

Heritage Care Limited

# Holmers House

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

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

The inspection took place on 31 May and 2 June and was unannounced.

The previous inspection was carried out on 10 June 2014 and was fully compliant at that time.

Holmers House is a purpose built residential home divided into three care units each with 16 places. Two units are on the ground floor whilst the other unit is on the first floor. At the time of our inspection there were 45 people living in the home.

There was a registered manager in place at the time of our visit. 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.

We were not able to speak to many people at Holmers House but these were some of the comments we received. One person told us, they liked living in the home and said, "It's ok as long as I have my music on". Another person told us, "It's alright but I would rather be at home". During both days of our inspection we observed people appeared happy and content living in the home.

Staff reported lack of support and supervision. One member of staff told us they had supervision sometime last year but could not remember when. Another member of staff told us, "We are short- staffed and it is difficult trying to keep my eye on what the agency staff are doing."

The risk assessment process to identify risks to people and how they were to be eliminated or managed were not always being carried out or recorded. This meant people were not always being protected from identifiable risks to their health and safety. People's care plans did not always reflect the care that was carried out.

Staff had received training in topics such as fire safety, manual handling and mental capacity.

The home had agency staff who work in the home due to difficulty in recruiting permanent staff. However, the home tried to ensure the same staff were requested from the agency.

Staff had received training in the administration of medicines. Medicines were administered safely and in a timely way. However, medicines were not stored safely within the correct temperature as advised by the manufacturer.

Activities were planned in accordance with the people who were able to participate. We saw people participating in activities on both days of our visit.

We observed staff to be rushed and task-focused and had little time to positively interact with people.

Internal audits had not identified areas for improvement. We made a recommendation in relation to audits.

The service did not have a cleaning schedule to identify areas that had been cleaned or were in need of cleaning. The kitchen had expired food stored in the fridge and we could not see any evidence that the kitchen had been cleaned.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

## 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 always safe.

Medicines were not stored safely.

Risks to people were not consistently assessed or recorded.  
Plans to eliminate or manage risks to people were not consistently recorded.

Infection control procedures were not in place. Standards of hygiene were not appropriate.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Staff were not always supported through regular supervisions and support to fulfil their role effectively.

People received support to attend healthcare appointments. However, people did not have their weight loss and risk of malnutrition managed effectively

**Requires Improvement** ●

### Is the service caring?

The service was not consistently caring.

The service did not always capture people's views and preferences about end of life care.

People were not supported to express their views and be actively involved in their care

Staff showed kindness and compassion to people.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive.

People did not always receive care that was responsive to their needs.

**Requires Improvement** ●

Reviews of care were not consistently undertaken. People's needs were not always acted on in a timely way.

Activities were available and tailored to people's abilities.

**Is the service well-led?**

The service was not always well led

A new member of staff was alone on a unit until the late shift arrived.

Staff told us they were not always supported.

People were at risk of receiving inconsistent care as records had not always been appropriately maintained.

The service did not monitor the cleanliness of the home.

**Requires Improvement**



# 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 took place on 31 May and 2 June 2016 and was unannounced.

The inspection team consisted of an inspector and a specialist advisor. A specialist advisor is someone who is experienced in a particular area. The specialist advisor was experienced in older people's care.

The service was previously inspected on 10 June 2014 where it was found to be fully compliant at that time. Prior to the inspection we reviewed notifications about the service and Provider Information Record (PIR). Notifications are important events that the service is required to tell us by law and a PIR is a form that asks the service what the service does well and any improvements they plan to make.

We looked at six care plans and case tracked two additional care plans. Case tracking involves looking in depth at how care is planned and delivered that reflects current needs. We looked at a variety of documents which included policies and procedures, medicine records, staff files, meeting minutes and audits. In addition we spoke with the registered manager, the regional manager, the deputy manager, seven members of staff, a visiting relative and two people who live in the home. The home supports older people; who are all living with dementia.

We looked around the premises and observed care practices and spent time on three of the units within the home. 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 to us. In addition we observed staff supporting people throughout our visits.

# Is the service safe?

## Our findings

The risk assessment process to identify risks to people and how they were to be eliminated or managed were not always being carried out or recorded. This meant people were not always being protected from identifiable risks to their health and safety. For example, a person identified as at risk of malnutrition did not have their weight recorded as the instructions stated in the persons care plan. Another person also at risk of malnutrition did not have their food and fluid monitored for a total of four days. In addition the person had been prescribed a food supplement to ensure they had extra calories. The service had not ensured these were received in a timely manner.

We asked the registered manager if they felt there were enough staff to meet people's needs. They said 3 members of staff on each unit were sufficient to meet people's needs.

Staff we spoke with told us they were short staffed. One member of staff said, "It is difficult when I am trying to administer medicines and keep my eye on what the agency staff are doing."

We observed staff were rushed and task focused. During the first day of our visit there were six agency staff on duty, we did not observe staff spending time with people apart from when they were assisting them with specific tasks. For example, escorting people to the dining room and taking people back to their rooms following lunch. Relatives said they were not sure who staff were, and this was made more difficult as staff were not identified by wearing uniform or name badges.

We recommend that the provider looks into ways to ensure that staff are easily identifiable to people and relatives.

The service followed safe recruitment practices. Personnel files we looked at showed an application form, appropriate references, and Disclosure and Barring Service check (criminal records check) to make sure people were suitable to work with vulnerable adults.

Medicines were administered safely and in a timely way. However we noted medicines were not stored safely. The clinical room and fridge used for the storage of medicines was required to be kept cool to ensure medicines do not lose their efficiency. However we saw that the room exceeded the required temperature of below 25°centigrade as advised by the manufacturer. On one occasion during an entire week the temperature was recorded between 26° and 28°.

At higher temperatures there is a risk that medicines efficiency will be adversely affected. This means that people may have received medicines that had lost their effectiveness. We spoke with the manager and they assured us a fan will be purchased to keep the room cool. We also found a urine sample in the medicine fridge next to people's insulin. We informed the manager who immediately removed the urine sample.

We recommend medicines are stored at the correct temperature and that any samples taken are stored appropriately in line with best practice.

Policies and procedures in relation to safeguarding of adults accurately reflected local procedures and included relevant contact information. All the staff we spoke with were able to explain the procedures in relation to the safeguarding of adults. Staff had a good understanding of their responsibilities for reporting accidents, incidents or concerns and told us they were aware of the whistle blowing policy and would not hesitate to report any concerns.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. For example people's personal emergency evacuation plan (PEEP) was kept in their care plans. However, we found one person's PEEP had the wrong information documented. It stated that the person lived in another home. We spoke to the registered manager about this during our feedback. They confirmed that the person previously lived in another home and the information had not been changed and updated. This placed the person at risk in the event of an emergency, not being offered the correct support.

We observed staff did not wash their hands prior to preparing people's food. On the first day of our inspection we noted there were no hand soap or paper towels in the kitchen area on one of the units. On the second day of our inspection there were still no facilities for hand washing. This put people at risk of associated infections caused by poor hygiene practices. We brought this to the attention of the regional manager who confirmed they had requested staff to ensure soap and hand towels were placed in the kitchen area. However, we could not find these, we asked staff how they had washed their hands before serving food and they could not confirm if this had taken place. We were aware one member of staff assisted a person with their food wearing gloves.

We inspected the main kitchen area and found, out of date food such as bacon and sausages in the main fridge. We made the kitchen assistant aware of this and they immediately disposed of the expired food. We asked to see the cleaning schedule for the kitchen and were told by the kitchen assistant that there is a form for staff to complete when cleaning has been carried out; however this was not filled in. This meant that standards of hygiene were not appropriate for the purposes for which they are being used.

We saw dried foods such as custard, cornflakes and jelly crystals with no expiry dates displayed. The kitchen was dirty and had a sticky floor. We saw a washing up brush placed in a container that was rusty. This put people at risk of developing infections relating to poor standards of hygiene and of receiving food that was not fit for consumption. We brought this to the attention of the registered manager during feedback of our visit.

We were aware that the floors on the units we visited were sticky which indicated insufficient cleaning. We spoke with the domestic person responsible for cleaning duties. We asked to see their cleaning schedule and they confirmed they had never had a cleaning schedule. We brought this to the attention of the registered manager during feedback of our inspection. The service did not operate a cleaning schedule or monitor the level of cleanliness.

This was a breach of Regulation 15 of the Health and Social care Act 2008  
(Regulated Activities) Regulations 2014

## Is the service effective?

### Our findings

Staff told us they had the training and skills they needed to meet people's needs. However, the training matrix we saw identified that 18 staff out of 63 had not completed fire training. We brought this to the attention of the registered manager during our feedback who acknowledged this and said they will look into this.

New staff were supported to complete an induction programme before working on their own. They told us they had an induction followed by an ongoing assessment of their competency to carry out care. Some staff told us they had not always felt supported working at the home. For example, managers and senior staff rarely offered assistance when there were staffing problems. Most of the staff we spoke with said they had received supervisions from their line manager. However, others told us they could not remember when they last had supervision. One senior member of staff said they had supervision sometime last year. We spoke with the registered manager during feedback about this and they said as they are relatively new to the home, it was a 'work in progress' to ensure all staff received supervisions on a regular basis.

A member of staff told us, "It is sometimes difficult when agency staff are on duty." Another member of staff said, "It's a lot to do and we are not always supported."

We recommend the service seeks advice from a reputable source, about good practice in supervising staff.

We reviewed how people's health care needs were monitored and how any changes in their health or well-being were referred to their GP or other health care professional. We saw one person was identified as in pain which was documented the day before our inspection on 30 May 2016 in the daily notes. However we could not see how staff were dealing with this. We could not see evidence that a request had been made for a GP to review the person. We spoke to a senior member of staff about this and they told us they were attempting to contact the doctor. However the doctor had not visited the person when we had completed the first day of our inspection at 16.00. Staff told us they had offered the person analgesia to help alleviate their discomfort; however the person had refused to take any pain relief.

We were aware of another person experiencing pain. We spoke with the person and they told us on the first day of our visit they were experiencing pain in their leg. They said, "I wanted to go to the doctors". We spoke with a senior member of staff about this and they told us they had been trying to request a GP to assess the person. However, on the second day of our visit, a GP had not come out to assess the person. We spoke with the deputy manager on the second day of our visit about this and they told us the surgery had not responded to their requests and they were still waiting for a visit from the GP. We were not aware that this was common in relation to lack of response from the GP surgery. However, we could not be assured that people's pain was being managed correctly.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's consent to care and treatment was sought in line with legislation. 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 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 taken on their behalf must be in their best interest 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made applications to the supervisory body.

People's capacity had been assessed in line with the MCA. When people moved into the home a capacity assessment had been carried out and where necessary a DoLS application submitted and any actions that needed to be taken recorded in the person's care plan. We saw an example of this when a person repeatedly entered another person's room. Plans were put in place in conjunction with family members to keep the room locked to avoid distress between both parties.

The registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out.

People were not always referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. Not all staff were not aware of people's dietary needs and preferences. People's needs and preferences were not clearly recorded in the care plans. For example, one person had a low weight of 42kg. The care plan identified the person to be at risk of malnutrition and instructions to staff were to weigh the person weekly. However, there was one weight recorded in January 2016 which was recorded as 41.75kg and the next weight was recorded in May 2016 which was 42kg. The person did not have any food and fluid charts in place to monitor their calorie intake. This meant the person was at risk of being malnourished as staff had not monitored their dietary intake to allow them to make a full assessment of the person's dietary needs. We spoke with a member of staff about this and they confirmed the person's weight had not been monitored as the instructions had stated. We also brought this to the attention of the registered manager during our feedback.

Another person was identified as being at risk of malnutrition and had a weight recorded as 34kg. The care plan had food and fluid charts in place. However the last entry was on 29 May 2016 which meant staff had not monitored the person's food and fluid intake for four days. We also saw that the person had diabetes which meant they may have been at risk of complications with regard to their condition. For example, if a person who is diabetic does not have adequate food and fluids they may become hypoglycaemic which would require immediate medical attention. We were aware that the person had been prescribed a food supplement on 26 May 2016; however this was not available at the time of our visit. This meant the person had not received their food supplement for a total of seven days from the date when it was prescribed. We brought this to the attention of senior staff and the registered manager who told us they would 'chase it up'. This meant that people's changing health care needs were not always responded to effectively and in a timely way.

People were offered a choice of meal on the day. Where people required a 'soft' diet, due to problems with swallowing this was catered for.

We were aware that one person remained in the same position sitting in a chair asleep with a blanket over them throughout our visit on the first day of our inspection. We observed the person to be in the same position on the second day of our inspection. We did not see any attempt at interaction with the person or any encouragement to eat or drink. Staff told us the person had continually refused food and a fluid.

However, the person had not been assessed for malnutrition and a care plan was not in place.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## Is the service caring?

### Our findings

People could not be assured that information about them was treated confidentially and respected by staff. For example people's care plans were not always secure and were kept in an unlocked cupboard on one of the units, we brought this to the attention of a senior member of staff and they told us 'the lock was broken'. This meant the service did not always ensure that access to personal data was secure to reduce the risk of unauthorised access to people's personal information.

People's privacy and dignity was respected, for example one person who was sleeping in a chair had a soft blanket covering them to ensure they were comfortable and warm.

During the first day of our inspection one person who was being assisted to the dining room by agency staff said, "I don't know who you are". However, the member of staff was kind and explained to the person what they were doing to reassure the person. This demonstrated staff showed kindness and compassion towards people in their day to day care.

People had memory boxes outside their rooms which contained photos mementos and information about memories that are important to individuals. However, some boxes were empty, we spoke with staff about this and staff told us 'it is not always possible to get the families to bring anything in'.

Staff were not always able to tell us about people's life history and personal preferences, and the importance of needing to know about people as individuals. Knowledge about care needs was limited and care was task-led rather than person-centred. For example, we observed staff supporting people with tasks throughout the inspection. But did not observe staff spending meaningful time with people. There may have been a risk that people would not receive care that was in line with their identified choices or preferences.

We recommend people's life history and individual preferences are identified in order to provide person centred care.

Care plans we viewed did not demonstrate how people or their relatives were involved in decisions about care and treatment. However, relatives we spoke with said that permanent staff were caring and they always contact them if there are any changes to their family members' well-being.

People were treated with kindness and compassion and staff were aware they needed to spend quality time with people.

We spoke with the registered manager about the recruitment of permanent staff and they said it is an on-going issue. However they were looking into ways of rectifying this by working with a recruitment agency who supply staff on a permanent basis.

Where people had made advanced decisions in relation to end of life care these were respected. However, we could not always see that the person's care plan was detailed and clearly documented people's

preferences. End of life training was on-going and the service intended to ensure all staff received this. Where people have been assessed as requiring end of life care, this was overseen by district nurses.

## Is the service responsive?

### Our findings

People or their relatives were not always involved in developing their care support and treatment plans. Care plans were not always personalised or detailed daily routines specific to each person. Not all staff were aware of people's care needs, for example people who required their food and fluids monitoring. Staff did not always carry out instructions documented in people's care plans. This put people at risk of receiving inconsistent care.

One person had refused their medicine consistently for a period of two weeks. The medicine was to treat high blood pressure which may have caused problems if not taken regularly. We could not find any information in the person's care plan how this was being addressed. For example, there was no evidence of a GP's involvement and a review of the medicine. We asked a senior member of staff if the person was having a review of their medicines and they were unable to confirm if this was planned. The person had also been prescribed specific cream for skin protection; the medicine chart showed the home had not had any stock for two weeks. This meant the person may have developed skin soreness if the cream had not been applied as prescribed by the GP.

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

People told us they had a key worker. A keyworker is a named member of staff that was responsible for ensuring people's care needs were met.

The home had an activity coordinator providing 30 hours of activities each week. We observed the activity coordinator assisting people to engage in activities during both days of our inspection. We saw an activity board on display in the reception area displaying what activities were taking place on a weekly basis. The service also arranged day trips out in a minibus to local areas. In addition, outside entertainers visited the home, such as visits from the local school children who sang to people that lived in the home.

The service had a Chaplain who visits weekly to offer communion for people wanting this. Priests from a local Catholic church visit to offer communion and prayers for people who request this.

Information on how to make a complaint was displayed in the reception area and information was given to people and their families when they first moved into the service. All complaints were responded to either verbally through a telephone call or in writing depending on what the person preferred. The registered manager completed a quarterly comments and complaint report which was sent to the regional manager to monitor for any patterns or themes. The service received two complaints since January 2016 which were investigated and addressed. We saw evidence of this including a complaint summary report for the month of April 2016.

## Is the service well-led?

### Our findings

Managers were aware of, and kept under review, the day to day culture of the service, including the attitudes values and behaviour of staff. We brought to the attention of the registered manager the attitude of a member of staff when we spoke with them. The manager confirmed they were monitoring the performance of staff members who did not display the values of the service.

The registered manager had recognised the challenges of the service and had only recently been appointed to manage the home. Staff told us, "The manager is doing their best." Other comments included, "We have a way to go yet" and "It was dreadful before, we hope things improve."

One relative we spoke with said the manager seems to be determined to 'get it right' and that they were always approachable when they visited.

We were aware a new member of staff was alone on a unit the late shift arrived. This was for approximately 15 minutes; the unit had 15 people resident. When we informed the registered manager the member of staff had been alone on the unit, they said this should not have happened and the afternoon staff should have arrived. They confirmed they will look into this. Staff told us they were not always supported. However, when we spoke with the registered manager about this, they told us, 'It's a work in progress' and they were committed to making positive changes.

During discussions with the registered manager they demonstrated they were committed to putting systems in place to ensure people received safe and consistent care. However, at the time of our inspection internal audits had not identified shortfalls in certain areas such as the safe storage of medicines, current up to date information in people's care plans, infection control including safe storage of food and staff training such as fire safety. The provider did not have effective systems in place to monitor the quality of care or support that people received. We discussed our findings of our inspection with the management team during our feedback. The registered manager told us they would endeavour to address the areas for improvement as soon as possible.

We recommend that internal audits are robust to enable areas for improvements to be effectively identified.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

The service worked in partnership with GPs, district nurses, and community psychiatric nurses. Feedback from professionals was mixed; one professional told us any issues that come up are dealt with in a timely manner. They told us the home always responded and areas that needed addressing were discussed in meetings with the managers. Whilst other comments were 'they are not coping fully' this was in relation to specific issues people had who were living with dementia. The professional went on to say; 'as they are a dementia home they should be able to address the issues'. However the service had addressed this and staff had completed further training in dementia with one member of staff completing a level three certificate in

dementia care.

People and relatives were empowered to contribute to the service by monthly meetings for people and their families. A quarterly comments and complaints report was used to monitor and observe for any patterns or themes occurring.

People and those important to them had opportunities to feed back their views about the home and quality of the service they received. Families were able to meet on an individual basis with senior staff when they requested or just 'drop in' when they wished to discuss their relative or the home environment.

Staff did not always have confidence the management of the service would listen to their concerns and be received openly and dealt with appropriately. One example of this was when broken wheelchairs had been reported over a period of time and staff told us, "Nothing gets done". We had confirmation of this when we saw the member of staff on the first day of our visit trying to locate a wheelchair that was in working order. We spoke with both the deputy manager and the registered manager about this during our feedback. They told us the wheelchairs were all in working order. However our own observations did not confirm this.

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  Care and treatment was not carried out in conjunction with the service user to ensure their needs were met.
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider did not ensure there were sufficient quantities of medicines to meet the needs of service users.
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs  The service did not meet the nutritional or hydrational needs of service users.
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment  The provider did not operate a cleaning schedule to ensure premises and equipment were kept clean. Cleaning was not carried out in line with current legislation and guidance.

