Haydn-Barlow Care Limited

Holmfield Nursing Home

Inspection report

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19 January 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 18 and 19 January 2016. The visit was unannounced on 18 January 2016 and we informed the provider we would return on 19 January 2016.

Holmfield Nursing Home provides accommodation, personal care support and nursing care to up to 22 older people living with health care conditions and / or physical frailty due to older age. At the time of the inspection 21 people lived at the home.

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 this inspection the home did not had a registered manager in post. The provider had appointed numerous managers at the home but there had been no registered manager since February 2013. A new manager had commenced employment in November 2015 and, in January 2016, had submitted their application to become registered with us.

At our previous inspection in July 2014 we found concerns with the maintenance of records. During this inspection we found no progress had been made to address the issues. We found further concerns with records, such as people's food and drink charts did not reflect their identified needs had been met.

We found people had their prescribed medicines available to them, however, we saw medicines were not safely managed by staff. For example, 'homely remedies' available for people's use were out of date and we found out of date prescribed food supplements. We could not be sure people always had creams applied as prescribed because records were incomplete. We also found medicines were not always stored securely.

Some risks associated with people's care had not been assessed and no action had been taken to ensure people were protected from harm or injury. Staff told us there were not sufficient staff on shift. We found care staff were allocated non-care tasks to complete such as kitchen and laundry tasks that took them away from keeping people safe and meeting their needs.

We found the storage arrangements of some items, such as prescribed dressings, were not suitable and presented a risk of contamination or infection. Some areas of the home were in need of maintenance. For example, we found some wooden window frames were rotten which allowed cold drafts into people's bedrooms and prevented effective cleaning.

Staff had completed some training to deliver care and support but they felt it was not always effective in giving them the skills or knowledge they needed to undertake their roles. Staff had a limited knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This meant some staff were not aware of their responsibilities under this Act. Staff did not consistently offer people choices about their food.

People identified at risk of malnutrition, did not always have the extra calories added to their food as required because items were not always available to staff. People were not consistently supported to maintain their health and were not always referred to health professionals when needed.

Staff had a caring approach to people and were kind and compassionate, but staff spoken with felt care was 'task-led' at times because of time constraints. People were treated with dignity and respect, but were not routinely supported to express their views or involved in making choices or decisions about their care.

Overall, staff knew people's needs, however, people's care plans did not always contain the information for staff to refer to if needed. There were limited social activities offered which did not meet people's needs.

Some systems were in place to assess the quality of the service provided but these were not effective. We found there was insufficient oversight, from the provider, to check delegated duties had been carried out effectively.

We found numerous 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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People had their prescribed medicines available to them but a safe management of medicines was not followed by staff. Not all risks associated with people's care had been assessed and actions put into place to reduce the risk of harm. The provider had not always completed or updated the required pre-employment checks to ensure staff were of good character. There were risks of infection to some items because storage arrangements were not suitable. The premises was in need of some maintenance to ensure a safe and secure environment for people to live in.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had completed some training to deliver care and support but they felt it was not always effective in giving them the skills or knowledge they needed to undertake their roles. Staff had a limited knowledge of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were not consistently offered choices with meals and were not consistently supported to maintain their health or referred to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives told us that staff were kind and caring towards them or their family member, and we observed examples of this. People were not routinely supported to express their views or involved in making choices or decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was personalised to

them. People's care plans were not always detailed to support staff in delivering care in accordance with people's needs and preferences. There were limited opportunities for people to pursue their hobbies, interests or engage in social interaction.

Is the service well-led?

Inadequate

The service was not well led.

The provider had some systems in place to monitor the quality of the service provided but had not ensured these were effective. This meant there were a number of shortfalls in relation to the service people received and actions had not been taken to drive improvement.

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 18 and 19 January 2016. The visit was unannounced on 18 January 2016 and we told the provider we would return on 19 January 2016. The inspection was carried out by two inspectors on both days.

We reviewed the information we held about the service. This included information shared with us by the local authority and notifications received from the provider, for example, safeguarding alerts. A notification is information about important events which the provider is required to send to us by law.

A few people living at the home were not able to verbally communicate to us about how they were cared for. However, we used the short observational framework tool (SOFI) to help us assess if people's needs were appropriately met and if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who, due to their frailty or health conditions, could not talk with us.

We spoke with ten people and spent time with other people in the home. We spoke with six relatives who told us about their experiences of using the service. We spoke with staff on duty including 12 staff, the cook, the maintenance staff member, the deputy manager, the manager and the provider. We spent time with care staff and observed them offering care and support in communal areas of the home.

We reviewed a range of records, these included care records for five people, six people's medicine administration records and nine people's food and drink records. We reviewed four staff induction, training, support and employment records, quality assurance audits and minutes of staff team meetings. We looked at health and safety checks and maintenance records for equipment and the home.

Inadequate

Is the service safe?

Our findings

We looked at the management of people's prescribed medicines and found medicines were not always stored safely and securely. On day one of our inspection we found the medication room door had been left propped open by a fire extinguisher. There were no staff about, so we raised this with the manager. They told us, "That should not happen." On day two of our inspection, we found the same issue with the medication door left open and unattended by staff. There was a quantity of unwanted medicines stacked in crates on the floor just inside the open door and 'homely remedies,' which are medicines people can take without a prescription, were stored on top of the locked medicine trolley. There were medicines stored in the unlocked medication fridge and medicines prescribed for one person, who had passed away, were stored on top of the fridge. These medicines were accessible to everyone because the medicine room was left unlocked and unattended.

One nurse told us the unwanted medicines should have been put into special secure plastic medicine bins. They said, "The medicines have all been there about four days, we just haven't had time to do the job yet." We asked when the unwanted medicines were due to be collected for safe disposal, and were told by the nurse, "We'll ask them to collect them later today." However, we saw the unwanted medicines were not collected and remained where we had seen them on both days of our inspection visits. We acknowledge that a new medicine cycle had recently been delivered to the home and commenced for people, and unwanted medicines were awaiting return. However, on both days of our inspection visit we found these were not always stored securely.

Some people living at the home had been prescribed food supplements. We found these were stored on a kitchen shelving area and also stacked in a kitchen cupboard; neither storage area was secure or was being monitored for temperature. We found 33 food supplements for one person that had passed away. We discussed this with the manager and they told us, "The individual passed away over three months ago, before I started here." We found other nutritional supplements called 'calogen shots' and saw pharmacy labels had been torn off. We saw the expiry date for their safe use was over one month ago.

We looked at the arrangements in place for homely remedies. We saw a communal-stock of homely remedies was available and stored on top of the medicines trolley. However, one nurse told us, "We don't tend to use homely remedies very often." Records confirmed this to us. However, we found effective checks had not been made to ensure stock was in date. We found all of the homely medicines were out of date. For example, we found a pack of 'wind settlers' had an expiry date of November 2014 but records showed us they had been administered to one person during January 2015. We found there was no information available to nursing staff about which homely remedies people could take, or for what conditions. There was no information about the judgement used to decide whether the homely medicine was suitable for a person. We discussed our concerns with the nurse and they told us, "I'll arrange for them to be disposed of."

We looked at the medicine administration records (MAR) for six people. We saw people's medicines were available to them as prescribed. People told us they thought they were given their medicines on time. One

person told us, "The nurse gives me my medicines with my breakfast."
We observed one nurse administering people's medicines, and saw most of the time the nurse observed people taking their medicines. However, on two occasions we saw people were left with medicines to take in a communal area. This was not in line with best practice and meant the nurse could not be sure if the medicines were taken by the right person.

Some people had medicine prescribed to be given 'when required.' For example, a medicine to help with constipation or for when a person was anxious. We saw protocols for people's 'when required' medicines did not give sufficient detail to inform staff when these medicines should be given. One nurse told us, "Although the nurses here know people quite well, last month, several agency nurses were used and may not have had the information they needed if they looked at these protocols. They could be better; I just haven't had the time to do this."

Some people had prescribed creams or eye drops. We found these were not always dated upon opening; this is important as some topical medicines have a limited time of when they should be used once opened. Records staff completed for the application of creams did not reflect the prescribing instruction. For example, one person was prescribed a cream, five times a day, for their lips. We saw they had dry lips and records showed signatures had not been entered in line with the prescribing instruction. This meant we could not be sure people received their prescribed creams as required.

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

People spoken with told us they felt safe living at the home. One person told us, "I feel safe because I know I am not on my own here." We saw some risks to people's safety had been assessed. We observed staff followed actions to safely transfer people from their wheelchair to armchair using a hoist. However, we found some risks had not been assessed. For example, we observed some people had bed rails (sometimes called bed sides) in place. One staff member told us, "They are for the person's safety, so they don't fall out of bed." We found no risk assessment in their care record for the use of their bed rails and no evidence of other options having been considered, such as a lower bed. On day one of our inspection we observed two people in bed with bed rails in place without 'bumper covers' to protect them from potential injury and entrapment from the bed rails. On day two of our inspection we observed a further person in bed with bed sides in place without 'bumper covers' in place. One staff member told us, "[Person's Name] did not want us to put the 'bumper covers' on their bed side." We found no risk assessment had been completed for this person and in relation to the other people, the manager told us, "Staff should use the 'bumper covers'." Bed rails are 'medical devices', which fall under the authority of the Medicines and Healthcare Products Regulatory Agency (MHRA). We found MHRA guidance on the 'Safe Use of Bed Rails' was not being followed by the provider.

We saw portable electrical plug-in heaters were used in the home, both in communal areas and people's bedrooms. These presented a risk of fire if accidently covered and / or a risk of harm to a person if fallen onto. We asked to look at a risk assessment for their use, but we were shown a risk assessment for wall mounted storage heaters. There was no risk assessment that had been completed for the use of the portable electric plug-in heaters in the home.

Throughout day one and two of our inspection visit, we saw staff used a piece of rock to wedge open the communal lounge door. Most bedroom fire doors had plastic door wedges in place. We dicussed this with the manager and they told us, "It would be better if all the fire doors were on the magnetic holders or all had the fire door stops in place that release automatically." We found that in the event of a fire, people that lived

there, staff and visitors would not be protected by the fire doors because staff wedged some open.

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

The manager told us there were no staffing vacancies, though said they did use agency nurses and care staff to cover sickness or leave when needed, if the home's own staff did not wish to do extra shifts.

We asked people and relatives if they thought there were sufficient staff on shift to keep people safe and meet their needs. One person told us, "It varies, sometimes the staffing is good and sometimes they are short. It puts lots of pressure on them (the staff). I use my call bell and sometimes they are quick, sometimes it takes five minutes." Another person said, "They do need more staff. I ask to go to bed at 9pm, but often they can't get to me until 11pm, it's a bit late for me then." Feedback from relatives about staffing levels included the comments, "Weekly staffing is fine. It drops at weekends and bank holidays." "Weekends are a problem for staffing," and, "I think they need more staff. The ones of shift, you can see, they don't stop. They try their best, but people do have to wait."

On both days of our inspection we saw some people were supported to get up and have their breakfast late morning. At 11.00am, on day one of our inspection visit, we overheard one person complain they were still waiting for their breakfast and people sitting with them commented about staffing levels. One person said, "We all have to wait. They are too busy. I'm sure you'll get it soon." On day two of our inspection, we observed one person was supported with their breakfast at 11.30am, the person told us, "I would have got up earlier but I had to wait for staff to help me. They were busy with other people." One staff member confirmed to us that the person had been required to wait while they (staff) supported other people to get up from bed.

All staff told us they felt they did not have enough staff on shift. One staff member told us, "I try to do my best. I'd like to spend more time with people but sometimes feel it is like a conveyor belt." The deputy manager told us, "We have previously discussed staffing levels with the provider. They told us they were meeting the legal requirement." We explained that staffing levels should be determined by the needs of people living at the home. We discussed this with the manager and they told us, "I don't think there are enough staff on shift. Most people living here require two staff to support them with personal care or transfers using the hoist."

Care records showed us that 17 of the 21 people were assessed as requiring the support of two staff for personal care tasks. We found the rota did not take account of the non-care tasks that nurses and care staff undertook. For example, we saw one nurse and one care staff were on night shifts to cover 21 people living at the home; over the two floors, and also undertook other tasks such as vegetable preparation in the kitchen, kitchen cleaning and laundry tasks including ironing people's clothing. We observed staff on the day shift were also responsible for non-care tasks such as people's laundry. The rota did not reflect the time staff spent on non-care tasks and the impact on people's care needs had not been considered by the provider. The provider informed us that they had, in 2014, increased care staff numbers by one staff member on morning and afternoon shifts to meet people's needs.

Staff meeting minutes recorded that some staff had raised concerns about a lack of time to undertake tasks. For example, we saw one kitchen staff member had reported they did not have the time to complete kitchen cleaning, ask people what they would like for lunch or offer people drinks from the 'tea trolley' during the morning as well as complete meal preparation. We saw the manager had reminded other staff to complete the tasks discussed. However, from our observations, we found this had not resolved the issue. One nurse

told us, "I see the care staff are so busy and need help to assist people to get up during the morning, but then I get behind with administering medication for example."

Most staff told us they recalled having an interview and checks being made to make sure they were of good character before they started their employment. However, one staff member said they did not have an interview or any checks. We looked at two staff employment records for new staff members that had just commenced their induction at the home. We found one new staff member's Disclosure and Barring Service (DBS) certificate was dated April 2014 and from previous employment. We discussed this with the manager and provider and they told us the staff member would not be working with people until their new DBS had been received. We looked at a further two staff employment records and saw one staff member had started work before their DBS had been received. The other staff member had not had a DBS check undertaken by the provider when they returned to work at the home after a gap of over two years. We saw their last DBS record was dated 2011. We found the provider had no system in place for updating DBS checks on existing staff members to ensure they remained of good character to work with people. The DBS is an organisation that holds details about people's criminal records.

We identified some concerns with infection control issues in the home. We saw the medicine room was carpeted and was visibly dirty and felt sticky underfoot. Most areas of the floor were used to store items, making effective cleaning difficult. We observed flies in the windowless medicine room. There was a risk of items, such as medicine pots, being contaminated by flies and dust.

We found a 'sharps box'; a special disposal container for used blood sugar testing lancets and injection needles, was stored on a ground floor window sill in one person's bedroom. We discussed this with the manager and they said, "It should not be stored there. I saw it last week and told the nurses. I'll remove it." The storage arrangement presented a risk of potential harm to people.

We saw boxes of prescribed nutritional bags of 'food' for people with a percutaneous endoscopic gastrostomy (PEG) in place, stored on a concrete floor in an unheated out-building. PEG is a medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. The manufacturer's guidance states the product should be stored at a 'cool temperature.' On day one of our inspection, the outside temperature was 1 degree Celsius. The storage arrangement presented a risk of contamination or infection and a risk of freezing a product that was not suitable for freezing. Temperatures in the out-building were not monitored. We saw further prescribed nutritional 'food' stored on the floor in one person's bedroom. This prevented effective cleaning and we saw this had led to a build-up of dust on parts of the floor in the person's bedroom.

We found that clinical items, such as prescribed dressings and items for catheters, were not stored in an appropriate environment that protected them from the risk of contamination. For example, in open boxes on bedroom window sills against visibly dusty areas, such as curtains an in a cupboard in a shared en-suite for two people, along with communal use board games. We discussed this with the manager and they told us, "I wasn't aware they were there. It's not really a suitable place." The provider said they would order some plastic lidded storage boxes.

We looked at the premises and equipment to check they were safe and fit for purpose and found some areas of the home were in need of maintenance. Some windows had rotting wooden frames that prevented effective cleaning and caused drafts into some people's bedrooms. We found some windows on the first floor of the home did not have window restrictors in place. Window restrictors prevent windows from being opened widely, to protect people from potential harm from falling. We discussed our concerns with the

provider and they told us they would take action to attach window restrictors, where these were missing, the day following our inspection visit and also said they would obtain a quotation to replace windows and undertake this work before the end of August 2016.

Requires Improvement

Is the service effective?

Our findings

Most staff told us they had received an induction and some training. However, all staff told us they felt the training needed to be improved upon, as most of their training was completed through 'question booklets' and they did not always have the information they needed to answer the questions. Staff said they felt frustrated by the provider's system of training because they wanted to learn and give their best to people. One staff member told us, "The quality of the training needs to be improved." Another staff member said, "Training needs to be practical, it does not work by just giving us question booklets to complete. We don't know if we are right or wrong. We rely on previous training from other employers and help each other." Although staff did not always feel they had the knowledge or skills to meet people's needs effectively, most people felt staff skills met their needs. One person told us, "The staff are lovely, they always help me with things I can't manage myself."

Some staff told us they had completed a question booklet on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), but others said they did not recall any training. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. A few staff thought people required a DoLS when they declined support with personal care, though agreed people had mental capacity and were making a choice. Most staff told us they felt they needed further training to understand the MCA and DoLS. Although staff said they would not force people to do things and tried to give people choices whenever possible. We found staff had a limited knowledge of the principles of the MCA and DoLS and were unclear about their responsibilities.

The manager told us everyone that lived at the home had mental capacity but one person had a DoLS in place, although some staff were not aware of this. The manager said further DoLS applications had been made, by the previous manager, for everyone that lived there. We discussed this with the manager and provider and were told guidance from an external agency had been followed by the previous manager. However, both the manager and provider agreed that people at the home may in fact not require their DoLS application to be pursued because their liberty was not being restricted in any way. This showed us the provider did not fully understand the legislation.

We could not be sure people were always offered sufficient food and drink to meet their needs. For example, one person's food and drink chart recorded they had refused what had been offered to them at breakfast, lunchtime and evening on day one of our inspection. The chart did not record any alternative had been offered to the person by staff. We saw the person's care record stated they needed to be offered a drink 'every hour' but their chart did not reflect this and recorded only 400mls had been given. We saw other people's food and drink charts had gaps so we could not be sure of what they had been offered. We found there was no effective check of people's food and drink records

We received mixed feedback from people when we asked them about their meals; the choices they had and the support they received from staff if needed. One person told us, "The food is lovely." Another person said, "I do get a choice." However, other people told us they did not have a choice, one person commented, "No choice, they just bring food to me in my room. I have diabetic meals and the puddings are boring, no choice." Another person said, "I think they do as well as they can with food. It's not always what I like. They don't ask me what I'd like all the time." A further person said, "Today I didn't like the lunchtime meal so staff gave me some bread and butter." We observed staff offered choices to people, such as what cereal they would like, but saw staff were inconsistent in offering people a choice at lunchtime. One staff member told us, "We try to give choices where possible, but can't cook lots of extra as that would mean wasting food. We try to offer supper, such as toast or crumpets." However, none of the people spoken with could recall being offered snacks or supper. We found people were not consistently offered choices at mealtimes and did not know what was on the menu for the day and had not always been involved in planning menus.

People told us they always received support from staff with their meals if needed, though sometimes had to wait. We observed one person was supported with their breakfast late morning (at 11.30am). A staff member told us this was because they had only just supported the person to get up because they had been supporting other people. One staff member told us, "We do our best to help people to get up and have breakfast, but it takes time. I won't rush people." We saw staff supported people to enjoy their meal, asking them if it was nice and took the time people needed to eat their meal.

A few people told us they would like their meals to be warmer. We observed meals were served hot but were taken, uncovered, to some people in their bedrooms. We discussed this with the cook and they told us, "I have no plate covers available. I'll use foil to try to keep people's food hot." On day two of our inspection we saw this was done.

People told us they felt they were offered enough to drink. We saw some people had accessible drinks, such as a beaker of squash on a table next to them and other people did not. Staff explained this was because some people needed support and were offered drinks from staff. We saw people were offered a choice of drinks in the communal lounge at set times during the day.

Care records told us some people were assessed as being at risk of malnutrition and / or dehydration. The cook showed us their information about people that needed extra calories added to their meals. However, we saw the information was not up to date and did not include one person identified as being at risk. We found the cook had the knowledge of how to (fortify) add extra calories to people's food but did not have the resources, such as cream and butter, to do so. The cook told us they often ran out of such products or did not receive them at all in the weekly food delivery. We discussed this with the manager and they told us, "The cook and I send a list to the operations manager who orders the weekly food delivery. But, we don't always get what we ask for, or it might run out. I have raised issues, such as being sent low fat yogurts instead of full fat ones. But, the issue reoccurs." Following our inspection visit, the provider told us 'clover' was stocked to fortify people's meals when needed. We acknowledge 'clover' was available for the cook to use. The provider told us they would ensure stocks of cream and butter were also available so people's meals could be fortified.

We observed snacks were not offered to people. The cook told us, "We don't do snacks in between meals here, but if someone asked for a biscuit, they could have one." We looked at the weight records of people identified as at risk of malnutrition. We saw their weights were overall, stable but had been identified as 'low' and in need of extra calories. We found meals were not 'fortified' as needed and snacks were not offered to people.

Relatives spoken with felt confident that staff would ask for a GP visit if their family member was unwell. One relative said, "The staff would call the doctor if needed. They are not neglected." Care staff told us if they thought someone was unwell they would tell the nurse. One nurse told us, "I'd check someone and call the GP if needed." We asked one nurse if people's medicines were reviewed by their GP and they said, "We are a bit behind with them and will be arranging them again."

Care records showed that some referrals to healthcare professionals had been made when needed, such as to dieticians. However, we observed one person coughed a lot when eating their meals. We saw their care record described them as 'at risk of choking'. Although risks had been assessed by staff we found no consideration had been given to making a referral to speech and language therapists for further guidance. This meant people were not consistently referred to healthcare professionals when needed.

We saw another person's feet had not been attended to and saw their nails were overgrown and cutting into their skin. One staff member said, "I don't think they've had a chiropody visit for well over a year." We discussed this with the manager and found that although they were aware, no action had been taken. We informed the manager of our concern and that we would take this further as a safeguarding concern if no action was taken to address the person's immediate and on-going needs. On day two of our visit we saw action had been taken to arrange a chiropody visit and future visits.

Requires Improvement

Is the service caring?

Our findings

We observed some kind, respectful and friendly interactions between staff and people living in the home. People felt staff were caring toward them, one person said, "I feel listened to and respected." Relatives told us they felt their family member was well cared for by staff and comments to us included, "The staff are really caring," "I've been thrilled with the care and the way the staff are with my family member," and "We're surprised how well [Person's Name] has settled here, they love it. They know all of the staff names." Relatives said they had no concerns about the caring approach of staff.

Staff told us they tried to develop caring relationships with people and we observed examples of this. For example, we saw one staff member comfort one person when they became upset. We heard staff talk appropriately to people and listen to them. One staff member told us, "I really want to be able to spend more time with people, we all do our best to be caring but sometimes people would like us to talk more with them, but once a task is completed we have to move onto something else. One person calls us because she wants some company but we can only give a minute because of the other jobs we have to do. More staff would enable us to be less like a conveyer belt here." Although we saw a task-led approach in the home, staff always had a caring approach toward people.

People we spoke with could not recall being involved in decisions about their care, although a few told us they thought their relative was. Some people told us the staff asked them if they were okay but could not recall management seeking their views. Staff told us that if people raised a concern with them they would tell the manager or provider. One staff member told us, "[Person's Name] told me they were not happy with some things (dressing packs) stored in their cupboard or on their window sill. I did mention this for them, but I don't think it changed."

Staff knew how to maintain people's privacy with personal care tasks. One staff member said, "We make sure the curtains are drawn to and the door is closed if we are supporting a person with personal care." One person told us, "Staff generally knock on my door before they come in. Some forget sometimes." We observed most staff knocked on people's bedrooms doors before entering.

People told us they felt staff respected their dignity. We observed staff maintain people's dignity, by placing a blanket over their legs, when they transferred them from their armchair to wheelchair using a hoist.

Requires Improvement

Is the service responsive?

Our findings

We asked people if staff were responsive to their needs and people said staff were but most felt there were not always enough staff. One person told us, "In our bedrooms we have buzzers so we can get staff if we need them. They do come but sometimes say they will have to come back when they have finished something else. I'd say generally they do come back." Another person said, "Here in this lounge, we just have to wait for staff to appear if we need something, there are no buzzers." We saw the communal lounge had a call point on the wall but no cord attached to it. However, people were not aware of the call point and we saw most people would not have been able to access it. We observed periods of time of up to twenty minutes when there were no care staff in communal areas which meant people were unable to call staff if needed.

Care records contained an initial assessment of people's needs although this did not always show people or their relatives had been involved in planning their care. None of the care records looked at contained information about a person's life history, preferences or wishes. However, one relative told us, "Staff gave us a 'life history' form to complete." Of the care records looked at, none contained information about a person's 'life history'. We discussed this with the manager and they told us, "Since starting here, I've been trying to work on the care plans and information in them."

People's care needs were identified in a care plan, but we found these lacked detail. For example, we saw one person's care record said "[Person's Name] can be aggressive. Staff to be aware" but provided no guidance to staff about how to respond to any behaviour they found challenging. Overall, staff were able to tell us about people's needs. One staff member said, "We get to know people and what they need, but their care plan does not always tell us. I know the manager is working on them." Staff told us they felt they did not always have the information from care plans or training to effectively respond to people's needs.

Some people's care plans were confusing, for example, one person's care plan identified that the person was 'nil by mouth' in one section, but in another part of their care plan it said they ate soft food. Although staff explained to us this meant they had to assess 'if it was a good day' we found no guidance for staff about how they should assess this to ensure safe and consistent care. New staff or agency staff would not have the information or guidance they needed to refer to.

We looked at care plans to see how people's specific health care needs were identified and monitored. We saw one person's care record showed their blood pressure needed to be monitored. However, there was no guidance as to what it should be for the person. We saw some people were diabetic and had their blood sugar levels monitored. However, we found there was no guidance as to what the desired range should be. We discussed this with the nurse on shift and they were able to tell us the desired ranges and when they would ask for the GP to attend. However, we saw only one nurse was on shift at any time and where agency nurses were used on shift, we found information was not in people's care records to be referred to.

Most people told us they felt there were not enough activities offered to them. One person said, "We used to have an activities staff member or people come in but that all stopped. Now it is just the television really. It

gets boring."

We asked people if they were offered trips out to places. One person said, "I've been here four years and have only been out once." Another person said, "I think I've only been out once in a year. I'd like to go to a garden centre just for a cup of tea. That would be nice." We saw the provider's guide about Holmfield described a 'dedicated activities co-coordinator who provided a range of daily leisure activities'. On day one of our inspection there were no activities offered to people and on day two we saw one person had their nails manicured. Staff told us they would like to be able to offer group activities to people. One staff member said, "We are meant to try to do activities for people in the afternoon, but we also have to do the drinks trolley, support people with drinks, help with personal care and get the teatime sandwiches ready plus wash up and clean the kitchen and keep up with the laundry. It is hard for us to fit in activities as well."

We discussed this with the provider and they told us the activities staff member had left in 2013. They said, "I did not replace the activities staff member, but increased care staff numbers on the afternoon shift from two to three carers plus the nurse. Care staff should, and do, offer activities in the afternoons, but we find most people want to sit. I brought the small table top football game and there are board games."

One person told us, "I enjoy doing jigsaws and use this space (the conservatory). I like it in here." Another person told us, "I like to listen to music but the television is on all the time." We saw people's care records did not give any information about how people liked to spend their time or what interests they had. Overall we found most people were not asked what they would like to do. We found people were not always supported to follow their interests and daily activities did not take place as suggested in the homes' brochure.

We asked people and relatives about what they would do if they wanted to raise a concern or were unhappy about an aspect of the home. Relatives told us they would tell a staff member or complain to the manager if they felt they needed to. Overall relatives told us they had no complaints. One relative said, "I've no complaints. I'm happy my family member is here." A few relatives told us they felt a more staff would be 'useful.' One relative told us, "My family member was promised a new carpet last year and has now been waiting five months. We have raised it but nothing has been done yet." We saw details of how to make a complaint to the provider were displayed on a notice board.

Inadequate

Is the service well-led?

Our findings

The manager informed us they had submitted their application to become registered with us in early January 2016. The manager was waiting for an interview date to assess their suitability to become registered as manager of the home. Overall, staff were positive about having a new manager at the home. One care worker told us, "The manager is approachable." Another care worker said, "The new manager seems nice and listens to us, but I'm not sure how much they can do to change things. It's early days."

Nurses, however, had some concern about their clinical support or guidance that might be needed on a day to day basis. One nurse said, "A senior care worker has, last month, been promoted to deputy manager and we have a new manager in place; both are approachable but neither have a nursing background." We discussed this concern with the provider and they told us, "I have promoted one of the nurses to the role of 'clinical lead nurse, they will be responsible for supporting nurses with clinical issues.' However, the clinical lead nurse told us no discussion had, as yet, taken place about their own support. We discussed this with the provider and they said, "It is a new role, so nothing is in place yet. We could buy someone in to give support such as a trainer or pharmacist." The clinical lead nurse said they had not been given any rota'd time to fulfil their role in providing support to nurses and no discussion had taken place about their own support needs. In creating the new 'clinical lead role' we found the provider had given consideration of nursing support needs but had not given consideration to the support needs of the nurse in the clinical lead role or time to do it. Following our inspection, the provider informed us they were considering allocating the clinical lead nurse identified hours for their role.

The provider had not completed their provider information return (PIR) to us. We discussed this with them and they told us, "If I'd received it, I would have sent it back completed." We looked into why they had not received their PIR and found the provider had changed their email address several months ago and had not notified us as required.

There had not been a consistent or registered manager at the home since February 2013. The registered provider had not provided sufficient oversight of the home. Staff told us the provider visited the home 'about once a week' and an operations manager also visited 'at least once a month and sometimes more often'. The provider told us they operations manager visited the home on a weekly basis. Audits to monitor the quality of the service provided were ineffective as we found a number of examples which had not been identified by management of the provider from their own audit processes. The operations manager had completed the home's annual audit in September 2015 and had scored the home at 94.14%. We found areas that required improvement that had not been identified in their audit. For example, issues with infection control, medication and the overall maintenance and safety of the home. We found no improvement had been made to people's personal records and other records following concerns we identified at our last inspection in July 2014.

We discussed the arrangements that were in place for ordering food with the manager. They told us, "The operations manager orders the food. The only involvement the cook and I have is to send a weekly list to them. Although we have identified issues, such as sometimes running out of things or ordering low fat items

such as mayonnaise and yogurts, it has not been resolved." The provider confirmed that the food ordering was a role undertaken by the operations manager.

The manager, who started work at the home in November 2015, told us they had completed an infection control audit in December 2015. On day one of our inspection we saw soiled incontinence pads had been placed directly into a yellow clinical waste bag which was left unsealed outside the rear door. Unused incontinence pads were stored uncovered in several areas of the home; such as on the top of storage heaters in corridors and in an out-building stored, on shelves under dust and cobwebs. Although we saw that the manager's infection control audit completed in December 2015 had not identified the inappropriate incontinence pad storage arrangements, the manager told us they noticed unsealed clinical waste bags outside the rear door. The manager said they had verbally informed staff not to leave the open clinical waste bags outside the rear door, but we found staff continued the poor practice, which presented risks of infection. Although we pointed out these issues to the manager on day one of our inspection, we found the same issues on day two.

Arrangements in place for medication checks but were not effective. The medication audit for December 2015 consisted of a medication quantity check for people but had not identified issues we found. For example, the out of date homely remedies on the medication trolley which one nurse told us were available for people's use. Stocks of unwanted medicines stored in insecure boxes instead of been placed in the secure medicine bins for safe disposal that were available; some of which would have been there in December 2015 because they were for a person that had passed away. We saw a pharmacy advice visit had taken place in June 2015 that had identified some of the same issues we found. This showed no action had been taken by the provider to improve.

Arrangements in place for checking health and safety were not effective, for example, we found window restrictors were not always in place where required. Window restrictors prevent windows being opened widely and being a potential risk of harm to people. We saw water temperature checks in some people's shared en-suite and shower facilities were recorded above the recommended temperature, of 41 degrees celsius, for safe hot water use in care homes. We discussed this with the maintenance staff member and they told us they had taken the same readings over the past four months and thought some hot water was too hot at 55 degrees, for example. They told us they had verbally informed the provider of this but were not aware of any action taken. We discussed this with the provider and they told us a company had installed water thermostatic regulators so there should be no problem. The provider should have checked and ensured the thermostatic regulators were working, so that the risk of scalding to people was prevented.

We looked at the home exterior and interior audits, dated 9 December 2015. The exterior home audit recorded a leak on a flat roof and noted felt had been 'patched' on 8 December 2015. We saw the action taken had not been effective because buckets were placed on the floor in the medication room, collecting dripping water. We were given mixed accounts of what action was planned to repair the leak by the maintenance staff member and manager. We discussed the leak with the provider, who told us they had only been made aware of the continued problem a few days ago and had arranged quotations for the repair work. Following our inspection, the provider informed us they had agreed for the work to be completed.

The home interior audit recorded everything that had been checked, such as heating, as 'satisfactory'. No problems or defects had been identified, but we were told there were problems. For example, on day one of our inspection, some people told us they were cold in the dining area and / or in their bedrooms. We saw some staff kept coats on whilst working in some areas of the home. We also felt cold in parts of the home. Some staff told us they thought the heating system was 'inadequate' in parts of the home. One staff member told us, "I've been here four years, and it's always been the same. That's why we've got the plug-in heaters.

We get them out to use over winter." The deputy manager told us additional heating was used around the home, including people's bedrooms, as the storage heaters did not always provide sufficient heating. We were concerned that inconsistencies with the heating system had not been identified on the audit. We discussed this with the provider and they told us they were not aware of any issue with the storage heaters.

The maintenance staff member told us they completed health and safety audits in the home, fire safety checks and maintenance checks. However, they told us, and records confirmed, they had not completed any health and safety or fire safety training. There was nothing to demonstrate the manager or provider checked the effectiveness of the audit delegated to staff to ensure they were an accurate assessment of the home.

Accidents and incidents were recorded but there was no evidence that these were analysed for trends and patterns or to prevent reoccurrence. We asked the deputy manager if any overall analysis of accidents and incidents took place and they told us only a summary sheet was completed that totalled the numbers of accidents and incidents, but added, "Actions might also have been taken on an individual level to make sure people are safe, but not always recorded in any analysis." The manager said, "I know that is something that will need to be done so that actions can be taken to reduce the risks of recurrent accidents. I plan to start to do that."

There was no system to check that staff training was effective and provided staff with skills and knowledge they needed for their roles. Most staff confirmed they had completed training and records confirmed this. However, all staff told us they felt most of the training provided was ineffective and left gaps in their knowledge. One staff member told us, "We have told the provider, but just got told that's what is used here."

Systems were in place to seek feedback from people and their relatives about their experiences of using the service. The deputy manager showed us the provider's response to feedback, dated May 2015, called, "You said & We did," which was displayed in the home. Although we saw some feedback had been acted upon, such as replacing worn dining room furniture, other issues had still not been fully implemented. For example, carpeting had been identified as needing to be replaced throughout the home. New vinyl flooring had replaced carpet in communal areas and most bedrooms, but we saw a few bedrooms still had visibly stained and dirty carpets. People had not been given a date for this to be completed, and we discussed this with the provider. They told us, "I've had to prioritise things due to the financial costs. It will be done during 2016."

We found other areas of the home that needed attention. For example, a number of bedrooms had rotten wooden window frames, some with gaps where wood had rotted and fallen away which meant cold air drafts entered people's bedrooms. We saw poorly maintained window panes with broken seals that had allowed rain water in, which had collected and become discoloured with time and some areas had mould growing. Staff told us these issues had been pointed out previously to the provider. One staff member told us, "The provider told us to put filler into the hole. The windows have been bad for ages." We pointed out our concerns to the provider and the potential impact of the cold air upon people in their bedrooms and infection risk. The provider stated that all the windows that required replacing would be replaced before the end of August 2016 and they would try and fill gaps in the meantime. We were concerned that timely action had not been taken to address issues of cold air drafts entering people's bedrooms.

At our previous inspection in July 2014, we found records had not been completed correctly, for example, people's medicine records. No analysis of accident or incident forms and insufficient information on staff training records. The provider had been unable to provide information to show nurses who worked at the home had a current Personal Identification Number (PIN). All nurses who practice in the UK must be

registered with the Nursing and Midwifery Council (NMC). Nurses have to pay a yearly fee and prove they fulfil the requirements of the NMC by keeping their skills and knowledge up to date. Once these requirements are met, the NMC issues nurses with a PIN.

At this inspection, we found no improvement had been made. Records relating to the administration of people prescribed variable dosages of warfarin medicine were unclear. The staff training matrix, which the manager said was a record of training undertaken, recorded some core training topics such as moving and handling but there were no details of nurse clinical training. We discussed this with the provider and they told us, "If we put everything on the electronic training matrix it will be too large. Details of nurse training are in their employment record." We looked at one nurse's employment record and saw their clinical training had been completed during their previous employment some years earlier. We asked to see the record of nurse's PINs. The manager gave us a list which showed records of all the nurse's PINs had expired; some by two years. One nurse told us, "I have updated my PIN, so it is in date." We found the provider had no system in place to check nurses had updated their PIN so that their personal file contained a current record of information. We discussed our concern about this with the provider and they told us a check would be made with the NMC. Following our inspection, we were supplied with current PIN numbers for nurses employed at the home.

We also found there was no effective audit to check staff completed people's food and drink records. This meant the provider could not be certain people were having sufficient to eat and drink.

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

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) Risks to the health and safety of service users were not always assessed or mitigated. A safe management of medicines was not followed.

The enforcement action we took:

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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 Regulation 17 (1) (2) (a) (b) (c) Systems or processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity were not effective. Risks relating to the health, safety and welfare of services users and others who may be at risk were not always assessed, monitored or mitigated. Records were not always accurate or complete.

The enforcement action we took:

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