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Holmwood Rest Home

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Holmwood Rest Home is a residential care home registered to provide care and support to up to 16 people. The building had been adapted and care was provided over two floors with stairs and a stair lift as access. There were 11 people living at the home at the time of inspection.

People's experience of using this service and what we found
Governance systems were not established and therefore not operating effectively as they did not identify the shortfalls found within this inspection. The provider had made staff responsible for undertaking management duties within the home but had not given the staff time to complete them. The home did not actively seek feedback on the service they provide in order to improve outcomes for people. The registered manager did not submit statutory notifications to CQC about events that had taken place in the home as required by law. The registered manager did not have day to day management oversight of the home. There was no measurable system in place to have oversight of the home at provider level.

Risks to people were not always identified and properly assessed to protect them from avoidable harm. Environmental and equipment checks did not always take place to ensure a safe living environment. People received their medicines as prescribed, however, medicines were not always managed and stored safely. Safeguarding procedures were not robust, the home did not report certain events within the home to the local authority as necessary. Staff had received safeguarding training but were unsure of the correct procedures for raising concerns and whistleblowing outside of the home.

Accidents and incidents were recorded but the information was not used by the home to learn lessons and reduce the likelihood of them happening again. Recruitment processes were not always robust as staff did not always have the necessary checks needed to work with people. There were enough staff on duty but recruitment challenges and unplanned staff absence had a negative impact on the home.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Consent was not sought from people for their care and support and where there were concerns of a person's capacity the necessary capacity assessments had not been carried out. The registered manager told us they were not sure of their responsibilities and staff did not have an awareness and knowledge of the Mental Capacity Act 2005. This meant that there were risks to people's rights and freedom.

Staff supervision did not happen as planned. Staff received training; however, this was not effective as staff knowledge and the subjects offered were limited. There was a risk staff were working outside their scope of competence, for example, with wound care.

People and their relatives told us Holmwood Rest Home was a safe place to be. People told us staff were

kind and they were happy living at the home. People had access to healthcare as required. There was enough to eat and drink, with choices and alternatives if needed. Staff told us they knew people well and were like family. People and their relatives told us they were kept informed and felt involved in their care and support.

People had enough to eat and drink and access to healthcare when needed. People, their relatives and staff told us the management of the home were kind and could be approached with any concerns. Staff told us they were confident the manager would follow up any concerns they had.

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

Rating at last inspection
The last rating for this service was good (published 21 December 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

Enforcement and Recommendations
We have identified breaches in relation to consent, risk management, medicines safety and the management oversight of the home at this inspection. We have made a recommendation about the provider's recruitment process.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Holmwood Rest Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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 one inspector.

Service and service type
Holmwood Rest Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Holmwood Rest Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority service improvement and safeguarding teams. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with members of staff including the registered manager, home manager, care workers and one health and social care professional.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 11 people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People did not always have risk assessments in place to ensure they were kept safe. Where people had an identified risk, assessments were not always in place to reduce or remove the risks. For example, one person had bed rails in place, a risk assessment had not been completed to determine whether they were safe to use. Another person had a risk of falls and did not have a falls assessment in place.
- Risk assessments were not always up to date. For example, assessments were not reviewed monthly as planned. They contained limited and general information and were not individualised to the person. This meant people were at risk of avoidable harm.
- Risks within the environment had either not been recognised, checked or robustly assessed. Gas and whole home electrical safety had not been established within the home. Annual electrical equipment checks had not been carried out since 2015. Risks from water borne diseases such as Legionella, had not been assessed as water checks did not take place.
- Accidents and incidents were recorded. However, analysis and review of incidents had not taken place. This meant patterns had not been recognised for people and could have increased their risk of harm, for example, where they had multiple falls.

The provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. Risk assessments were completed for one person who did not have them in place. Gas and electrical safety checks were arranged.

- Staff knew people well and told us they understood their risks. One person said, "They know I find walking a little difficult and they always make sure I have my frame."
- People had personal evacuation plans in place. These gave staff instructions on what support people needed to leave the building in an emergency. Fire safety checks had been undertaken by an external company. A fire risk assessment was in place for the home.

Using medicines safely

- Medicines were not always managed safely. The provider could not assure themselves medicines were stored at safe temperatures as this was not monitored. This meant medicines may not be effective and become damaged.
- Medicines that required stricter controls by law, sometimes called 'controlled medicines', were not always

stored correctly and the necessary checks made. We found a controlled medicine in the main medicines trolley for a person who was no longer at the home. The controlled medicines record was not accurately completed, which meant the provider was not in compliance with the law.
● Where people were prescribed medicines that they only needed to take occasionally, guidance was not always in place for staff to follow to ensure these medicines were administered in a consistent way. This meant there was a risk people may not receive their medicines when they needed them.
● Liquid medicines and prescribed creams did not have the opening date on them. This meant that their effectiveness could be affected. Guidance for prescribed creams was not clear, for example, cream was to be applied, 'as directed' with no further explanation or pictorial guide, such as a body map.
● Staff who gave medicines had received training and their competency assessed after the training. However, staff were not given regular competency checks to ensure practice was always safe.

The provider had failed to ensure the safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The controlled medicine was secured, and the record book was corrected.

● People received their medicines as prescribed. Medicines administration records were clear and complete.

Staffing and recruitment
● Recruitment processes were not always robust. Staff did not always have the necessary checks to ensure they were safe to work with people. One member of staff had a basic check, by the Disclosure and Barring Service (DBS), staff who work with people in care homes must have an enhanced check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We raised this with the registered manager and an application was made to the DBS.
● There were enough staff on duty. People and their relatives told us staff were available to them when they needed. However, the provider did not determine staff numbers to meet people's needs, this meant there was a risk staffing levels would not be safe.

We recommend the provider seeks advice from a reputable source to ensure their process is robust for the safe recruitment of staff.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding procedures were not always robust. The provider is required to report certain events to the local authority such as unwitnessed falls and medicines errors. This had not been done.
● Staff had received safeguarding training. However, they were unsure of who to contact outside of the home if they had a concern about safety.

The provider failed to ensure safeguarding referrals were made as appropriate and people were protected from harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. Safeguarding information was sent to the local authority.

● People, their relatives and staff were confident any concerns they raised with the registered manager would be acted upon and taken seriously.
● People and their relatives told us Holmwood Rest Home was a safe place to be. Some comments we received were: "Yes, they are safe, the staff are very good, very caring", "I feel my loved one [name] is safe as I feel free to ask any questions and check in with them", "I feel safe because of the staff and their friendliness", "I am really happy here", "They care for my relative's [name] needs well", "They give me patience and encouragement."

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home was cluttered in some area's which meant the provider could not be sure all areas of the home were clean.
● Staff practiced good infection control. However, the provider's infection prevention and control policy was out of date and did not contain current and relevant guidance for staff. The policy was last updated in 2018 and therefore did not include for COVID-19 safety procedures.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● Visits to the home were conducted in line with the latest government guidance.

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 our last inspection we rated this key question good. At this inspection the rating has changed to 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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People's rights were not always being fully respected. There were no records of consent for the care and treatment for 10 people. Where there was a suggestion in care records a person lacked capacity, capacity assessments had not been conducted.
● One person had a MCA assessment for the decision of having their medicines administered, this showed they lacked capacity. No best interests' discussions or consultations were recorded. The provider had signed consent forms on behalf of the person without the legal authority to do so.
● The registered manager told us their knowledge of the MCA was limited. Staff who had previously received MCA training did not know what it was and any details about the MCA.

Systems were either not in place or robust enough to ensure the service was working in accordance with the Mental Capacity Act 2005. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home was not always working in accordance with the Deprivation of Liberty Safeguards. We found that applications to deprive people of their liberty had not always been made, this meant people were at risk of being unlawfully restricted.

The provider had failed to ensure the service had the necessary lawful authority for people to be deprived of their liberty for the purposes of providing care or treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection, they told us they would seek guidance and ensure the proper documentation was in place.

● We observed staff asking for people's consent before supporting them, offering choices and using respectful language.

Staff support: induction, training, skills and experience
● Staff told us they felt supported in their role. However, supervisions and appraisals had not taken place as planned. Formal recorded supervision had not taken place for over a year, this meant staff did not always have the opportunity of one to one time to discuss any concerns or support needs.
● Staff received an induction when they started to work at the home. Staff told us they were shown what to do. There was no documented probation completion and the registered manager had not confirmed their competence.
● Staff had access to training. The registered manager told us they had recognised the training was not robust enough and had changed from a video-based training to online, they told us this was starting in January 2023.

We recommend the provider seek guidance from a reputable source to ensure staff have the opportunity to discuss their needs and support and have access to training which meets the needs of the people living at the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to receive health care services when they needed them. Referrals were made from the home to a variety of professionals, such as doctors and nurses. However, we received feedback which suggested referrals were not always timely. We spoke to the staff member responsible and they had taken on additional responsibilities during the COVID-19 pandemic. They told us they would refer everything to the relevant professional.
● People's records showed input by professionals such as nurses and therapists who visited the home as well as visits to hospitals and consultation with the GP. A relative told us, "We always access medical services for my loved one [name]."
● Communication across the staff team was effective, there was a handover book in place and staff told us they read the information at the start of every shift and when they returned from leave. This contained information such as updates on people's wellbeing and any important changes to their care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had their care needs assessed before they moved into the home. The assessments formed the basis of their care plans.
● People's needs and preferences were noted in their care plans.

Supporting people to eat and drink enough to maintain a balanced diet
● People had enough to eat and drink and the feedback was positive. Some comments we received were: "The food is fantastic", "We have all different things, such as roasts, if I want something different they get it for me", "It's very good", "They do their best and they provide softer foods", "Lovely lunch."

● People's likes and dislikes were known to staff. There was a variety of meals and people were offered choice and alternatives. People confirmed they could have what they liked.
● We observed mealtimes to be a relaxed, social occasion with people having conversations with each other and staff. Drinks were served which included alcoholic and non-alcoholic choices.

Adapting service, design, decoration to meet people's needs
● Holmwood Rest Home was an older style, adapted building. The décor was in keeping with the age of the building. Bedrooms were decorated as needed.
● The home was accessed over two floors. Most of the bedrooms were on the ground floor and the first floor was accessed by a stair lift.
● People were encouraged to bring in their own personal belongings, they told us it was important to them. A person told us, "You can bring your own furniture in, it's nice to have your own things around you."
● Rooms were adapted to meet the needs of the person. For example, bed positions for access to the bathroom.
● People were able to move through the home with ease and there was level access to outdoor spaces.

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 our last inspection we rated this key question requires improvement. The rating for this key question has changed 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we made a recommendation the provider seek opportunities to link with external professionals and consider national best practice guidance to evaluate and improve oversight at the service. Improvements had not been made.

● Quality assurance systems did not operate effectively. Audits and monitoring were not in place and therefore had not identified the shortfalls found within the inspection. For example, risk assessments and medicines management.
● Oversight from the registered manager had not identified the shortfalls within the service. There was no formal audit or measurable system for checking the standard at which the home operated.
● The registered manager told us they had not kept up to date with legislation and did not have oversight of the home. They told us they had stepped back from the management of the home. This meant there was a risk the home was not safely managed.
● Policies and procedures were out of date, last updated in 2018, the registered manager told us they were out of date. Policies did not always reflect current legislation and regulations. They advised outdated and unsafe practices, for example, the moving and handling policy described how to manually lift a person without equipment. This meant the home did not have a framework in which to operate safely, which put people and staff at risk of harm.

The provider had failed to ensure governance systems were operating effectively to ensure risks were managed, medicines were safe, people's rights were respected, and the service improved. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had not made statutory notifications to CQC as required by law. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. The registered manager had not submitted statutory notifications since July 2021. The home manager told us there were four notifications they needed to submit, during the inspection we found a further five notifiable events that had not been submitted. We told the registered manager to submit the notifications to CQC retrospectively.

The provider had failed to inform CQC about events that occurred in their service as required by law. This

was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

The provider responded immediately during and after the inspection. The provider submitted statutory notifications retrospectively and gave verbal assurance they would submit notifications as required.

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

- The provider did not seek formal feedback from people, their relatives and external professionals and use it to drive improvements within the home. However, staff told us they asked people continually for their views.
- Meetings did not take place within the home. The provider could not assure themselves they were listening to people's views and they were involved in their home.
- The home had not made links in order for people to be part of their community.

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

- The registered manager told us they understood the duty of candour, that is, their duty to be open and honest about any incident that has placed a person at risk of harm. A relative told us, "They are open and always keep me informed, I am consulted." Records showed the relevant people had been informed.
- The registered manager and staff were open throughout the inspection, accepted the shortfalls found and immediately sought to rectify them.

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

- Staff told us they felt appreciated, involved and listened to.
- People, their relatives and staff were positive about the management of the home. Some of the comments we received were: "Oh, the home manager [name] is wonderful", "The home manager [name] is supportive and helps every day."
- Staff felt proud to work at Holmwood Rest Home. Some of their comments were: "I feel proud and we all get along, I spend a lot of time here and I am happy. Everything is just easy, residents are lovely", "The home manager [name] is very good, anything you ask they will do it. Everything is about the residents. They help all the time", The registered manager [name] is nice and comes in to visit", "The home manager [name] is particularly good and goes the extra mile."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to inform CQC about events that occurred in their service as required by law.

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 The provider failed to ensure safeguarding referrals were made as appropriate and people were protected from harm. The provider had failed to ensure the service had the necessary lawful authority for people to be deprived of their liberty for the purposes of providing care or treatment.

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 Systems were either not in place or robust enough to ensure the service was working in accordance with the Mental Capacity Act 2005. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe management of medicines. The provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were operating effectively to ensure risks were managed, medicines were safe, people's rights were respected, and the service improved.

The enforcement action we took:

We issued a warning notice.