Heritage Care Limited

Holmers House

Inspection report

Holmers Farm Way
Cressex Road
High Wycombe
Buckinghamshire
HP12 4PU

Tel: 01494769560
Website: www.heritagecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 18 and 19 December 2018 and was unannounced on the first day. We previously inspected the service in April 2018. The service was not meeting all of the requirements of the regulations at that time and was rated 'requires improvement'.

Following the last inspection, we asked the provider to complete an action plan to show how and when they would improve the key questions safe, effective, caring, responsive and well led to at least good.

Holmers House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
Holmers House accommodates 48 people in one adapted building. The service accommodates 16 people across three separate units, each of which have separate adapted facilities. All of the units specialise in providing care to people living with dementia. At the time of our inspection there were 33 people using the service.

The service had a registered manager in post. 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.

At out last comprehensive inspection on 10 and 11 April 2018 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The service failed to provide person centred care that met people's needs and reflected their preferences. This inspection found a continued breach of Regulation 9 and a breach of Regulations 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

We received mixed views from people about feeling safe living at Holmers House. Several people confirmed that they were still susceptible to falls, however, were able to confirm that their environment was safer for them than where they lived previously. Some people told us they had been hit by another person at Holmers House.

We observed medicine administration and checked the stock levels of prescribed medicines. We found some people had been without their medicines due to insufficient stock. We saw some people were on fluid charts due to their assessed needs. The system used by the service to record people's fluid intake had been incorrectly calculated. This meant people were at risk of dehydration and we made the registered manager

aware of this during our inspection.

The provider did not have systems in place to ensure the service offered quality care and support. Some people were at risk of harm from other people living at Holmers House. Risks to people were not managed safely. Providers are required by law to notify us of significant events that occur in services. We found safeguarding alerts had been made by the service and managed appropriately.

People told us there was a choice of meals and said there was plenty to eat. Staff were aware of the support people required during meal times.

We found four breaches of the Regulations. Full information about our regulatory response to the more serious concerns found during inspections, is added to reports after any representations and appeals have been concluded. We found one domain being rated inadequate, we will re-inspect within six months and if this or any other domain is then rated inadequate, the service will go into special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service did not keep people sufficiently safe.

Events concerning people's safety and welfare were not always reported in a timely manner.

Risk assessments did not protect people from challenging behaviour displayed by other people at the service.

Some people had not received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

We observed interactions where people were not afforded choice and control.

Staff received regular supervision to monitor their development.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their families were not always involved in care and treatment plans.

People's dignity was protected and respected by staff.

People were encouraged to personalise their rooms with items of their choice.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service did not always respond to people's changing support needs.

People were not able to take part in activities on a regular basis.

The service had a complaints procedure in place for people to

follow if they wished to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits were not robust to ensure the service provided safe and compassionate care.

Staff said they were supported and could contact the registered manager if they had concerns.

Holmers 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.

The inspection was prompted in part by notification of an incident following a physical assault of a person living at the service by another person living at the service. This incident is subject to investigation by the local authority and is ongoing. As a result, this inspection did not examine the circumstances of the incident.

However, the information the provider shared with CQC about the incident, indicated potential concerns about the management of risks to people. For example, challenging behaviour and unsafe management of medicines. This inspection examined those risks.

We were aware of past injuries sustained at the location and explored particular aspects of current care and treatment during this inspection. Those incidents have been brought to the attention of the local authority and police.

This inspection took place on 18 and 19 December 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience on the first day and two inspectors on the second day. An expert by experience is someone who has personal experience of using this type of service. We had not requested a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the provider is required to send us by law. In addition, we requested feedback from the local authority commissioning who have experience of working with this service.

We spoke with the registered manager, a deputy manager from another of the provider's services, the

administrator, six members of staff, two visitors and 12 people who live at Holmers House. We reviewed the care records of five people, including observational charts and we looked at the medicine charts for all of the people living at the service. We also reviewed records relating to quality assurance and other documentation relating to the way the service was run.

We observed practice throughout the service and used a Short Observational Framework for Inspecting (SOFI). SOFI is a way of observing care to help us understand the experience of people who were unable to communicate with us.

Inadequate

Is the service safe?

Our findings

People reported that they felt safe living at Holmers House. Whilst several people confirmed that they were still susceptible to falls, several were able to confirm that their environment was safer for them than where they lived previously. Comments were, "Oh yes I feel perfectly safe living here." A relative said "Mum, I think she is safe and happy here." However, we found this was not the case because of the risks people were clearly exposed to. People reported that responses to pressing their call buttons was good and consistent. Although there were two or three examples of people not receiving their correct medicine or that one of their tablets was missed but "We have them on order."

We reviewed medicines for each person living at Holmers House. We found three people had been without their medicines as prescribed due to insufficient stock. For example, one person had been without six of their prescribed medicines for one day. The medicines were to treat high blood pressure, heart failure, depression, cholesterol, regulate stomach acid and treat constipation. The second person had been without their medicine to treat high blood pressure for one day and the third person had been without prescribed medicines to manage pain for four days. This means people were at risk of health deterioration or complications to their assessed needs. For example, not receiving medicines to treat high blood pressure may lead to further strokes and not receiving analgesia may cause pain and discomfort for the person. We discussed this with the registered manager and they confirmed this was an oversight and the medicines had not been ordered before they ran out. We sought advice from a pharmacy inspector following our inspection in relation to people not receiving their medicines. They told us that as systems were not in place to ensure continuity of supply and that medicines could not be administered as prescribed this may have had an impact on people in particular one person being without pain relief for four days.

Two people reported, "A couple of times they've said they hadn't got some of my pills that I take, but "we've ordered some more now" and "Once they only gave me four of my tablets instead of five, I told them and the nurse went to look at my records and saw that I was right and should have five."

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

We were aware of an incident following our inspection where one person was witnessed by staff taking medicines of an unknown origin. The person does not self-medicate and staff did not know where the person found the medicines. The person was transferred to hospital following this incident. The hospital carried out blood testing which showed the person did not have toxic levels of drugs in their system. We discussed this incident with the registered manager following our inspection. They told us they did not know where the person got the tablets from and may have brought the tablets in with them. The registered manager told us they will be more vigilant regarding items people brought in with them in the future. The person was admitted to Holmers House on 12 December 2018.

We were also aware of an incident which happened on 2 January 2019 following our inspection where one

person went into another person's room and put their hands around their (person's) throat. This incident is under investigation by the local authority. We have requested further information from the registered manager however have not received this at the time of writing this report. One person told us, "My son would be livid if he knew what goes on at night-the pushing and pulling that goes on between people". We became aware of another incident following our inspection. The incident happened on 17 January 2019.Two people living at Holmers House were assaulted by another person. This resulted in one person having their arm twisted and the other person having a handful of their hair pulled out. Staff attempted to intervene but were not successful and had to call on senior staff for support before the assault could be diffused.

We were also aware of another incident that was not reported to us, when a relative found their family member with bruising to their face. However, the safeguarding alert was not raised until 19 September 2018 and the incident occurred on the 15 September 2018. Staff had not identified the person had bruising to their face until the 18 September. The person's family member said they were concerned they were not informed about the incident and it was only disclosed after the bruising was queried. There was a delay in reporting this as a safeguarding concern which questions if other people were potentially at risk. For example, some families were not always able to visit and some people did not have relatives, therefore did not have an advocate to speak on their behalf. The service was aware that the person who caused harm had a history of physical aggression. Measures were not put in place to protect other people. We were aware that the person had caused other injuries to people in September 2017. However, the service did not make referrals to the relevant team such as the person's social worker at that time for a review of the person's behaviour. The person's behaviour charts did not suggest that their behaviours could not be managed. The service is registered to provide care and support for people living with dementia. This evidence shows that the service did not effectively protect people to ensure their safety.

We were informed of this incident by the local authority. The local authority told us that staff had informed the person's relative that the reason for the bruising was because another person living at Holmers House 'bashed her one'. We have asked for further information from the provider in relation to this incident.

Two other people told us that they had been hit by another person. One said, "He was alright when he first came but not now- if he comes into my room I just scream out and people (staff) come", "It is often not pleasant but I know that the office knows all about him." I've had some knocks and bruises from him." Risk assessments were in place for moving and handling malnutrition and skin integrity. However, people were not protected from risks from other people living at the service.

We reviewed accident/incident records. We saw that one person had three incidents of falls in November 2018 and another in December 2018. A Falls Risk Assessment Tool review on 25 November had stated 'Falls referral not required at present.' This demonstrated that risks were not always managed appropriately.

The administrator explained that the service's safety and maintenance works were arranged through the landlord. We saw that various contractors carried out the required checks and work. The manager told us that the provider's records were stored electronically on the service's system.

We saw, in the water hygiene log book, that the most recent Legionella risk assessment was carried out on 13 November 2017 and the next risk assessment was due in November 2019. Monthly emergency light tests for October 2018 (most recent in the folder) showed there were 11 items 'to repair'. We asked the registered manager if these works had been completed. They told us they would check the November record electronically to see if these repairs had been done. We requested this information was sent to us following our inspection. We had not received this information at the time of writing this report.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes were not established to prevent abuse of people.

Staff we spoke with told us they had undertaken training in safeguarding adults and were aware of their responsibility to record and report concerns. A member of staff told us that "physical abuse" might be indicated by "marks on the residents, the first thing we do is inform the senior. Another member of staff told us that "verbal and physical" were types of abuse and "rough handling" by staff was an example of abuse that could occur in a service. They told us the service had "safeguarding posters." Staff we spoke with were aware of whistleblowing. A member of staff told us "If something happens, you report it." Another member of staff told us it was about "Telling of things you've seen." They added they had completed a workbook that covered whistleblowing.

Staff we spoke with told us they had been interviewed had provided references including previous employer and had disclosure and barring service checks (DBS) prior to starting work at the home. We reviewed staff files that confirmed this.

We noted documentation that the following checks had been completed: Gas safety; electrical installation; lifting operations and lifting equipment (LOLER). We reviewed the service's fire safety folder. A fire drill had taken place on 29 August 2018.

The annual fire risk assessment dated 17 May 2018 concluded that there was a 'tolerable' level of risk if certain works were completed. Work such as compartmentalisation of roof spaces were planned to be completed by February 2019. The manager showed us email correspondence with the property landlord who had commissioned the risk assessment, regarding completion of these works. We saw a fire inspection/ service certificate dated 11 April 2018. Fire equipment inspections had taken place on 3 July 2018 and 28 September 2018.

When we reviewed the provider's 'Health, Safety and Environmental audits for September 2018, we noted the following entries for two units. In response to the audit question, 'Is there a Fire Emergency Plan in place which summarises the fire safety arrangements for the site and the evacuation strategy?' We saw, 'This needs reviewing as some concerns raised on FRA visit.' We requested this information was sent to us following our inspection. We had not received this information at the time of writing this report.

We checked the 'grab bag' for use in emergencies. This contained personal emergency evacuation plans (PEEPs) and torches. We found that two PEEPs lacked a photograph of the person and that only one small torch was functioning. The service administrator replaced the torch batteries promptly. We asked the registered manger to update the person's photographs.

The home was arranged in three units (each with a capacity of sixteen places) on two floors. At the time of our inspection, thirty-three people lived at the home, with fifteen vacancies. We visited the ground and first floors of the home. We saw that people had complex needs, including physical frailty, mobility and needs related to dementia.

During our inspection, three care staff, including a senior member of staff, were on duty in each of the units. A shift leader based in a ground floor office, was also present and had overall responsibility for the three units. Care was arranged in day shifts of 0700 to 1430 and 1400 to 2100. Care staff sometimes worked a long day. At night, there was one carer on duty in each unit supported by a shift leader.

We observed that a high proportion of staff were from an external agency. On the second day of our

inspection, the shift leader told us that seven of the nine members of staff on duty were employed by external agencies. Agency staff worked regularly at the service and were aware of people's needs. Staff told us that there were sufficient staff to meet people's needs. They told us "There's enough staff" and "I would say so." A senior staff member told us that "We haven't got enough permanent staff. We've got a lot of agency." They added that staff were "leaving for various reasons". They also told us "We haven't got fully fledged seniors." We did not feel there were adequate senior staff to ensure people's needs were met.

We observed that a housekeeper was on duty in each unit of the home. One housekeeper told us that people's rooms and bathrooms were "deep cleaned every single day". We saw the premises were cleaned to high standards. Staff told us they had completed infection control training. We saw that staff wore personal protective equipment such as disposable apron and gloves (PPE) when serving food.

Requires Improvement

Is the service effective?

Our findings

A person who had been living at the home for eight weeks said, "I would love to go in the garden but no one has taken me out there yet." Other comments we received were, "I'm not happy here, I haven't been out at all, not since day one, I am a bad sleeper now after my earlier stays in hospital and I can't sleep at all sometimes," " I get down sometimes- I am bored most of the time," "When I went for a walk the one time, the assistant was very pleasant and I enjoyed it but that was the only time I have been," "It is rare they can get an assistant to go with you if you do want to go on a walk- so you have to stay in," "I'd like someone to talk to about things-otherwise you just sit here all day," "I am very happy living here," "I sit here bored, it feels like I'm wasting my life," "I think some of the carers are taking the mickey sometimes" and "A lot of residents all seem to be bored together, I sit here all day and do nothing."

Other comments we received were, "I only talk to a couple of the other residents here, no one else," "I'm getting lazy living here, I do wish I could go outside sometimes" and "We just sit here and do nothing and just twiddle our thumbs- it is lucky that I have so much patience."

We observed other interactions where people were not afforded choice and control. For example, in the afternoon we arrived at one units' kitchen area; two members of staff were standing chatting to each other; five people were sitting silently in the lounge unattended.

We saw a person who was prescribed several tablets a day, offered a glass of cold water to wash the tablets down. Almost immediately the person started coughing badly; this lasted for a few minutes. The person explained "Taking my pills with cold water always makes me cough badly- I prefer warmer water then I don't cough."

We saw a person was handed an inhaler by a member of staff. The member of staff took it from the person and said that they had taken too many puffs from the inhaler; the person contested this statement strongly and clearly had detailed understanding of the various inhalers they were prescribed and the optimum number of puffs allowed. There was quite a standoff between them. The member of staff was unsympathetic and merely told the person they were wrong. The person told us "I did not have the allowed number of puffs that I am supposed to have, they watch you and tell you that you have had too much already and I have hardly started- they stop me and I am not happy, you don't know where you are and you never know why they do it without explanation, it is very annoying."

We observed a member of staff approach a person sitting quietly at the lunch table; "You look sleepy, do you want to go back to your room?" The person answered "No." The member of staff attempted a second time but the person became angry and said, "I said 'no,' I am not sleepy and I don't want to go to my room." The member of staff had the grace to give up. Shortly afterwards another member of staff, oblivious to the earlier interchange came to the person and without using her name said, "You look sleepy shall we go to your room?" The person understandably was upset and said "No" firmly and remained where they were sitting.

We observed that one person remained in bed for their safety. However, the person wished to get up but the equipment to facilitate this safely, namely a recliner chair, was not available. The registered manager told us they had made a referral to the occupational therapist. They told us that the issue was with the local authority's contracts monitoring officer as the responsibility for funding any necessary equipment had not yet been determined.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care failed to reflect people's preferences.

We observed that people had equipment in place to support their skin integrity. We saw that some people had pressure relieving mattresses in place. These were automatic so did not require setting according to the person's weight. In a care plan, we saw a reference to four hourly repositioning.
'DN (district nurse) has advised that (the person) is turned four hourly and all areas of pressure are to be creamed' (13 December). We did not see a completed repositioning chart on the electronic care plan. Repositioning was mentioned in the progress notes. For example, 'eyes closed, hourly checks bedding, nightie, pad changed was turned'. However, there was no indication of position changed from or to, for example back to left side.

We also saw staff assisting with drinks and food, and with mobility. In reviewing the electronic care plans, which contained fluid intake charts for some people, it was difficult to ascertain how much fluid a person had actually taken in a twenty-four-hour period. This was because charts were not always completed and lacked a target amount but also because staff told us they could not distinguish between fluid offered and fluid taken on the system. It showed only fluid offered. Daily amounts of fluid recorded were in some cases inadequate and meant people were at risk of dehydration. We saw the provider's audit of care plans had identified that fluid intake charts were not always complete. We discussed this with the registered manager who said they would look into this.

Staff completed mandatory training and updates including safeguarding, moving and handling, fire safety and infection control. A housekeeper told us they were "100 per cent up to date" including safeguarding and "the lot."

A member of staff told us their induction included two weeks of shadowing experienced members of staff. "For a long time, they would come behind me and watch what I was doing." Another member of staff told us they were up to date with training and did a course recently on alcohol related dementia, they said, "It was useful." They had completed training on "end of life" care and "types of dementia. Records we viewed confirmed staff were up to date with their training.

A senior member of staff we spoke with had completed or were completing level three in health and social care. A member of staff told us they had undertaken training on person-centred approaches in care. A senior member of staff told us they had supervision bi monthly with a team leader. Records we saw confirmed this.

We saw that the local authority had awarded a rating of '1' for food hygiene. We discussed this with the registered manager who confirmed this was because fridges were not cold enough. They told us they had recently purchased new fridges. We saw the fridge temperatures were within an acceptable range to ensure food was kept at the correct temperature.

Meals were served from a prepared 'cook chill' system. People were offered a choice of main meals. A member of staff showed meals to people to assist in choice making. A person said, "This is enormous. I'm sure it's enough for three people." We observed that a person was supported with a meal in their room. We

did not see fresh fruit offered at the home. We observed that staff provided one to one support with drinks and meals in people's rooms. Jugs of water and juice were replenished daily. Some people had a fortified diet. In a care plan, we saw that a person was 'at very high risk on their Malnutrition Universal Screening Tool (MUST) score'. It continued 'Staff are to fortify all hot drinks using two tablespoons milk powder per 250ml drink. Staff are to offer a fortified milkshake twice daily.'

Various external healthcare professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. Professionals included the GP (who visited during our inspection) and district nurses. We saw that a person's skin integrity had been monitored by visits from the district nurse.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires that as far as possible people make 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. We saw examples of decision specific mental capacity assessments that provided some detail on how the person's capacity to understand, retain, weigh and communicate particular decisions was determined. Decisions for which we saw mental capacity assessments included '(The person) lives at (the home) where she is behind key padded doors and not able to leave the building on her own.' A member of staff we spoke with told us they had completed training on Mental Capacity Act 2005 (MCA) on e-learning.

Some staff could cite the key principles of the MCA 2005. One member of staff cited key principles including "assuming capacity" and acting in the person's "best interests" should they lack the capacity to make a decision. A member of staff told us they had been shown how to conduct mental capacity assessments, for example by checking that a person could retain information by asking them to recall a detail mentioned earlier in the conversation. The manager told us that "everyone has an application".

Policies and procedures were in place to guide staff in relation to the MCA and DoLS. Staff had completed training in this area and demonstrated an awareness of the act. Where decisions had been required to be made, we could see evidence that formal capacity assessments and best interest meetings took place with relevant parties. 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 were being met. The provider had submitted applications to the local authority for a number of people who used the service.

There was a lack of dementia friendly equipment or signage visible. Whilst some dementia friendly food plates (coloured plates) were evident most people drank from conventional china cups and mugs and glasses. The corridors of the premises were bright and well-lit and appeared to have been recently painted but handrails were not distinctively painted.

Requires Improvement

Is the service caring?

Our findings

We observed that housekeepers at the service showed a flexible approach and carried out actions beyond their roles. For example, assisting a person who required one to one support with meals and helping with an activities session.

People told us the home was "very nice." When we asked if staff were helpful, they replied, "Yes, that's right, I did have a shower the other day." When we asked if the person was happy for us to be in their room they replied, "Yes, I should think so. I can't get out to meet you." Another person told us "I made up my mind that I'll enjoy it (at the home)."

From observations, relationships between staff and people were varied. Staff were mostly polite but lacked spontaneity or ongoing conversations with people. Staff were able to describe the methods used to ensure people's dignity was upheld and respected. We saw that staff knocked on people's doors before entering. People were appropriately dressed and well kempt.

One person told us about a member of staff who helped out and interacted with people. "He is alright but you don't know how to take him- you only can see one side of him."

Another person told us about the process of being helped to shower by staff; "Sometimes you get a good carer and they will get a sponge, nice hot and soapy water and do you all over, but most of them just hold the water spray and stand back and leave you to do it all yourself except the two bits I can't reach and do (back and feet)."

We received comments such as, "When I was living at home I had carers come in to help me wash and dress twice a day but I feel I have less attention living here- they are certainly less thorough when they wash me," "Yes, my carers are mostly young and female," "They are polite, I suppose," "They are mostly lovely girls, everyone here has a kindness, but you do know not to push them too far," "She is always in a bit of a hurry and rushing off" and "They don't have a lot of time to talk to you."

Details of advocacy services were not available for people living at Holmers House. Advocates are people independent of the service who help people make decisions about their care and promote their rights. This meant people who required support to express their point of view about their care were less likely to be able to access independent help to achieve this.

The Accessible Information Standard (AIS) is a framework in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service assessed and recorded people's cognitive functions, communication barriers and methods of ensuring meaningful information were provided. Information about how to communicate with people effectively was included in care records.

People could be assured that information held about them was treated confidentially which complied with the General Data Protection Regulation (GDPR). GDPR came into force on May 25, 2018 and was designed to modernise laws that protect the personal information of individuals. Records were stored in locked offices and on the services computer system.

The service had policies and procedures in place relating to the Equality Act 2010 to ensure people were not treated unfairly due to any characteristics that were protected under the legislation.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service failed to provide person centred care that reflected people's preferences. We found during this inspection the service continued to fail to provide person centred care that reflected people's preferences.

For example, we saw one person had a favourite seat and position in a lounge; They told us "I sit here (with another person) but they have moved the furniture and I can't sit where I like to sit now." We asked people if they felt their preferences were met and they could choose what they wanted to do. Comments were, "That is debatable- they have no time, it is rare they stop and take time, it would only take them two or three seconds to stop- they could put their hands up and say 'I'll see you in a minute, I'm busy just at the moment'- but they don't", "The carers are always in a hurry and they are not looking at you as they pass by", "[Name of staff] is one of the best, she is nice and very helpful- indeed she is one of the best".

When we asked about responding to people's changing needs, a member of staff we spoke with told us that care plans were updated by shift leaders. They also told us, "They do reviews," including "meetings with the family." However, files we viewed did not evidence that reviews had taken place with people and or their relatives. A senior staff member told us, "They don't always get a handover." However, following our inspection we were told there were three handovers daily in addition to daily meetings.

We reviewed five people's care plans. Care plans were in an electronic format. Some documents such as those related to DoLS and Do Not Attempt Resuscitation (DNAR) were kept in paper files in the shift leaders' office. We saw that some sections of the electronic care plans were entirely blank. For example, the profile sections comprising, 'My relatives/friends,' 'A little bit about myself,' 'What is important to me,' 'My likes' and 'My Dislikes,' had not been completed in any of the care plans we reviewed. In addition, the care/support plan audit of 18 December 2018 stated, 'Complete profile, and 'Life history, for [name of person]. We saw reference to a 'do not attempt cardiopulmonary resuscitation' (DNACPR/DNR) form for a person. We did not see the form itself. The care/support plan audit 18 December 2018 stated, 'No DNACPR in place, to be reviewed,' for two people, 'Advance care plan to be completed' for three people. This meant that some people may be at risk if they had inconsistent or incorrect information relating to their DNACPR orders.

We did not see that regular reviews took place with people and their families to ensure they were involved in decisions about their care and support. The service had not held residents and relatives' meetings to enable families to feel more involved in the running of the service and to provide an opportunity to raise any concerns or issues. However, staff meetings were held on a regular basis.

We reviewed fluid charts for people. We saw one person's fluid intake chart showed an intake of 202mls for 15 December, 74mls for 16 December, 210 mls for 17 December and 180 mls for 18 December. These levels, if accurate, would be inadequate. We discussed this with the registered manager who said they would look into this. Another person had no target amount stated on fluid intake charts. However, the summary care plan stated a target of 1600mls. We saw that the person had a recorded cumulative intake of 950mls for a

day.

An activity worker was present at the service for three days each week. During the two days of our inspection, we observed two activity sessions. These involved a visit by children from a local primary school in the morning and making Christmas cards in the afternoon. Both activities took place on one wing during our inspection.

A person who used to attend church regularly before he moved to Holmers House told us, when we asked him if he still went to church, "No but I wouldn't refuse it if the opportunity arose. I think that there were some carols here but I didn't know about them and missed it until it was nearly over."

The registered manager summed up the activities provided for people as, "A bit hit and miss to be honest." A relative said, "There were no summer events at the home at all, as far as I know there are no special Christmas events arranged either, there are certainly no signs or notices of carols or church services or community events that are going to be held." The relative continued, "I think it would be helpful if there could be events which allow families of residents to meet up with each other."

We received comments from people about the activities such as, "We do have songs and carols, sometimes we do paintings and dolls and have a walk," "(Activities person) does quizzes, I like to walk and get out," "Apparently the nursery kids come once a week but I certainly didn't know that they had been in today," "There are other things going on here sometimes but I don't really join in-watching television in the evening is my main interest."

In addition, another person told us, "I don't think we get told something is going on in another department unless you wander around the home yourself, but then you can't get through all the locked doors, you can't get any further. I know you have got to have some security but I want to go further, I'm not happy at all, I can't do some things but I am restricted, they stop you."

The registered manager had identified one person as receiving end of life care. However, we observed that the person had food and fluid intake charts in place. The person was alert, speaking and eating some lunch on the first day of our inspection. The district nurse had visited the person to support skin integrity needs. We were told that the local palliative care team was not yet involved.

Systems were in place to respond to complaints. We saw complaints were responded to according to the provider's policy. One complaint dated 17 July 2018, was in relation to a person's toenails being so long their family member said they (person) could no longer walk. We saw photographs of the person's toenails which the family member had taken. We saw the nails were some 7 cm in length. We asked the registered manager how staff had not reported this and how the person's nails had gone unnoticed. They told us they were unaware how this happened. We saw the registered manager had responded to the family member's concerns according to the service's policy.

Requires Improvement

Is the service well-led?

Our findings

On the first morning of our inspection (the registered manager was not yet present), we spoke with a deputy manager from another of the provider's services. They were unsure how many people lived at the home and how many staff were present. They explained that their role was to audit care plans.

Subsequently, the registered manager told us that there were "no deputies" whereas there "should be two". Things had been "quite difficult" and the deputy manager from another of the provider's homes had been "coming over once a week." They commented, "We have not made many improvements since the last inspection due to dealing with reactive issues." They told us this was due to staff leaving and safeguarding concerns.

A senior staff member told us, "We're not getting the appropriate time to do everything that's required. You'll be constantly distracted. You need allocated time to do the required necessary paperwork. It's very difficult at the moment." The provider's audit of care plans had identified that fluid intake charts were not always complete and care plans required updating and reviewing.

Staff could not describe the service's vision and values and how these may impact on care delivery. One member of staff told us they were not consulted when changes happened. For example, changing the layout of the lounge and changing the rota. They told us, "When I came back from my holiday my hours had changed without any consultation. We don't know whether we are coming or going half the time, it's change this, change that. But I think we have improved since last time."

Some staff we spoke with told us that senior staff were approachable and they were well supported. A member of staff told us, "I feel supported" and that they could approach senior staff, "If you have any problems."

The service had several notice boards that were supposed to have information about the staff and their photographs. The main notice board in the reception area was redundant and had just two pictures/names of staff. The equivalent notice boards on each unit were better populated but were still incomplete and out of date.

We asked people about the management of the service. We received comments such as, "No, I don't know who the manager is," "I'm not sure," "I wouldn't know who is in charge," "The organisation here leaves a lot to be desired," "The staff do not seem to get much time off," "The carers [staff], are always changing but if they do stay you do get to know them and can have a laugh, if that happens it makes all the difference", "The boss, you don't see him very often", "The two fellows in the office are really nice," "[Name of registered manager] came to show me his jumper and he is very nice" and "Registered manager] is very nice, I would make any complaints to him or his mate"

When we reviewed care/support plan audits dated 13 December 2018, we saw that entries included, 'Has a

fluid chart in place, however there are gaps in this and the daily target amount is not completed on the chart.' Another stated, 'Has a fluid chart in place, however there are gaps in recording on some days'. The audit dated 18 December 2018 noted, 'fluid chart incomplete,' for several people. Progress notes we reviewed were not always written appropriately. For example, '(the person) has been fed, and assisted with personal care, remains in his room' (the person was female).

There were systems to monitor the quality of the service. However, we found these were not effective. Several actions that had been identified from the audits undertaken, were still outstanding at the time of our inspection. We were told audits were being completed during our inspection.

Records we viewed were inconsistent, inaccurate and incomplete in some areas. Systems and processes to assess and monitor the quality and safety of care were not effective. The registered provider had failed to ensure that accurate and contemporaneous records were kept in respect of people supported.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of service users.