Haydn-Barlow Care Limited

Holmfield Nursing Home

Inspection report

291 Watling Street
Nuneaton
Warwickshire
CV11 6BQ

Tel: 02476345502

Date of inspection visit:
10 November 2016
11 November 2016
24 November 2016

Date of publication:
02 January 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 November 2016. The visit was in response to information of concern which is being investigated as a safeguarding concern by another agency. The inspection was unannounced on 10 November 2016 and we informed the provider we would return on 11 November 2016. Prior to our visit, we had shared this information with the Clinical Commissioning Group (CCG) and this inspection was conducted as a joint visit with them. CCG's are clinically led NHS bodies responsible for the planning and commissioning of health care services for their local area.

We informed the provider we would return, with the CCG, on 11 November 2016. We gave feedback about concerns we had identified to the registered manager, operations manager and provider on 10 November 2016. To reduce risks to people, the provider agreed to impose a voluntary placement stop on admissions to the home whilst improvements were made. Further feedback was given to the registered manager, operations manager and provider on 11 November 2016. Following our inspection visit, the provider sent us an action plan telling us what improvements they would make. Two inspectors returned, unannounced, on 24 November 2016 to check if immediate actions had been taken in response to concerns identified had been implemented by the registered manager and provider to address the issues we identified.

Holmfield nursing home provides accommodation, nursing and personal care and support for up to 22 older people living with physical frailty due to older age and complex health conditions. At the time of the inspection 15 people lived at the home. The home has two floors; with a communal lounge and dining area on the ground floor.

The home is required to have 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 and associated Regulations about how the service is run. At the time of our inspection there was a registered manager in post who had become registered with us in March 2016.

We inspected the home in August 2016, to check if improvements had been made following our inspection visit in January 2016. In January 2016, we found breaches of the regulations and rated the home 'inadequate.' We took enforcement action and served warning notices on the provider. In August 2016, we found some improvements had been made to people's care and safety and in the governance of the home and the provider told us about further planned improvements. In August 2016, we rated the service as 'requires improvement.'

At this inspection we followed up on the concerns we received from a member of the public and healthcare professional, as well as checking to make sure, planned improvements had been made. We identified improvements had not always been effective or sustained. The provider's improvement plan for the clinical support of the registered manager had not been effective. We found breaches in the regulations relating to safe care and treatment, staffing and governance of the home.

The provider had quality assurance systems and processes in place to monitor the service, but these were not always effective.

People felt safe living at the home because staff were on shift to support them. However, people told us staff were 'rushed.' Staff told us there were not enough of them to do their job 'properly.'

Sufficient numbers of staff were not always available to meet people's needs in a way that promoted their safety and planned improvements to staffing levels had not been sustained.

People were assessed to reduce the risk of harm or injury, however, actions staff needed to take to reduce the risks were not always shared with them, so risks to people were not always minimised.

Staff felt they did not always have the equipment they needed to ensure people were comfortable and risks to people were minimised.

Some people felt cold in their bedroom and parts of the home were cold.

Staff had been trained to safeguard people and knew what to do if they had a concern. However, people were not always protected against abuse because senior management had not always followed their safeguarding policy in reporting a concern to the local authority.

People had their prescribed medicines available to them and were supported to take these by trained staff. Records of people's medicines were not always kept as required.

We rated the home as 'inadequate' and placed the home in 'special measures,' which meant we will keep the service under review. We have written to the provider to tell them to update us on a fortnightly basis about what improvements are made.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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.

People were assessed to reduce the risk of harm or injury, however, actions staff needed to take to reduce the risks were not always shared with them. This meant risks to people were not always minimised.

Staff did not always have the equipment they needed to ensure people were comfortable and risks to them were reduced.

Staff had been trained to safeguard people and knew what to do if they had a concern. However, people were not always protected against abuse because senior management had not always followed their safeguarding policy and reported concerns to the relevant authorities.

Sufficient numbers of staff were not always available to meet people's needs in a way that promoted their safety. Planned improvements to have an additional staff member had not been sustained.

People had their prescribed medicines available to them and were supported to take these by trained staff. Records of people's medicines were not always kept as required.

Is the service well-led?

Inadequate

The service was not well led.

Planned improvements had not been effectively implemented or sustained in the governance of the home. The provider's improvement plan for the clinical support of the registered manager had not been effective.

Quality assurance systems and processes were in place to monitor the service. However, these were not always effective.

Holmfield Nursing Home

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 10 and 11 November 2016. The visit was unannounced on 10 November 2016 and was in response to information of concern which is being investigated as a safeguarding concern by another agency. Prior to our visit, we had shared this information with the Clinical Commissioning Group (CCG) and we undertook a joint visit. We informed the provider we would return, with the CCG, on 11 November 2016. Two CQC inspectors returned, unannounced, on 24 November 2016 to check if immediate actions had been taken in response to concerns identified had been implemented by the registered manager and provider to address issues we identified.

The provider had previously completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to this inspection, a request for a new PIR was not made. During our inspection, we gave the provider an opportunity to supply us with key information, which we then took into account during our inspection visit.

We reviewed the information we held about the service. This included information shared with us by the local authority and statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. The registered manager had not always kept us informed about events we needed to be told about.

Some people living at the home were not able to tell us about how they were cared for due to living with complex health care conditions. We spent time with them and observed the care and support they received from staff.

We spoke with seven people who lived at the home and four relatives. We spoke with five care staff, two nurses, one cook, the clinical lead nurse, the registered manager, the operations manager and provider. We

also spoke with two healthcare professionals involved with people's care and treatment.

We reviewed a range of records, these included care records for six people, skin care records and nutritional information logs and two people's medicine administration records and other medicine records. We reviewed staff training and quality assurance audits and minutes of meetings.

Inadequate

Is the service safe?

Our findings

At our last inspection in August 2016, we found improvements had been made and the requirements of the warning notice served on the provider, in January 2016, had been met. For example, improvements had been made in the safe management of medicines and risks to the health and safety of people receiving care and treatment had, overall, improved. In August 2016, we found further improvments were required and the provider informed us how they planned to implement these.

We returned to do this inspection in November 2016, because we had received information of concern which is being investigated as a safeguarding concern by another agency. At this inspection we had concerns that actions were not always being taken to minimise risks to people. We found that the provider had not ensured sufficient and suitably skilled staff were allocated to shifts to keep people safe and meet their needs.

At our last inspection in August 2016, we were told that nurses had received training to use a specialist treatment for one person that had a pressure area and we were told that further tissue (skin) viability training was planned for. On this inspection, the registered manager informed us that of the 15 people living at the home, seven had skin damage, such as a skin wound or pressure area. The registered manager told us, "I don't think people are getting the pressure care they need, such as regular repositioning by staff. I have identified this as an issue and reminded staff of the importance of this." The registered manager added, "One nurse has booked a one hour session on skin training for staff later this month." Further discussion of this revealed this was a skin dressing manufacturer's sales person offering a talk about their products. This was not tissue viability training.

We found risks to people's skin becoming sore or damaged were assessed and some equipment, such as special pressure relieving cushions and bed mattresses were used. However, actions were not always taken by staff, to appropriately prevent skin damage from occurring. For example, staff had placed a pillow on top of one person's special pressure relieving mattress to elevate the person's foot because their heel had a pressure area. We identifieid that nurse's actions caused a potential risk to other areas of this person's skin because their elevated legs transferred pressure to elsewhere on their body and also created risks of skin damage to this person's legs from 'shearing' from the pillow and bed covers, which nursing staff had not identified.

This person had a skin care plan, where one nurse had recorded 'skin improving' but one day later a photograph of one area of skin damage did not show improvement. The description entered on this person's wound management plan, by a second nurse, did not correspond to the previous day's entry. We discussed this with the first nurse and they told us when they had recorded 'skin improving' they had not checked this person's skin. This nurse told us, "I just wrote that because I thought it was improving, I had not looked at their skin." We discussed our concern with the registered manager and provider and they told us action would be taken to improve nurse performance.

On the third day of our inspection visit, we looked to see if the provider had taken steps to improve. One

nurse told us, "We are not using the pillow now and have suitable equipment to place on top of the mattress to reduce further risks to this person's heal." However, this person's skin care plan showed their dressings needed to be changed on 22 November 2016. Records showed this nursing task had not been completed. On 24 November 2016, one nurse told us, "I have been on leave since your last visit (10 and 11 November) and noticed other nurses had overlooked changing this person's skin care dressings. I will be doing this today." This nurse later informed us the person's dressings had been changed and photographs were taken to assess progress and healing.

Staff did not always have information they needed to refer to so that identified risks were minimised. For example, one person's health care plan, dated 10 October 2016, identified they had a specific health care need. A risk assessment had identified their nutritional intake should limit certain food products including proteins and potassium. We found this information was inconsistent with their nutritional care plan which had been completed by the registered manager. This recorded (dated 10 October 2016) the person to have 'normal meals.' The cook and staff who prepared teatime meals told us they referred to the kitchen nutritional information file which we found did not have the correct information for this person. On the third day of our inspection visit, the operations manager told us they had offered to prepare the teatime meals and we asked them if they were aware of this person's specific nutritional needs. They said, "No, not until you just told me. I'd have just looked in this kitchen file. That's another thing we need to update then."

We saw one person had been seated by staff in an armchair with their legs raised because their feet were swollen. This person's lower legs and feet were hanging over the end of the chair because the chair was not suitable for their needs. This meant that effective action was not being taken to reduce swelling to this person's legs. A further risk of skin damage was posed from the pressure put on the skin of this person's lower legs One staff member told us, "We only have one large armchair that is already being used and the foot rest we have is too low. We do not have sufficient equipment here. Staff have mentioned this to the manager before, but nothing has happened." The registered manager informed us they did not hold budgets and any requests had to be forwarded to the provider. The registered manager added the provider had allocated financial resources to some urgently needed improvements this year, such as décor and general maintenance of the home.

This was a breach of Regulation 12 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2016, we discussed concerns we had about there not always being enough skilled staff on shift to keep people safe and meet their needs. The registered manager informed us that an additional care staff member had been recruited, as planned for, but had not stayed long and the post had not been re-advertised. This meant that plans to ensure sufficient numbers of suitably skilled staff were available to keep people safe and meet their needs had not been effectively implemented or sustained by the provider.

On this inspection, we found the provider and registered manager did not ensure there were sufficient numbers of suitable staff on shift. One person told us, "The care staff do their best, they are kind and caring, but always rushed." We saw some people were still in bed and had not had breakfast by 10.00am. Staff informed us those people that wanted to get up had to wait until staff were available to support them and confirmed they had not had breakfast. One staff member said, "We support people to get up and then we have to get the person's breakfast, such as their cereal and toast. There is not a separate staff member to do breakfasts. If a person requests a cooked breakfast, the cook will do that, except Thursdays, due to the food delivery."

We identified records of an incident during November 2016 where one person had made an allegation against another person. Records showed one person was assessed as requiring 'staff to ensure they were not left alone in communal areas and to be observed' due to the risks of inappropriate behaviours towards others. This incident had not been reported to us or to the local authority as a safeguarding concern. We discussed this with the registered manager who told us they had discussed the incident with the operations manager. The operations manager agreed similar incidents had been reported but no action taken so had not reported this allegation made by a person living at the home.

The registered manager agreed that in the future any such incidents would be reported to the relevant authorities and in line with their safeguarding policy.

Over the course of our inspection visit, we identified times on each of our three days when this person did not have staff observing them in the communal lounge despite their care record saying 'not to be left alone' in the lounge. We discussed this with the registered manager and they told us, "What it says in this person's risk assessment does not always happen because staff are not always in the communal areas all the time. Staff keep an eye on this person when they walk through the lounge and are about most of the time but not all the time."

Staff told us there were not enough staff to enable them to do their job 'properly'. People's bathing and showering records stated 'insufficient staff' on three dates during November 2016. Staff told us they had annotated this to record why baths and showers were not offered to people.

Staff told us, "There is not enough time to give quality time to people." Staff said they could not spend time supporting people's emotional and social needs, because they were too busy with practical care tasks and non-care tasks, such as kitchen and laundry tasks. They told us when two staff were supporting one person, who needed two staff to assist them, and the nurse was busy administering medicines, there were no other staff to support people in the lounge or to prepare the teatime food, drinks and other snacks. Staff told us that other tasks, such as managing people's laundry, took important time away from supporting people, observing those who needed it, or spending time with them to prevent social isolation.

Staff told us they frequently worked long days from 7:00am until 8:00pm, because there were not enough staff employed and available staff. Staff felt increased pressure when colleagues were off work, because there was such a 'small pool' of staff to call on to cover planned and unplanned absences. One staff member told us, "Six staff have left recently and they have not been replaced. There are not enough staff at weekends." Another staff member told us, "We need two more staff in the morning and one more in the afternoon." We discussed this with the registered manager and operations manager. The operations manager informed us that of the fifteen people, eight people required two staff to support them with personal care. We found dependency assessment tools were not used effectively to calculate staffing levels to ensure people needs were met safely.

Relatives shared some of their concerns about staffing levels and said it was sometimes hard to find staff as they were busy supporting people in other areas of the home. A visiting healthcare professional told us, "It's always hard to find staff at this home."

Another healthcare professional told us they felt nursing staff did not always have the clinical skills they needed, for example to 'complete basic observation checking for poorly people'. Also, a 'lack of adequately skilled nurses capable of catheterisation and managing skin care'. This healthcare professional told us they felt communication could be improved upon. For example, a poor handover between morning and afternoon nursing staff meant that when health care professionals visited in the afternoon staff at the home,

were are unaware of the issues with people and why a professional visit had been requested by morning staff.

This was a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they felt safe at the home because they trusted the staff to look after them and keep them safe from harm. They told us, "I love it here". Another person told us, "There has been a lot of staff changes, but it is still good care. They would do anything for you. They have a lot to do, and little time to chat."

The registered manager told us staffing levels were set by the provider. When we returned on 24 November 2016, the registered manager informed us that following feedback from the first two days of this inspection, the 'twilight' care shift had been re-advertised. The provider told us there had been a change in the nurse undertaking the clinical lead nurse role with immediate effect. The nurse confirmed this to us and told us they would discuss, with the provider, how many weekly supernumerary hours they would have to fulfil the clinical lead supportive role. They told us, "The provider has suggested four hours a week, though I think a day is more realistic. We will have a conversation about this." The registered manager told us they felt an extra nurse and two care staff would be beneficial to staffing levels and rota planning and said they would have a discussion with the provider about this.

People had their prescribed medicines available to them and were supported by nurses to take them when needed. One nurse told us, "The new cycle of repeat medicines has started on 22 November and nothing is missing, everyone had their prescribed medicines available to them. There are no current problems with medicines." We looked at two people's medicine administration records and found they had received their medicines as prescribed.

However, we identified one person had a missing tablet from their new medicines pack that had arrived on 22 November 2016. The registered manager told us, "I have not been informed about of this, I'll speak with the night nurse."

The arrangements for the safe and timely disposal of unused and unwanted medicines required improvement. We saw five large special pharmaceutical tubs full of unwanted medicines and two full tubs of sharps waste awaiting collection for safe disposal. We discussed the quantity of unused controlled drugs that were waiting safe disposal, one nurse told us, "The people who these medicines belonged to, have passed away and the kit required for the safe destruction has been ordered. As soon as it arrives, these will be destroyed."

One nurse told us, "We have to arrange a special collection for these tubs as they do not go back to the pharmacy. They need collecting." The nurse could not show us a planned date for their collection.

A safe system of recruitment system was followed by the provider and registered manager for employing staff at the home. One member of staff told us they had worked at the home for five months, had previous experience in care, and had achieved a level two nationally recognised qualification in health and social care. They said they had shown their certificates of training to the manager and had completed infection prevention and control training on-line, followed by an on-line assessment. Two recently recruited staff members told us they had provided two references and details so that a criminal record check could be completed on them.

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2016, we saw that the provider was not displaying their CQC rating and reminded them of the regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. On this inspection, we found the provider was, again, not displaying their rating as required. Following our inspection we wrote to the provider to tell them to confirm to us they will meet the requirement of this regulation and display their CQC rating.

In August 2016, we found improvements had been made and the requirements of the warning notice served on the provider, in January 2016, had been met. For example, improvements had been made in general maintenance of the home. We found further improvements were required to the governance of the service. This included the clinical support for the registered manager, who did not have a nursing background.

In August 2016, we found that parts of the clinical lead nurse role, planned for by the provider in January 2016, had not been implemented. The provider informed us they would put processes in place to support the clinical lead to take on these responsibilities. They said they would arrange for a pharmacist from their supplying pharmacy to offer guidance and support to the clinical lead nurse. They added they would also formalise clinical support meetings between their business consultant, who has a clinical background, and the clinical lead nurse. Meetings would ensure best practice, skills and knowledge were assessed by them in their competency assessments of the nurses and recorded for the registered manager. On this inspection, we found these improvements had either not been implemented or were not effectively sustained.

The nurse that the provider had informed us was the 'clinical lead', informed us that this role had not been confirmed to them in August 2016, as we had been told, but only at the start of November 2016. The nurse told us, "I was not formally in this role or being paid for it until two weeks ago. It had been discussed with me, but I have not completed any 'clinical lead' tasks because I was not formally doing the role." The registered manager told us they had not been aware of this. We discussed this with the provider and they told us, "We did appoint the nurse but it was on a 'trial' to see if they wanted the role. At the start of November (2016) they confirmed they would do the role and this is when it was agreed." The provider confirmed to us that no clinical support meetings between their business consultant and nurses had taken place yet, or where scheduled for, to ensure nurses followed best practice and had the skills and knowledge to undertaken nursing duties effectively. The provider told us, "It is something that is going to happen but has not yet done so."

At our last inspection, in August 2016, we found some improvement had been made to the provider's systems to monitor the quality of the service provided. Further improvements were required in, for example, taking action when issues were identified and also recording that further checks had been made to ensure action taken had resolved issues where improvements were needed. At this inspection we found these improvements had not been implemented.

We looked at the 14 October 2016 medicines audit. Of the six people's medicines and records we looked at,

the audit identified errors on four. The errors included, for example, medicine that had been signed for as given but had not been given. The next audit, dated 28 October 2016 recorded 'there are no concerns raised on this audit, all correct apart from two missing signatures'.

We found some issues that the provider's medicines audits had not identified. For example, we saw one person had five tablets that had been recorded in the controlled drugs register during October 2016. The tablets were not in the designated cupboard and the controlled drugs register had no record of their administration or safe disposal. We saw another person had medicines stored from the 16 October 2016 and were awaiting safe disposed, however, we found no record of these in the home's controlled drugs register. One nurse confirmed to us, "I can't find them in the controlled drugs register either, they should be there but are not." This meant that the audits, delegated to nurses, were not effectively undertaken. A lack of effective oversight meant the registered manager and provider had failed to identify further improvements were still required.

The registered manager kept a list of people assessed as being at risk called 'residents at risk monthly profile.' We looked at the document dated October 2016, which one nurse told us was completed at the end of October. We saw one person was recorded as having lost 8.8 kilograms in weight and the comment on action recorded 'not eating well referred to dietician and speech and language team'. However, this person's care records confirmed they had already been assessed by a dietician on 14 October 2016, and the outcome was that the dietician would write to the person's GP to request a food supplement be prescribed. We found this person's food supplement had not arrived as planned for and the registered manager told us nurses had not made them aware of this as a part of the end of month risk profile. The registered manager told us, "If I had been made aware, then I would have chased this directly with the GPs to avoid delays with dietician letters."

The registered manager told us that they used agency nurses to cover shifts when needed. They said staff had made them aware of a medicine error that had occurred over the past weekend. The registered manager told us this incident had been reported to the care agency and the nurse would not be offered future shifts at the home to reduce the potential risk of reoccurrence. We asked to look at the agency nurse profile, the file we were given contained profiles of some agency staff but not the nurse we asked about. The operations manager told us, "Usually the agency sends us a profile and we print it off and put it in that file. It's a bit of a mess and needs updating. Half of those agency staff are no longer doing shifts here. I don't know where the email is with the nurse profile attached. The agency probably sent it, but we might not have printed it off." We could not be assured that the registered manager or provider had seen the agency nurse profile to check important information including a valid nurse registration and that training was up to date.

We looked at fluid intake records for those people identified as being at risk and how the provider and registered manager audited these to check for completeness and accuracy. We found that there was no desired total, the amounts a person had drunk were not totalled and where one person had not been drinking there was no action taken. The registered manager told us, "The senior carer should total them and check them before filing them."

Some people required additional calories and were to be offered snacks between meals. One staff member told us, "There are snacks available if people ask for them." We saw snacks, such as fruit, yogurts and cakes, were stocked, however, people were not always able to ask for these and people's care records stated staff should encourage and promote snacks. People's food charts did not record what snacks had been offered and we saw some people, who required additional calories, had lost weight during October 2016. The registered manager told us, "Care staff should offer the snacks to people with the 'tea trolley' and the senior should check the daily food charts have been fully completed."

We saw in one person's care plan that their needs had changed following a hospital stay, but their care record had not been updated to reflect their current needs. For this person, this meant staff, such as agency nurses, did not have the information they needed.

On the third day of our inspection people were not able to have a cooked breakfast because there were insufficient staff. One person told us, "I generally like an egg on toast in the morning, but staff have not got time to do that today, I'll have one tomorrow." The cook explained their role was to prepare cooked breakfasts and lunch. However, on Thursdays cooked breakfasts were not available because their time was spent putting away food from the delivery. The cook said, "You can see today I've had 20-30 crates of food to put away and then I need to prepare lunch." The operations manager arranged for the weekly food to be delivered in a set time slot but had not assessed the impact of this on the cook's other tasks and people's preferred choices.

This was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found overall improvement had been made to the maintenance of the home and the provider informed us further improvements, including some first floor window frames in need of replacement, would be completed before the end of October 2016. At this inspection we found these had not yet been completed as planned for, the operations manager explained this was because the supplier had not been able to visit. The operations manager told us the provider was planning to arrange a new date so the work could be completed.

Some equipment, such as a bain-marie for the kitchen to keep people's meals heated, had been purchased as planned for. However, staff told us they felt further equipment was needed, such as footplate rests for wheelchairs so people could be moved safely. One staff member told us they had identified, during staff meetings, various improvements they felt were required in the amount of equipment available to work safely and effectively. Another staff member said they felt it would be more useful if every bathroom was converted to a shower room in accordance with people's preferences. This staff member was not confident this improvement would be understood or progressed by the provider, because they had not been successful in obtaining replacement equipment, such as face flannels, when they had identified a need for it previously.

We identified shortages of some required equipment, such as portable radiators. Some people felt cold in their bedrooms and we felt cold in some rooms, such as the conservatory. The provider said they had purchased some portable radiators used to supplement heat from the home's general heating system. However, a staff member explained some rooms remained cold because there were not enough portable radiators provided. We discussed staff concerns about the lack of some equipment, including sufficient suitable chairs and foot rests for people to use, with the provider and they told us they would ensure an 'equipment needs' audit was completed, so that further equipment could be purchased.

Due to concerns we identified during our inspection visit on 10 and 11 November 2016, we returned to the home on 24 November and asked the registered manager and provider to show us what action they had implemented to make immediate improvement. The provider informed us they had made a change to the nurse in the clinical lead nurse post. The provider told us, "I will allocate additional hours so that [nurse's name] can fulfil their clinical supporting role. There will be weekly support for the next five weeks for the clinical lead nurse, from my business consultant, so that improvements can be made. Following that, there will be on-going support by telephone and whenever the clinical lead nurse wants extra support in addition to the three monthly meetings I will arrange."

The registered manager informed us they would be having weekly meetings with the clinical lead nurse, and the purpose would be to review all of the people living at the home and any current issues or changed needs, so that action could be implemented. The registered manager showed us a record of their first meeting from 23 November 2016, we saw this was detailed and included actions to be taken for people. The clinical lead nurse said, "Those actions will be completed today and signed off."

The clinical lead showed us revised skin integrity care plans. They told us, "These have clear sections about what information should be recorded and where. I will be ensuring these are completed for people with skin damage and checking them."

The Clinical Commissioning Group had provided the registered manager and provider with information about a local hospital that offered tissue viability workshops for nurses to equip them with skills, and refresh knowledge, in managing risks to people's skin. The registered manager told us nursing staff would be booked to attend the workshops scheduled for December 2016, March and May 2017. We discussed this with the registered manager because that meant some nurses would not attend for a further seven months. The provider informed the registered manager that alternative staffing could arranged to enable all nurses, senior carers and the registered manager to attend the December 2016 and March 2017 sessions.

On the third day of our inspection, we found some improvements had been made in the oversight of people's care needs being met. The registered manager told us, "Since 21 November, I have started a 'manager's daily check' walk around the home." They showed us their record of this and we saw this was detailed and recorded key information and issues that had been addressed on the shift. This meant that staff had leadership and guidance.

A new recording tool had been introduced to log people's drinks (fluid intake). Each of these had individual desired totals based upon the person's needs. These had been completed and most had been totalled, where one person had a low intake an action to encourage the person with drinking was recorded. The registered manager told us, "Staff are still getting used to the forms, but it is better than before. The nurses also have a responsibility to check them twice over a 24 hour period." This meant that actions could be taken if a person was not drinking enough to minimise the risk of them becoming dehydrated.

We observed one member of care staff offering drinks to people and saw some snacks, such as biscuits and crisps, were on the trolley and offered to people. The staff member told us, "I will record what people have had." However, we saw there were no soft snacks on the trolley for people who required a soft diet and several of these people were those identified as requiring additional calories. The staff member knew about this and they told us yogurts were in the fridge if anyone asked. We asked the staff member if these could be on the trolley so they could encourage people in line with their care plan and the staff member added soft snack options to the trolley.

Further improvement plans were shared with us. These included improvement in staffing, with an additional staff member working from 1.30 to 8.00pm to offer activities to people, prepare drinks and snacks and the teatime meal and complete laundry tasks in the evening. The operations manager told us this would be maintained seven days a week.

The operations manager informed us they were acting upon information and guidance shared with them by the CCG about the Ambulatory Care Service. The Ambulatory Care Service provides an outreach service to cover people living in care homes. People referred to the service, by staff at Holmfield, will receive assessment, diagnosis and treatment from qualified and experienced healthcare professionals. The anticipated outcome of this service is to improve people's experience and avoid unnecessary acute services

attendance at a local hospital when services can be provided at Holmfield.

The provider agreed to impose a voluntary placement stop on admissions to the home whilst improvements were made. These actions meant that the registered manager, operations manager and provider had responded to concerns identified to them by us and the CCG and had taken urgent action to address issues and implement improvement, with further improvement planned for. We have written to the provider to tell them to update us on a weekly basis about what improvements are made.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because risks were not always assessed. Action was not always taken to mitigate identified risks. Staff providing care or treatment did not always have the skills or competence to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did were not effective in assessing, monitoring and improving the quality of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed by the service provider in the provision of a regulated activity.