Heritage Care Limited

Holmers House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Holmers House is a purpose-built residential home divided into three care units, each with 16 places. The service supports people who are living with dementia. One unit is on the ground floor whilst the other two units are on the first floor. At the time of our inspection there were 41 people living in the home.

The inspection of Holmers House commenced on 16 August 2017 and was unannounced. This was a scheduled inspection that followed up breaches from the previous inspection when the service was rated requires improvement. We discovered on arrival at the service that the registered manager was not currently in post and was not working at the service. We were told that this was due to the provider identifying lack of progress in working towards the action plan to address requirements from the previous inspection. The deputy manager was managing the service in their absence. We were aware that a compliance company were working with the provider to ensure improvements were made. We were told that a manager from this company would be in place at the service the week following our inspection visit.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection carried out on 31 May 2016 identified breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 and found a number of improvements were required at the service. We asked the provider to take action to make improvements in relation to the management of medicines, meeting nutritional and hydration needs, ensuring the premises were clean and carrying out care and treatment in conjunction with people's needs. The provider sent us an action plan setting out how they would take action to address the breaches in regulations.

Following this inspection, we do not consider that the service has attained compliance with regards to the previous breaches of regulations.

People using the service were not always treated with dignity and respect. We observed undignified care practices during our inspection. People's rights and choices had not always been respected.

Staffing levels were not assessed using a dependency assessment tool. Relatives told us and our observations showed that care and support was not always provided in a timely manner. We received different views from people and relatives we spoke with about the staffing levels. Some told us it was satisfactory whilst others said sometimes there was only one member of staff available. We observed staff did not identify themselves by wearing their name badges. Comments from relatives were, "none of your staff wear name tags which can cause problems identifying people."

The quality assurance systems in place were not effective. We found continued issues as part of our

inspection relating to accurate completion of records. Quality assurance systems had identified some of the issues; however it was not always clear that they had been acted upon.
A visiting professional told us simple instructions were not followed by staff. They also commented on the lack of leadership and that there did not appear to be anyone managing the units.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. Policies and systems were in place regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We observed practice on one unit which did not afford people the right to make decisions about their care.

The service had documents which were used to record food and fluid intake for people who may be at risk of dehydration and malnutrition. However, examples we reviewed were not always completed effectively. For example, some charts we viewed showed on some days people only had a total of 600ml of fluids. In addition staff had documented in one person's record, "urine was dark and cloudy", but had not referred this to the GP or taken any other action.

Staff had received training in topics such as fire safety, mental capacity and moving and handling. Staff had not received regular reviews of their performance and supervisions were not carried out on a regular basis.

People were not always safeguarded from abuse at Holmers House. Staff had received training in safeguarding and told us they knew what to do if they suspected someone was being inappropriately treated. However, this did not correspond with our inspection findings. We were made aware of inappropriate treatment of a person but staff failed to report this practice. We have made the deputy manager aware of this and investigations have commenced.

Staff had received training in the administration of medicines and were assessed as competent to carry out this role. However, we found medicines were not managed appropriately and we found some people had not received their medicines due to insufficient stock.

Health and safety checks had not identified that fire extinguishers were not in the correct place to ensure in the event of a fire staff would be able to easily access them. For example, we saw all of the fire extinguishers in one of the units were taken off the wall and placed in the corridor. We discussed this with the deputy manager who told us every time they put the extinguishers back on the wall a person who resides on the unit took them off the wall. This practice had been going on for a year. We asked the regional manager to rectify this situation with immediate effect. They said they will look into alternative ways of ensuring the person cannot remove the extinguishers from the walls. We spoke with the local fire brigade inspector following our visit who said they will visit the home to check the risks to people.

We noted that window restrictor checks had not been completed weekly as stated in the health and safety file. This had been alerted to staff on the electronic care plan system but remained incomplete. We raised this with the deputy manager. They told us they would address this with immediate effect.

Records relating to the safe use of a repose mattress had not been completed. Weekly mattress checks were incomplete. We saw several gaps in the completion of this task; from 21 June 2017 to 12 July 2017 nothing had been completed to evidence the mattress was in correct working order.

The provider failed to act on information found during the audit process. We saw some actions of audits had not been completed or signed off as completed by the relevant person.

The provider did not have robust recruitment procedures in place prior to staff commencing their employment. The files we viewed did not have proof that the member of staff had a Disclosure and Barring Service check completed (DBS). We asked for further information following our inspection.

We found people's care was task-focused and not person-centred. We observed staff took people into the lounges where they spent the day asleep in front of television sets without staff interaction. Some people we saw were walking up and down corridors for most of the day without any interaction or distraction from staff. One family member told us they had told staff they did not want their relative pacing up and down the corridor as it tired them out. The relative told us, "nothing changed."

People's or their family member's involvement in the review of care plans was not always clearly recorded. However, people we spoke with said they were happy with the service they received and that they felt safe. The service had policies and procedures in place for reporting any concerns they had about the safety of people they supported.

The majority of people and their family members told us that they knew how to raise a complaint and felt confident that the staff and management would act upon them. The service had a complaints policy and procedure in place. However, records showed that complaints had not been dealt with appropriately.

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.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

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

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.

Medicines were not always available for people.

Staff did not always report concerns when they witnessed poor care practices.

There was not always enough staff on duty to ensure people's needs were met.

Recruitment checks were not robust enough to ensure only suitable staff were appointed.

Is the service effective?

Inadequate

The service was not effective.

Fluid charts were not accurately completed, or analysed. People were not protected from the risk of dehydration.

People at risk of malnutrition did not always have their weight recorded to ensure their health did not deteriorate.

Staff had received training in topics such as fire safety, mental capacity and moving and handling. Staff had not received regular reviews of their performance and supervision meetings were not carried out on a regular basis.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not supported to have maximum choice and control of their lives.

People's dignity was not always respected.

People's confidentiality was protected. Personal information was appropriately stored.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always reviewed with people and their families.

Complaints were not always responded to in line with the provider's policy and procedures.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's quality assurance systems were not effective.

The provider had failed to identify unsafe practices. Staff felt unsupported.

The provider had notified us, as required, about incidents that had occurred at the service.

Holmers House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16 and 17 August 2017 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Prior to the inspection a Provider Information Return (PIR) had been requested and one was submitted by the provider on 7 July 2017. A PIR is a form that asks providers to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with three people who used the service, three relatives and one visiting professional. We also spoke with the deputy manager, the regional manager, and five members of staff. We received feedback from commissioners of the service prior to our inspection.

We looked throughout the home and observed care practices and people's interactions with staff. We reviewed five people's care records and the care they received. We looked at medicines administration and records relating to medicines people received. We reviewed records relating to the way the service was run such as personnel files, quality monitoring and documents associated with premises and quality monitoring audits.

Observations were from general observations and where people could not communicate with us we used the Short Observational Framework for Inspection (SOFI). SOFI is a tool to help us understand the experience of care people receive who were unable to communicate with us.

Inadequate

Is the service safe?

Our findings

At the previous inspection on 31 May 2016 the provider was found in breach of Regulation 15 and 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014. Cleaning was not carried out in line with current legislation and guidance we saw out of date food which was not fit for consumption. The provider failed to ensure there were sufficient quantities of medicines to meet people's needs. An action plan was received from the provider on 22 October 2016 informing us how the provider intended to make improvements to the service.

We found during this inspection a cleaning schedule was in place to see what areas had been cleaned and this included the kitchen. However, we found that kitchen assistants had not always completed this. We saw one entry in relation to the cleaning of the kitchen was not completed. We brought this to the attention of the kitchen assistant on duty during our inspection who confirmed some staff do not always complete the schedule. We saw the kitchen's microwave was dirty and the heated food trolley was not clean.

We were also aware that domestic staff did not always inform management when they found items in people's rooms that should be replaced and discarded. For example, one relative asked us to inspect their family member's room and note the unpleasant odour coming from the room. We inspected the room and uncovered the bed linen and saw the mattress was soaked in urine. However, the bed had been made by domestic staff who had not reported this to management. We informed the deputy manager who replaced the mattress immediately. These practices presented a risk to people using the service in terms of acquiring infections.

This was a continued breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) 2014.

We found during this inspection medicines were not managed effectively. Staff had received training in the administration of medicines and had been assessed as competent to carry out this role. However, we found medicines were not managed appropriately; some people had not received their medicines due to insufficient stock. One person had been without their regular medicine for on-going constipation for three days. This may have caused the person to suffer pain or a serious health condition.

We raised this during feedback with the deputy manager. They told us that some of the medicines had been overlooked in terms of ensuring adequate supplies were available. One person was transferred from another care home, without their medicine. We noted the person had not received their medicines for a total of seven days. The person's medicine was to reduce gastric acid and to prevent the formation of ulcers or to assist the healing where damage has already occurred. If the medicine was not taken as prescribed, pain and inflammation in the stomach could occur. We saw that on two occasions people had not received their prescribed creams for skin conditions as staff did not know where to apply them. The creams were for the treatment of fungal skin conditions. This meant people's skin condition could deteriorate further without their prescribed treatment. We saw body charts were in place in the medicines folder but had not been

completed to inform staff where the creams should be applied. During the inspection we followed up on a previous safeguarding medicine incident. The service reported to safeguarding that quantities of sedative medicines were missing. We were told this was still being investigated despite being originally reported on 12 February 2017.

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

We looked at fire safety around the service. We saw that on one of the units the fire extinguishers were removed from the walls and placed along the corridor. There were six extinguishers in total. This put people and staff at risk in the event of a fire, as the extinguishers could not easily be located. We discussed this with the deputy manager on the first day of our inspection and they told us one person who resides on the unit continually takes the fire extinguishers off the wall and places them along the wall of the corridor. We were also told sometimes the person sets the extinguishers off and this has been happening for one year. We looked at the health and safety audit which made reference to the person removing the extinguishers. The audit made no other reference in relation to what action to take in relation to the fire extinguishers. We discussed our concerns with both the deputy manager and the regional manager during feedback of our inspection. We were told the service will look into alternative ways of ensuring the safety of people living at Holmers House by having a lockable cabinet to house the extinguishers. We contacted the fire brigade following our inspection to raise our concerns. They informed us they will contact the service to assess people's safety.

We looked at people's risk assessments and care plans. We found that where people were at risk of dehydration and weight loss. Records had not been completed fully to evidence adequate fluids had been consumed and weights monitored to ensure people remained within a safe weight range to promote their health.

One person remained in bed due to their frail condition and had a repose mattress in place to reduce the risk of damage to their skin. A repose mattress is an inflatable air mattress which can be inflated to reduce the risk of pressure damage. Records relating to the safe use of the mattress had not been completed. Weekly mattress checks were incomplete. We saw several gaps in the completion of this task; from 21 June 2017 to 12 July 2017 nothing had been completed to evidence the mattress was in correct working order. We saw a total of six entries where the mattress had become deflated. The mattress may have been faulty if it had become deflated on several occasions. However, this had not been reported by staff to management to clarify if the mattress needed replacing. This meant that the provider was not doing all that they could to protect this person from the risk of developing pressure ulcers.

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

Staff members told us they had a good understanding of the different types of abuse and what action they need to take if they had concerns. Records confirmed staff had received training in safeguarding. During conversations with staff we were made aware of an incident of unsafe moving and handling practice that took place at the home which could have caused injury to the person. We were also told the person had been given food unsuitable for their condition. For example the person should have had pureed food only, as they had swallowing difficulties, but had been given a 'normal' meal which could have resulted in them choking. Two members of staff knew this unsafe practice had taken place but had failed to report this. Staff had not followed the correct reporting procedure in line with current guidance. We raised our concerns with the deputy manager and the regional manager. The management commenced investigations in relation to our concerns. This resulted in the member of staff who carried out the unsafe practice not permitted to return to the service.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at recruitment files during our inspection and found these were not in order. The provider did not have robust recruitment procedures in place prior to staff commencing their employment. The files did not have proof that the members of staff had Disclosure and Barring Service checks completed (DBS). We have requested further clarification in relation to staff files following our inspection. We have not received evidence to satisfy the shortfalls found during the inspection. In addition we were told a DBS is checked every three years but only asks staff to sign a form to confirm they have no convictions. We have not received evidence to confirm full DBS checks had been completed. However, we were told these were held at the services head office.

Discussions with people and their families confirmed and we saw that staff did their best to meet the needs of everyone on the units. Feedback we received indicated dissatisfaction with agency staff that worked at the home. We were aware the service had a high use of agency staff but they used the same agency staff where possible. We asked to see the dependency tool used for assessing staffing requirements. However, we were told this was not something the service used. We could not be sure staffing levels met the requirements of people's needs. We saw that three members of staff were on each unit; however one of them would be responsible for the administration of medicines. This would leave two staff members during this time. We spoke with a member of staff about the staffing levels and they told us, "I was on my own up here this morning until the agency staff arrived." We saw they were alone on the unit for one hour until other members of staff arrived. We saw the rota for the unit and noted that three members of staff had been allocated to work on the unit. However, staff had not arrived until later that morning. We discussed staffing levels with the deputy manager and they told us they often helped out when required. Comments we received from a member of staff were, "Sometimes it can be challenging. I don't think there are enough staff on each floor to look after service users and because of that the service users don't get a 'one to one'. Also they do not get quality attention."

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

The service had a policy and procedure in place to review and monitor accidents and incidents. Accidents and incidents reports had been completed as required when events occurred at the service.

Inadequate

Is the service effective?

Our findings

At the previous inspection on 31 May 2016 the provider was found in breach of Regulation 9 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not carried out in conjunction with people to ensure their needs were met. The service did not meet the nutritional or hydration needs of people who used the service. An action plan was received from the provider on 22 October 2016 informing us how the provider intended to make improvements to the service.

We found people were still at risk of not having their hydration or nutritional needs met. For example, we were aware some people were at risk of dehydration and had fluid charts in place for staff to complete to monitor their fluid intake. However, examples we reviewed were incomplete on some days charts showed people only had a total of 600ml of fluids. The British Dietetic Association (BDA) guidelines state that over a 24 hour period the average intake for adults including the elderly should range from 1600-2000mls. People's health was placed at risk due to lack of appropriate recording demonstrating fluid intake. These omissions had not been identified as part of the quality monitoring system and as part of the on-going checks of people's care at the service.

We saw one person's chart where staff had documented, "the urine was dark and cloudy" but had not referred this to the GP or taken any other action. Staff did not act on health issues they identified. This meant people's health may deteriorate. We noted one person had previously been admitted to hospital where it was found they were dehydrated and had to have intravenous fluids to rectify this. Staff told us they gave the person fluids but forget to document this. The person's relative told us staff did not offer their family member enough to drink. The person's relative visited on the second day of our inspection and offered their family member a large glass of water. The person drank the water eagerly and finished the whole glass. The relative said, "See what I mean?" We discussed this with the deputy manager and the regional manager. They said they will discuss with staff the importance of ensuring people had adequate fluids. We reported this issue to the local safeguarding team.

Where people were at risk of malnutrition and had a weight chart in place to monitor their weight, this was not always completed as directed by the care plan. For example, we saw one person had a low weight and the care plan advised staff to weigh the person monthly. However, we saw only one entry recorded in May 2017 and one in August 2017. This demonstrated the service did not monitor identified risks to ensure people's health did not deteriorate.

We observed meal time on the units during both days of our inspection. We saw most people sitting at the dining table enjoying their meal. A choice of meal was offered to people on the day. However, we were aware of one person sitting in the lounge area with their meal in front of them on a side table. We saw the person was asleep and was not eating their meal. The person woke up periodically and ate a spoonful of their food. Later we saw a member of staff shout to the person to wake up and eat their food. However, the person remained asleep and staff took the food away. We discussed this with the deputy manager who told us this often happened. We asked if it may be possible for the person to sit at the table with everyone else. However, we were informed the person likes to sit in the lounge for their meals. This does not demonstrate

that people were always effectively supported to eat and drink enough to maintain a balanced diet.

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

One relative we spoke with told us they felt the food was not appropriate. We were unable to clarify what the relative meant by this statement. The service did not have a chef who prepared meals but had ready meals delivered. We saw people's preference regarding their meal displayed in the dining room.

Staff told us they did not always feel supported and they "just get on with it". We saw records which confirmed supervisions did not always take place. We saw two members of senior staff had not received any supervision in 2017. During our previous inspection we were aware supervisions did not take place on a regular basis and we made a recommendation to the provider.

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

Staff identified people who required specialist input from external health care services, such as district nurses and speech and language therapists. However, records of visits including what was discussed were not always documented. We spoke with a visiting health professional and they told us the service was not always good at following advice from them when required. They told us, "From our point of view we struggle." We were told by a health professional of an example where they had asked staff to assist in assessing whether a person could pass urine independently. The health professional had removed the person's catheter and asked that the person was supported to use a commode. The health professional told staff they would return in an hours' time to see if the person had passed urine independently. However, when the health professional returned they found this request had not been carried out. This meant the person had to be re catheterised, putting the person at continued risk of having invasive procedures carried out in relation to the management of their catheter. In addition, this does not represent choice and control for the person in terms of their care and support.

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

New staff, as part of their induction, were required to shadow more experienced staff. This ensured staff were familiar with people's support needs. Competency assessments took place as part of the induction process. Once staff had been assessed as competent they were able to work on their own. Staff told us and records showed that regular training was undertaken to enable staff to meet the needs of people they supported. All staff had undertaken training in areas such as fire safety, moving and handling food hygiene. In addition further training in specified areas such as caring for a person with dementia had been completed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Policies and procedures were in place to guide staff in relation to the MCA and DoLS. Staff had completed

training in relation to the MCA and demonstrated an awareness of the act. However, we saw this was not always followed. For example, people did not always have choice and control over their day to day routines. Where decisions had been required to be made we could see evidence that formal capacity assessments and best interest meetings took place with relevant parties.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had submitted applications to the local authority last year for a number of people who used the service. The service was waiting to hear the outcome of some of these applications.

Requires Improvement

Is the service caring?

Our findings

We did not find staff were always caring in their approach to people and people's dignity was not always maintained. We saw an example of one person being persuaded to do something they clearly did not want to do. We observed during one morning of our inspection staff entering the lounge with scales as it was 'weighing day'. One person was assisted by two members of staff out of their chair and on to the scales. The person demonstrated they did not want to be weighed by shouting at staff saying, "No, no, I don't want to." However, the staff were task-focused and ignored the person's refusal. Another member of staff who was situated at the rear of the room shouted "stand him up." The person was weighed and was assisted back in the chair they were originally sitting in. We raised this with the deputy manager and the regional manager who confirmed that they would take action to address this undignified practice immediately.

Another example we saw of when people did not have their dignity respected was when one person walked along the corridor with their trousers rolled up to their knees and their urine catheter bag visible. We saw that staff assisted the person to enter the lounge for activities but had not noticed the way the person was dressed. We asked staff to adjust the person's clothing to preserve their dignity. Another observation of people's dignity not being respected was during lunch time. We saw one person sitting in a lounge chair with their urine catheter bag resting on the carpet. However, a member of staff rectified this when they became aware of this. We raised these incidents with the deputy manager and the regional manager during our feedback. They said they would take action and discuss this with staff.

We were aware of one person transferred to another service in an unkempt state. We were given this information from the registered manager at the service. We discussed this with the interim manager at Holmers House who said they are investigating how this happened. We were aware the new service had submitted safeguarding alert following this incident.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service used an area located on the first floor to hang people's clothes. We saw a large rail where people's clothes were hung prior to them being taken to people's rooms. This did not constitute respect for people's privacy.

We asked staff how they respected people's privacy. They told us they would always knock on people's doors before entering. There was evidence that people had the opportunity to have personal effects around them, which included pictures and items of furniture.

Notice boards in the main foyer of the home provided information for people and their relatives. Information included activities taking place, how to safeguard people and the complaints procedure. People who used the service had been provided with information at the start of their stay about standards they should expect and other key pieces of information such as how to make a complaint. Records containing people's personal information were kept secure in a locked office ensuring confidentiality was protected.

Requires Improvement

Is the service responsive?

Our findings

One relative told us on the second day of our inspection, "It [the care provided] seems so lackadaisical, and most of them [staff] don't care. I have told them [my loved one] is not to be marched up and down the corridor, but it is still happening." The relative was referring to another person living on the unit continually encouraging the relative's family member to walk up and down the corridor. We were aware the relative had requested on several occasions that this does not happen. However, we observed this still took place. We saw the person being walked up and down the corridor on both days of our inspection. We spoke with the deputy manager about this and they told us the staff had been told to intervene when they see this happening. However, we were aware the service had made arrangements for the person to be moved to another service as they were unable to meet their needs.

Through our discussions with staff most were able to describe people's routines, personal preferences and support needs. Care plans covered people's identified needs such as personal care and managing medicines. The service used a document called 'life history', this was information relating to the person's past life. We reviewed information relating to people's previous life and found that records contained limited information and some people's life history was not completed at all. This demonstrated the service did not always record people's previous backgrounds to give a picture of them as an individual. This did not demonstrate the service carried out individualised care planning.

Care plan reviews did not always take place with people and their families. One relative we spoke with told us they had a care plan review when their family member was first admitted to the service, but have not been involved in one since. Another relative told us their family member had not been involved in formulating their care plan. We asked to see evidence of reviews that took place with people and their families. However, staff confirmed this was not taking place. We were aware of a residents' meeting that had been held following our inspection.

The service had an activity coordinator providing activities for people. We observed activities taking place on both days of our inspection. We saw an activity board on display in the reception area of the service displaying what activities were taking place throughout the week. The service also arranged trips out in a minibus to local areas. In addition, outside entertainers visited the service such as local school children who sang to people living at Holmers House.

The service had a Chaplin who visited weekly to offer communion for people who requested this. Priests from local Catholic churches visit to offer prayers and communion at people's request.

Most people told us they knew how to make a complaint. Families told us they were aware of the complaints procedure. Complaints were responded to either verbally through a telephone conversation or in writing depending on the complainant's preference. The service had received one complaint this year which had not been resolved and according to the complaints folder we viewed was still not resolved. There was no evidence the complainant had been satisfied with the response following the complaint. This is not in line with the provider's policy and procedure which stated complaints should be resolved and responded to

within a 28-day timeframe. We noted the complaint was in relation to the cleanliness of their relative's room, the care plan not up to date, a broken television and the approach of staff members towards the relative. We made reference to the outstanding complaint with the deputy manager who acknowledged this was something the registered manager would have been responsible for. However, due to present circumstances the deputy manager told us they will look into the on-going complaint.

Inadequate

Is the service well-led?

Our findings

During our inspection the registered manager was not managing the service. The service was being managed by the deputy manager. The provider had become aware that the action plan from our previous inspection had not been completed. This resulted in the absence of the registered manager. The provider had made arrangements for a compliance consultancy company to work with the service to enable improvements to be made.

We identified during this inspection that effective systems and processes were not in place to monitor and improve the quality and safety of the service. Audits completed at the service did not capture all of the issues we identified as part of our inspection. Where audits had identified outstanding issues from prior months, we saw that these were still not actioned. For example, we found the service had identified issues with medicines safety. However, actions that included updating 'as required' medicines risk assessments and updating signatures for staff who administer medicines were not completed. We noted that window restrictor checks had not been completed weekly as stated in the health and safety file. This had been alerted for staff to complete on the electronic care plan system but remained outstanding. We raised this with the acting manager. They told us they will address this with immediate effect.

We also found the service failed to ensure the malnutrition tool reflected people's current care plans. We noted that none of the audits we viewed had been signed off by the registered manager or the regional manager. On-going concerns related to the accurate recording of weight and fluid charts for people who were at risk of dehydration and malnutrition were also not identified by the provider. Records related to checking of a pressure mattress for people at risk of developing pressure areas were not adequately maintained. This demonstrated the provider's internal audit system was not effective. Safety and quality systems in place to protect people from risk and harm had failed.

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

The culture, leadership and management of the service did not ensure transparency and openness. The provider had not developed the staff team to make sure they displayed the correct values and behaviours towards people they supported. Safeguarding matters were not always reported to ensure people were protected. Staff told us they did not feel they worked in a supportive environment. This could have a direct impact on people using the service. We were aware inappropriate care practices had not been reported by staff to keep people safe.

Staff told us management were too authoritative in their approach which made them feel uneasy. They went on to say they did not get support from management. One member of staff said, "This home needs fresh ideas. They are stuck in their ways."

The local authority raised some concerns with us regarding the service, which we followed up during our inspection. They were working with the provider to ensure improvements were made. The recently appointed regional manager had acknowledged our concerns following our inspection and was in the

process of addressing these. We received an action plan following our inspection to address the concerns raised.

Residents' and relatives' meetings had not been taking place, but we were aware meetings had commenced and we noted a meeting had taken place following our inspection.

People and those important to them had opportunities to feed back their views about the quality of the service they received. The service sent out surveys to people who used the service annually. Results showed that the majority of people were happy with the care they received. However, some people said staff do not wear name badges to identify themselves and it was difficult to know who the staff were. We saw on the first day of our visit staff did not wear name badges to identify themselves.

We noted that no follow up from the survey received in 2016 had been carried out in relation to issues raised by people and their families.

The service had notified us of significant events which had occurred, in line with the relevant regulations. We were aware that measures were being put in place to improve the management of the service. We were told about a programme for the development of leadership, process and culture the service will be involved in in due course.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment did not meet people's needs.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed appropriately. Some people had not received their medicines due to insufficient stock. People were place at risk of developing pressure sores. Pressure mattress checks were not robust. Fire safety checks were not completed effectively to ensure people were protected in the event of a fire.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected against abuse and improper treatment

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people were not met.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not maintained to acceptable standards of hygiene. Some foods were not fit for consumption.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to monitor and improve the quality and safety of the service.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive appropriate support and supervision to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

We imposed a condition on the provider's registration.