further information as to how staff could minimise the risk of the person falling or what to do if they did fall. A second persons continence care plan identified that they were at risk of repeated infection but did not detail what signs might indicate an infection, or what staff should do about it.

●Food and fluid charts were not being used to monitor how much people who had experienced unplanned weight loss were eating and drinking; where they were being completed at the request of a dietitian they had not been completed in line with the advice of a health professional. For example, one person's food chart had eight meals recorded for a period of seven days. Another person's care plan stated there was a maximum amount of fluid they should drink in a 24-hour period due to a heart condition, however this was not documented on the fluid chart.
●In advance of the second day of inspection the registered manager sent us information about people's level of need and identified that were no 'turn charts' in place. This was despite there being 24 people with pressure relieving equipment in place and at a medium or high risk of suffering damage to the integrity of their skin.
●One person, whose care plan identified they needed to be checked every two hours, had a gap of seventeen and a half hours with no checks.

People were not protected from receiving unsafe care and treatment, from avoidable harm or risk of harm. Risks to people's health and safety were not thoroughly assessed. This 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
●Systems and processes were not established or operated effectively to protect people from abuse.
● Allegations of abuse were not always reported to the local safeguarding authority or investigated by the registered manager or provider. A staff member told us a person had made allegations of abuse, including staff hitting them. Records relating to the individual stated their leg had also become entrapped in their bedrails and on another occasion their mattress had to be changed because it was 'drenched in urine'. We shared this information with the registered manager who said they were unaware of the allegations. The local authority had not been informed and CQC had not been notified.
●The provider's representative said these concerns would be investigated to clarify why safeguarding alerts had not been raised.
●CQC had received multiple concerns over the months preceding the inspection. It was alleged that people were not being assisted to have a bath or a shower. The provider had told us they had investigated and were assured that people were having a bath or shower in line with their wishes, however during this inspection we found no consistent records were being kept in relation to this.

Systems and process were not established or operated effectively to prevent the abuse of service users. 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.

●People told us they felt safe; they did not have uninvited people entering their rooms. People responded well to staff; they looked relaxed and at ease with them. The local authority community and safeguarding team had been kept informed of changing risks for two people and were involved in changes to their accommodation and care.
●Staff knew to contact a senior member of staff if they observed or heard about abusive practice in the home and said they would do this immediately. There was clear information in the home for staff to follow with contact details for external agencies, such as the local authority safeguarding team and CQC. Staff attended safeguarding awareness training.
●Information from the local authority safeguarding team showed the staff team at Holmesley Care Home alerted them appropriately to unwitnessed falls. There were no concerns of abuse or neglect in relation to these incidents.

Using medicines safely

●People received medicines safely, however, records relating to topical creams did not demonstrate that they had been applied in line with prescribed directions.

●We raised concerns during our last inspection regarding the application of prescribed topical creams. Records kept in people's rooms did not demonstrate they were being applied in accordance with the direction of the prescribers. Senior staff were signing the records as being complete when they were not. We raised this with the registered manager in October 2020 and they said they would address it.

●During this inspection we found people's cream charts were still not being completed correctly. For example, several people's creams were prescribed for application twice daily, however, records only demonstrated they were applied once daily, and some days were missed. Some body maps, which indicate to staff where the cream should be applied, had not been completed. Senior staff were still signing that these charts were complete, when they were not.

●People told us they received their medicines on time, and one nurse told us about the importance of time sensitive medication and how they structured their work around this.

●We observed a nurse administering medicine covertly. We saw permission for administering medicine covertly was in the person's file, and observed the nurse interacting with the person in a kind, caring and encouraging manner.

●Competency checks including observation of practice were made to ensure staff administering medicines were competent to do so.

We recommend the provider consider current guidance on recording on how prescribed creams are administered and recorded and take action to update their practice.

Learning lessons when things go wrong

●Systems and processes were not robust enough to ensure lessons were learnt when things went wrong.

●There were no systems in place to regularly review falls, incidents and accidents in order to identify themes.

●The provider's systems and processes did not ensure learning had been implemented. For example, communication records detailed one person's leg had become entrapped in their bedrails and on another occasion their mattress had to be changed because it was 'drenched in urine'. Because there was no system in place to record and review incidents such as this, the registered manager was unaware of the allegations or the entrapment incident or the reason why the mattress was changed, therefore no learning could take place.

Staffing and recruitment

●We had received concerns there were not always enough staff to meet people's needs, during this inspection we found no evidence of this.

●We had received concerns that call bells were not always answered promptly. The provider and registered manager told us they had been monitoring call bell response times and were confident that changes they had recently put in place had resulted in more efficient staff practices and quicker responses to call bells.

●During the inspection we observed people in the upper lounge for around 15 minutes. A person living in the home told us that if they needed to call for staff assistance, they would use the call bell on the opposite wall. We talked with the registered manager and provider's representative about the risks of people not being able to reach a call bell easily. The registered manager told us they would look into the possibility of providing more mobile call bells.

●Consideration had been given to people's dependency levels based on the amount of staff they needed to assist them, and the time of day they preferred to get up. Staffing levels were planned in accordance with this.

●New roles and a daily structure had been introduced to improve efficiency, and to ensure staff were always able to take a break. This included 'floating' members of staff who would support where most needed.
●One staff member who had worked at the home for over a year said staffing levels had improved in the last few months. People were not concerned about call bell responses.
●The provider was actively monitoring call bell response times to ensure people were not waiting too long for assistance.
●People told us "staff come quickly if I need help", "they are very patient", "they are very kind" and "they put their heart and soul into it."
●Identification documents and police checks were completed prior to new staff working with people living at the home. The importance of references to judge people's suitability for their role had been recognised, however further work was needed to ensure previous care references were appropriately documented. Risk assessments were undertaken where information suggested there could be a potential risk regarding staff's suitability to work in a care setting.
●Staff and records confirmed they spent their first day with a senior member of staff during which they completed a tour of the building, were introduced to people and covered 27 different topics on an induction sheet.
●Staff said how much they enjoyed working at the home. Comments included; "The rewards are fantastic", people have "amazing stories" and "good atmosphere" and "instantly fell in love with the job."

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 not rated. At this inspection this key question has been rated as Requires Improvement. 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.

- Staff demonstrated a lack of understanding of their roles and responsibility under the MCA and DoLS procedures.
- Decisions were being made for people outside of the framework of the MCA. For example, the home was depriving some people of their liberty through the DoLS procedures without first having undertaken a capacity assessment to establish if the person was able to make the decision for themselves.
- A specific decision had been made for one person without having undertaken a capacity assessment to establish if they could make the decision themselves or seeking their views. There was no documentation in relation to a best interest decision making process. This potentially put the person at risk of their decision making rights not being met.
- It had been identified by staff in June 2020 that capacity assessments had not been completed and were required for some people, however these had not been completed at the time of our inspection.

Consent from the relevant person was not always sought or recorded before providing care and treatment. This was a breach of Regulation 11, Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was some good practice evident around restrictive decisions, and capacity assessments and best

interest decisions had been documented regarding the use of bed rails and pressure mats to prevent falls.
●Following the inspection, information from local authority showed deprivation of liberty applications had been made when sensor mats were used to notify staff if people had got out of bed unaided. A person living at the home who had capacity to make informed decisions said staff had removed the mat from her room, at her request, once her mobility and her health had improved.

Staff support: induction, training, skills and experience
●Staff did not always have the training, assessment and supervision necessary to ensure they knew how to perform their role.
●Records showed most staff, including senior staff, had not completed relevant training as detailed in the home's training programme.
●Some staff said working with people living with dementia could be challenging. Records showed that only half of the staff team had completed any form of dementia training. The provider's representative said this would be addressed with the help of a senior staff member who had previous experience of working alongside people living with dementia.
●Health care assistants were delegated to assist people to eat. They described being shown by a senior member of staff how to assist people who were identified as being at risk of choking. However, their practice had not been signed off as competent and safe.
●Despite people being provided with end of life care at the home on a regular basis, training in this area of care was not covered in health care assistants or senior health care assistants' training programme.
●Records showed only seven staff had completed oral health care training; we saw there were significant gaps in people's oral health care records.
●Staff had not received individual supervision to check on their well-being, progress and training needs. All staff had received core supervision in January 2021 which staff said was about roles and structure in the home.
●There was no system in place to record staff supervisions and appraisals, and the provider's quality assurance framework completed in February 2021 confirmed no appraisals had taken place.

Staff did not receive appropriate support, training, professional development, supervision and appraisal. This was a breach of Regulation 18, staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Prior to our inspection, we received concerns about how people were assisted to move in the home. Records showed staff completed a full days training on moving and handling. They were complementary about the quality of their training. People told us they felt safe when staff used equipment and helped them to move, and we saw staff being conscientious when they supported people to move, for example checking their feet were on foot guards before moving a wheelchair.
●Some people had been identified as being at risk of choking and needing assistance with their meals. External health professionals' advice had been sought to manage this risk and staff were provided with guidance, for example the preparation of food to meet individuals' needs and the consistency of fluids.
●A specialist nurse who had provided training regarding a specific piece of equipment said, "When I provided training the session was well attended by the staff, some of whom had agreed to come in on a day off, showing a level of commitment to their learning and care of their resident."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●People's needs were not always fully assessed, and inconsistent record keeping meant the home was unable to demonstrate the delivery of care in line with expected standards.
●During our last inspection In October 2020 we raised concerns that care plans frequently lacked specific

detail and instructions regarding people's care. We discussed this with the registered manager and were told that work reviewing care plans was ongoing. At this inspection we found this work was still not complete.

●One person we spoke with told us they lip read and asked us to pull our mask down so they could understand us. When we checked their communication care plan, there was no detail about how to support them with this, or what staff could do to communicate effectively.

●Another person's care plan had not been updated to reflect their changing needs. Daily notes at the end of January 2021 recorded that the person had "come to the office and if they could have more help going to bed, and that they feel they need more care." No changes had been made to their care plan to reflect this.

●During our last inspection we raised concerns daily records and charts did not contain enough detail to evidence the care provided. We discussed this with the registered manager, and they told us it was being addressed. In advance of this inspection we had received concerns that people were not being assisted to have baths or showers and were not receiving care in a timely way. We found daily notes and records still failed to record care provided.

●Staff completed a 'care hygiene chart' daily. Care staff put their initials next to a 'task' to indicate it had been completed. No detail was recorded regarding the support given. No records were kept to evidence what support was provided for people who required continence care.

●On the second day of inspection we found 'Intentional rounding' charts were being used for some people. Staff used these charts to record that they had checked the person and if they had assisted them to re-position. These charts were not consistently completed.

●Daily notes were not sufficiently detailed to demonstrate what care people had received or how they had spent their day. For example, one person's daily notes said; "had a settled night, no concerns" and "been to the dining room for all their meals, no concerns." Another person's records said, "settled day, meds taken." There was not sufficient detail to demonstrate adequate support had been delivered or to measure people's well-being.

●Some care plans which had been updated contained very specific and detailed information, which demonstrated those people's needs had been assessed and gave staff clear information about how to meet their needs. One person, who was unable to communicate verbally, had a communication care plan which stated they were unable to call for assistance. The care plan gave sufficient detail to guide staff, such as the use of communication cards and how to recognise non verbal communication cues from the person.

Supporting people to eat and drink enough to maintain a balanced diet

●People were able to choose from a selection of main meals, and a dessert fridge held a variety of choices including homemade cakes and desserts. On the day of inspection, the cook had made an impressive cake to celebrate a person's 101st birthday.

●People were positive about the quality of the food and drink provided at the home; staff knew people's preferences, and where appropriate, made suggestions based on people's past feedback. Menus were on display on each table in the dining room and people were consistently offered choices around food and drink. There was a range of drinks on offer; a number of people chose to drink alcohol with their meal. Staff recognised some people's wish to remain as independent as possible; people used adapted cutlery and eating aids. People routinely had filled water jugs and glasses close at hand in their rooms.

●Information about people who needed a modified diet was clearly displayed in the kitchen, as were allergies, likes and dislikes. The cook knew people well and had worked at the home for many years.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

●Staff worked effectively with other health professionals.

●Staff were pro-active in contacting other agencies when required and copies of correspondence were kept

within people's care plans. Efforts were made to follow professionals' advice; however, this was not always well documented. For example, one person had seen a doctor after experiencing a fit or fainting episode. The doctor had noted "staff to monitor overnight", however no records were kept in relation to this and the notes recorded "had a settled night no concerns." Another professional had asked for monitoring paperwork to be completed to help them support a person who was becoming distressed, this had not been completed correctly.

●Following the inspection we contacted professionals who had worked with the home for feedback, one said "members of my team have described the registered manager as helpful and quick to respond to requests for information", another said, "I have worked with the home on several different matters. I have always found the registered manager approachable, easy to contact and willing to provide any information I request." A third professional said, "I have always found the registered manager and care team to be super helpful, efficient and in tune to the resident's needs."

Adapting service, design, decoration to meet people's needs

●The design and adaptation of the home did not always meet people's needs.

●We spent time in the dining room at lunchtime and saw space was limited, which was commented upon by people living at the home. The home is registered for 55 people, but we saw only 14 people could have their meal at the same time in the dining room. For example, several people could not find a space to sit at a table; they had to leave and then return later. One person was also encouraged to leave their table to provide space for another person to have their meal. One staff member suggested a person ate their meal in the lounge instead. This impacted on the social element communal mealtimes usually provide for people. However, staff who assisted people with meals did so at a pace to suit them. Other people said they preferred to eat their meals in their room.

●Many people living at the home used equipment, such as frames or wheelchairs, which created additional space issues. Staff also had difficulty manoeuvring wheelchairs through one of the dining room doorways because of the width of wheelchairs or if people had their legs extended. The provider's representative said they had plans to extend the dining room in recognition of the lack of space.

●People told us they liked their bedrooms, including the space they had to add personal belongings, such as furniture, books and plants. They appreciated the assistance of staff to help make their rooms homely. For example, one person said the positioning of a picture, which reflected their faith, gave them strength and comfort as they could see it from their chair. People appreciated the grounds and views from their windows, with several people saying they regularly took daily walks in the grounds, which we observed.

●A Covid-19 visiting room had been created to enable people to see their loved ones without sitting in the garden. This room had been specially adapted with floor to ceiling clear barrier, and an external door for the visitors to use. Two family members told us that this was welcome, however, there were difficulties with communication due to the sound quality.

●A visiting professional told us "I have met residents in a lovely room at the rear of the property which has been made COVD19 secure (screen). Holmesley Care Home implemented this facility very quickly after the first lockdown and was a welcome addition. Often I have to be sat outside in the cold under a marquee at other homes in the area."

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 good. 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.

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

- There were widespread and significant shortfalls in the way the service was led.
- A staff member tested positive for Covid-19 on 22 February 2021. The registered manager did not inform CQC of this during our second day of inspection on 26 February 2021, despite infection prevention and control in relation to the Covid-19 pandemic being a focus of our inspection. We were informed of an outbreak of Covid-19 initially affecting 15 people and two staff on 2 March 2021. Following this, we received specific concerns regarding the initial management of the outbreak. There is a current Police investigation into the circumstances of the outbreak of Covid-19. No conclusions have been drawn.
- We received feedback from staff about their experience at the home. One staff member told us they had previously raised concerns with the registered manager but that they had been "brushed under the carpet." They also informed us "We have no faith in the way [the registered manager] runs the home, and no faith in her keeping staff and residents safe."
- One staff member told us there was a culture of "fear, backlash and bullying" and they had felt excluded and uncomfortable after speaking with our inspectors on day one of our inspection.
- The culture of the home was not open. Minutes from a head of department meeting held on 22nd February 2021 documented the registered manager encouraging staff to be wary of outside professionals.
- Some language used within both care plans and staff documents were not person-centred. For example, meeting minutes from a heads of department meeting on 22 February states "some residents are gaining a lot of weight, some are too large."

The culture and leadership of the home was not person-centred, open, inclusive and empowering and did not lead to good outcomes for people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Immediately following the inspection, most of the management team were absent from work due to the outbreak of Covid-19. The provider re-deployed management from other parts of their business to support the home and was open and accepting of support offered by the local authority and clinical commissioning group whilst this was being arranged and put in place.
- Some staff told us they felt the atmosphere in the home was positive. One said there was a "good atmosphere", another told us they "instantly fell in love with the atmosphere." One person said, "I can't speak highly enough of [registered manager], so approachable."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●Systems and processes to monitor quality performance were either not in place or not effective, and the structure and responsibilities of the staff team were not always clear.

●Systems that had previously been in place to review risks to people such as falls, accidents and incidents had not been maintained. The Registered Manager reviewed falls and accidents on an individual basis, but no longer reviewed them on a monthly basis. This meant trends and patterns could not be identified and people may be at risk of further harm.

●There were no systems in place to audit and have oversight of risks to individual people. For example, where there was a requirement for a food and/or fluid intake to be monitored. Therefore, it had not been identified that these were not completed correctly.

●The registered manager relied on senior staff completing a 'duty checklist' to confirm all required tasks had been completed by care assistants. No checks were made to ensure this was completed correctly, and so the registered manager was unaware that some care records were not being fully completed.

●The provider's quality assurance systems did not identify where improvements were required. During our inspection we identified that accidents and incidents were not being analysed, both UK Government guidance and the provider's own protocol regarding admissions was not being followed and that DoLS application and management was not taking place in line with the Mental Capacity Act.

●A new management structure had been introduced, including the creation of new senior roles. The scope and responsibility of these roles had not been clearly communicated to staff. One staff member commented they "never know who's doing what, too many people with titles – it's fragmented." Another said they had raised concerns about a member of staff who had then been promoted to a "made up job."

●Records were ineffective as they were not reviewed. This meant the provider did not identify where improvements were needed.

●Senior staff had signed to say all records had been correctly completed but our findings did not support this.

Effective systems and processes were not in place to asses and monitor the service. This was a breach of Regulation 17, good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Work had begun to introduce clarity to the management teams' roles and responsibilities, and to create structure to each shift. Implementation and communication of this had begun at the time of inspection, however it had not had time to be communicated to all staff or be embedded into practice.

●It was evident that some members of senior staff were working incredibly hard to drive improvement and to implement systems and processes to address the concerns identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●The communication systems in the home were not always effective. Staff said there was no overlap time between shifts for information to be effectively passed on. Handovers took place between nurses on each shift; seniors were also updated; a new file had recently been implemented to record key information. However, health care assistants said they were not always informed of significant changes. Several staff said it could be upsetting to visit someone only to find they had died and there to be a new person in their room.

●Staff said they were told to check in the red files in people's rooms for changes, but we saw these were not routinely kept up to date. There was no written summary of people's key individual care needs to share with all staff providing care support. This meant there was the risk of a change not being passed on to all relevant staff, particularly if they had not been working for several days.

●There were no systems in place to provide a summary of people's key care needs for agency staff. We were told this was not necessary as most agency staff regularly worked at the home. However, following the outbreak at the home, this issue had to be addressed because of the number of new staff working at the home.

Effective systems and processes were not in place to asses and monitor the service. This was a breach of Regulation 17, good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The home had sought feedback from people and their families, and whilst they had not carried out a formal staff survey, staff had been given the opportunity to give feedback through workshops facilitated by a quality manager.
●Staff were positive about the supportive atmosphere of the home from other staff and knew who to approach for information and advice. One staff member said the provider's representative spent time at the home and they had been able to share their concerns on staffing levels which had been addressed. A person said they could not speak highly enough of the registered manager's approachability.

Continuous learning and improving care
●Learning from current performance was difficult due to the lack of systems and processes in place. Because information from incidents, investigations and complaints were not reviewed and analysed, it could not be used to drive improvement.
●The provider's oversight systems failed to evaluate the service being provided against current guidance.
●Systems were being established to recognise staff performance. For example, an 'employee of the month' scheme was being re-started.
●An electronic call bell system was being used and regularly evaluated by the provider to improve response times.

Working in partnership with others
●The home had shared information with other relevant agencies where it had identified the need to do so, for example making safeguarding referrals. However, because of the lack of systems and oversight of incidents some information which should have been shared, was not. The provider's representative said these concerns would be investigated.
●People's care plans demonstrated the home worked in partnership with others when required and sought other professionals' advice when appropriate.
●Whilst records relating to partnership working were not always correctly completed, visiting professionals were complimentary about the home and the registered manager. One said "Holmesley work in partnership with any cases I am managing and the [registered] manager's knowledge of residents likes, dislikes, family dynamics and this information is so important, especially if they have been previously unknown to our service." Another said, "I have been working closely with [registered manager] with regard to a number of individuals recently and they have been extremely supportive and responsive."

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	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Consent from the relevant person was not always sought or recorded before providing care and treatment

The enforcement action we took:

We imposed conditions to the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not protected from receiving unsafe care and treatment, from avoidable harm or risk of harm.

The enforcement action we took:

We imposed urgent conditions to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and process were not established or operated effectively to prevent the abuse of service users

The enforcement action we took:

We imposed conditions to the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The culture and leadership of the home was not person-centred, open, inclusive and empowering and did not lead to good outcomes for people. The provider did not always act on the duty of candour. Effective systems and processes were

not in place to asses and monitor the service

The enforcement action we took:

We imposed conditions to the providers registration

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 Staff did not receive appropriate support, training, professional development, supervision and appraisal

The enforcement action we took:

We imposed conditions to the providers registration