Lakeland Care Services Limited

Holmewood Residential Care Home

Inspection report

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Date of inspection visit:
20 October 2022
09 November 2022

Date of publication:
01 December 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Holmewood Residential Care Home is a residential care home providing personal care to up to 26 people. The service provides support to older people. At the time of our inspection there were 25 people using the service. Holmewood Residential Care Home accommodates people in one adapted building.

People's experience of using this service and what we found
People were at risk of harm because of widespread shortfalls in safety across the service. Staff had not always received the appropriate training or had their competence assessed prior to providing people with specialist care tasks. There were not always enough staff available to provide people with safe and timely support. Feedback from people and staff was that people did not always receive their care when they needed it. The provider had not always carried out appropriate checks to ensure staff were safely recruited.

People were at risk as health and safety issues had not always been identified or addressed. Risks to people were not always well managed as they had not always been identified or robustly assessed.
Systems were not always in place to ensure people received their medicines safely and as prescribed.

People were supported against the risk of infection. Arrangements were in place to enable visitors to visit family members and friends living at the service. We have made a recommendation about the provider's visiting policy.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were at risk of not receiving high quality care as the provider did not have effective systems in place to assess, monitor and improve the service. Changes with the provider's management structure had led to a lack of oversight of the service. The provider had identified some areas where changes were needed prior to our inspection, however, they had not identified the extent of issues we found. The registered manager and provider started to make improvements following our inspection, these had yet to be embedded and sustained. We have made a recommendation about the specialisms the provider wishes to offer at the service.

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

Rating at last inspection
The last rating for this service was good (published 13 February 2019).

Why we inspected

We received concerns in relation to health and safety, staffing levels and people's quality of care at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Holmewood Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, fit and proper persons employed and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Holmewood Residential Care 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 two inspectors.

Service and service type
Holmewood Residential Care Home is a 'care home' without nursing. 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. 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 CQC 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.

Inspection activity started on 20 October and ended on 09 November 2022. We visited the service on 20 October 2022.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority who work with the service. 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.

During the inspection
This inspection was carried out by conducting a site visit and speaking to relatives and staff remotely. We spoke with 5 people who used the service and 4 relatives about their experiences of the care provided. We spoke with 9 staff including the nominated individual, registered manager, deputy manager, supervisors, care staff and chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. These included 4 people's care records. We looked at multiple medicines' records. We reviewed staff recruitment and supervision records. A range of records relating to the management of the service, including staff training, accident and incident records, health and safety records and a sample of the provider's policies and procedures were also reviewed. We sought feedback from health and social care professionals that worked alongside the service.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People did not always receive support from staff who had the appropriate qualifications, competence, skills and experience to provide their support.
- Care staff carried out specialist care tasks for which they had not always received training or had their competence assessed to ensure they were safe to provide this.

We found no evidence people had been harmed. However, the provider had failed to ensure staff providing care to people had the qualifications, competence, skills and experience to do so safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider did not always ensure there were enough staff to ensure people received safe and timely support.
- The provider had taken the decision to reduce staffing levels for financial reasons without considering people's care and support needs.
- Feedback from people and some relatives showed they had concerns about staffing at the service. One person said, "The shortage of staff is chronic. I can buzz [using a call bell] and nobody comes. There is no staff to answer the buzzer, they come as soon as they can."
- Staff told us staffing numbers meant they had to work in task-centred ways to meet people's care and support needs. One member of staff told us, "We can't have the chat with people that really need it. Sometimes they just buzz to see your face. The care is alright, it's the human aspect.'"

We found no evidence people had been harmed. However, the provider had failed to ensure there were sufficient numbers of staff to support people safely and effectively. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Full recruitment checks were not always carried out to help make sure suitable staff were employed.
- Staff recruitment records did not always contain information about their employment histories and evidence of their conduct in previous jobs related to their current roles.

We found no evidence people had been harmed. However, the provider had failed to ensure appropriate checks had been carried out prior to recruiting staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had identified gaps in staff recruitment records prior to our inspection and had started to gather information to address these.

Assessing risk, safety monitoring and management
● People were at risk as the provider had taken limited action to assess, monitor and improve the safety of the service.
● Risks to people were not always managed effectively as they had not always been identified or fully assessed. For example, risks linked to people's diabetes had not been assessed.
● Information about people's dietary requirements was not always shared effectively within the service between kitchen and care staff to ensure these were safely met.

We found no evidence people had been harmed. However, the provider had failed to assess risks to the health and safety of people using the service and take action to reduce these risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was working to improve and update people's care records, including risk assessments following the provider changing to an electronic care records system.

● Recommendations identified as requiring immediate or prompt action in health and safety reports from specialists arranged by the provider had not been acted on. This included actions in fire and legionella risk assessments.
● Fire safety was not managed safely. Fire doors were not always capable of preventing the spread of fire.
● Not all staff had been involved in fire drills or simulated evacuations to prepare them for how to respond in the event of a fire or other emergency.
● Health and safety checks were not always carried or effective at monitoring the safety of the premises. Areas of the home that could present a risk to service users were not always secured to prevent them being accessed.

We found no evidence people had been harmed. However, the provider had failed to assess the risks to the health and safety of people using the service and take action to reduce these risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We made a referral to the local fire and rescue team during our inspection to review fire safety risks and support the provider.
● The provider had identified some shortfalls with health and safety at the premises prior to our inspection and was seeking further specialist advice. The provider had started to address the recommendations made.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is

usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely
● Medicines systems did not support their safe and proper use.
● Staff responsible for administering medicines had not always had their competence assessed to consider if they had the knowledge and skills needed to provide this support safely.
● People did not always receive time specific medicines at the time given in their prescription. This can impact on the effectiveness of these medicines for people.
● 'As and when required' protocols were not in place to ensure these occasional medicines were given safely and as prescribed.

We found no evidence people had been harmed. However, the provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, the registered manager had carried out supervisions with supervisors responsible for administering medicines to improve medicines practices.
● The provider was introducing additional medicines records and quality checks to support safe medicines practices at the service.

Preventing and controlling infection
● The provider did not always have robust systems in place to support and monitor infection control risks.
● The registered manager and provider had not always carried out infection risk assessments in-line with government guidance to identify risks specific to each person.
● Infection control checks were not being carried out regularly or reviewed by the registered manager to monitor and identify risks in the service.

We found no evidence people had been harmed. However, the provider had failed to assess and manage infection risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was acting on advice from the local infection prevention and control team to improve practices at the service.
● Staff used PPE appropriately.

Visiting in care homes
● Visitors were able to visit family and friends living at the service at the time of their choosing.
● People gave positive feedback on the visiting arrangements. One person told us, "My family come and visit, they're marvellous; I haven't been a day without having a visit."
● The provider's visiting policy did not reflect visiting practices taking place at the service or current government guidance.

We recommend the provider reviews and updates their visiting policy and make this available to visitors.

Systems and processes to safeguard people from the risk of abuse

● Staff clearly understood their responsibility to protect people against abuse and the risk of abuse. They knew how to identify and raise any concerns they may have about people.
● People felt safe living at the service and with the staff supporting them.

Learning lessons when things go wrong
● The provider had processes to follow in the event people experienced an accident or incident.
● Accidents and incidents were recorded. This helped ensure appropriate action had been taken to keep people safe.
● Accidents and incidents were not analysed to look at any trends or patterns and support learning across the service. The provider told us a new system would be introduced to support this.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems were not in place or well established to support ongoing monitoring and improvement at the service.
- Changes within the provider's management team and management at the service had led to a lack of oversight of the service.
- The registered manager and provider had not always identified the extent or seriousness of the issues we found on inspection putting people at risk of harm. For example, fire safety, medicines, staffing, infection prevention and control, policies and procedures.
- The provider's policies and processes were not always followed to ensure consistency across the service. For example, the provider's medication policy was not always followed with regards to staff competency assessments and 'as and when required' protocols.
- People's care records did not always contain full and accurate information about people's care and support needs and how to meet these.
- Staff records did not always include information about their inductions and probation meetings to show how they had been supported to familiarise themselves with the service and the provider's practices.

We found no evidence people had been harmed. However, the provider had failed to have effective systems in place to assess, monitor and improve the quality of the service and maintain complete records for people and staff. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had identified some shortfalls with the service and had developed an action plan to support improvements.
- Following our inspection visit and feedback, the registered manager and provider started to make further changes to the service.

- The provider had previously decided the service would specialise in supporting older people. We were not always assured that people being admitted to the service did not have other specialist needs, for example dementia.

We recommend that the provider reviews the specialist types of care they are providing at the service and ensure staff and the home environment are able to meet these needs.

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

● Staffing levels at the service did not always support high quality person-centred care. One person told us, "We can't fault the staff but there aren't enough of them." One care worker said, "People should be getting good quality care, we can't do this."

● People and their relatives commented on the welcoming and homely feel at of the service. One relative said, "I think it's a lovely home, it's very homely."

● People's diverse and individual needs were accepted and supported by staff. People felt part of a community living at the service.

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

● The registered manager had set up a 'knit and natter' group to provide an informal opportunity to spend time with people on a regular basis and listen to any points they may wish to raise.

● People and relatives found the registered manager approachable and felt able to share their views on the service. One person said, "The registered manager is very easy to talk to."

● The registered manager held regular meetings with staff to update them on any changes to the service. These provided a forum for staff to share their feedback. One member of staff said, "We can speak out and say what's going wrong and what's alright, the registered manager listens."

● The deputy manager and registered manager had good working relationships with other health and social care professionals.

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 understood the need to be open and honest with people if things went wrong.

● The provider submitted notifications to CQC for events they are legally required to inform the commission of.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess risks to the health and safety of service users, including the risk of infection and do all that was reasonable practicable to mitigate these. The provider had failed to ensure staff providing care to service users had the qualifications, competence, skills and experience to do so safely. The provider had failed to ensure premises were safe for their intended purpose. The provider had failed to ensure the safe and proper management of medicines. (2)(a)(c)(d)(g)(h)

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 systems or processes were in place to support the governance of the service. Systems or processes were not in place to effectively assess, monitor and improve the quality and safety of the service and service user's experiences. The provider had failed to maintain accurate, complete and up to date records for service users and staff. (1)(2)(a)c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure required

checks were carried out in relation to staff employed.
(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff deployed. (1)