Care Expertise Group Limited

Holmwood Nursing Home

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

Summary of findings

Overall summary

Holmwood Nursing Home provides nursing and care for up to 48 people most of whom are living with dementia. Care and support are provided over two floors. Each bedroom has en-suite toilet and washing facilities. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were 38 people living at the service at the time of our inspection.

There was 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 2008 and associated Regulations about how the service is run. The registered manager was present during the inspection.

This unannounced inspection took place on 3 September 2018. At the last inspection we identified breaches of regulations as risks to people were not always managed and some areas of the service smelled. There were not always enough staff deployed to meet people's needs and the quality assurance processes had not been effective at ensuring people received good quality care. At this inspection we found that the safety and quality of the service had deteriorated.

There were not enough staff to safely meet people's needs which affected all areas of care delivery. Relatives told us that weekends were affected the most however we saw, and staff told us, there were not enough staff working. Safe staffing levels based on the provider's dependency tool had not been maintained for 27 out of 28 days over a four-week period. Infection control practices were poor which placed people at risk. People's rooms were dirty and the smell of urine was noticeable throughout the service. Equipment such as hoists were also dirty, the lift had not been working for a month and the premises required improvement.

Risks to people were not always acted upon or reduced to keep them safe. People who were nursed in bed had their pressure mattresses on the wrong setting and were not always re-positioned when they should be. Lessons were not always learned when things went wrong as accidents and incidents were not analysed for patterns or trends. People were not protected from the risk of abuse as safeguarding incidents were not reported appropriately to the local authority. Medicines management required improvement in some areas however medicines were stored and disposed of appropriately.

Staff did not always follow safe moving and handling procedures and training in mandatory areas was not always completed. This affected the quality of care people received. Mealtimes for people were a poor experience as there were limited food choices available. People's specific dietary requirements were not always followed.

The principles of the Mental Capacity Act 2005 (MCA) was not always followed. Decisions were not always being made lawfully or in people's best interests. The design and adaptation of the premises did not meet

people's needs. People living with dementia would not be able to orientate themselves as there was inadequate signage to guide them. There were duplicate numbers or no numbers on people's bedrooms, which made it confusing for people to find their bedrooms. Outcomes for people were not always positive although people had access to healthcare professionals to help maintain good health.

People were not living in a dignified manner. The lack of staff and problems with the environment contributed to a service that was not caring. Staff did not always treat people well or with kindness and respect. People's privacy and dignity was not maintained and they were not able to express their views about the care they received. There were instances when people were treated well by staff who were able to take time to reassure and help them appropriately.

People who were nursed in bed did not have meaningful activities provided and were at risk of social isolation. For people who could communicate, some activities were provided on the day of the inspection, however for others who could not communicate there were limited things for them to do. Care plans were not person-centred and were not always completed fully. The care plans focused on people's medical needs and did not give information on people's likes, dislikes or their personalities. People who were approaching the end of their life did not have information for staff to follow as some advance care plans were not completed.

There was a lack of leadership and direction at the service which affected people's care and meant staff were not supported or monitored. The provider was not meeting its organisational aims and objectives which affected the quality of care people received. Quality assurance processes were not effective at identifying areas for improvement. Complaints were recorded about various issues such as the smell of urine and missing laundry. These were not always responded to or resolved appropriately.

Areas of concern had not been addressed despite these being raised by the local authority. People, relatives and staff were not always involved in how the service was run. The service did not work in partnership with other agencies. Important events were not always notified to CQC.

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.

During the inspection we found 10 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one, continued breach of the Care Quality Commission (Registration) Regulations 2009. 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.

Safe staffing levels were not being maintained which placed people at risk.

Infection control practices were poor. The service was dirty, smelled of urine and required a thorough clean. Equipment was also dirty and the maintenance of the environment required improvement.

Risks to people were not always acted upon or reduced to keep them safe. Lessons were not always learned when things went wrong.

People were not protected from the risk of abuse as safeguarding incidents were not reported appropriately.

Medicines management required improvement however medicines were stored and disposed of appropriately.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always follow safe moving and handling procedures. Not all training had been completed but staff and supervisions were not effective.

People's mealtime experience was poor with limited food choices.

Application of the Mental Capacity Act 2005 was inconsistently applied which meant people were not always having decisions made in their best interests.

The design and adaptation of the premises did not meet people's needs.

Outcomes for people were not always positive.

People had limited access to healthcare professionals to help

maintain good health.

Is the service caring?

Inadequate

The service was not caring.

People were not living in a dignified and pleasant environment. Staff did not always treat people well or with kindness and respect.

People's privacy and dignity was not maintained.

People were not able to express their views about the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have meaningful activities provided and were at risk of social isolation.

Care plans were not person-centred and only focused on medical needs.

Complaints were recorded but not always responded to appropriately

End of life care planning was not always taking place.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership and direction at the service and the previous breaches of regulations had not been met.

The provider was not meeting its organisational aims and objectives which affected the quality of care people received.

Quality assurance processes were not effective at identifying areas for improvement.

People, relatives and staff were not always involved in how the service was run.

The service did not work in partnership with other agencies.

Important events were not always notified to CQC.

Holmwood 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 was brought forward as we had been advised by the local authority and visiting healthcare professionals they had concerns about the standard of care provided to people. The concerns included lack of staff, poor manual handling practice, poor infection control practice, poor cleanliness with the environment smelling of urine and risks to people not being managed appropriately. These concerns had been subject to a local authority large scale enquiry meeting attended by CQC. We used the information we received to request information from the provider on staffing levels and training prior to our inspection. Analysis of this information helped focus on the areas we needed to look at.

This inspection took place on 3 September 2018 and was unannounced. The inspection team consisted of four inspectors, one of whom had a nursing background.

We did not request a Provider Information Return (PIR). This was due to the inspection being brought forward due to the concerns raised with us. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also reviewed notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

Where people were unable to tell us about their experience of living at the service we spent time observing how they were cared for. We spoke to nine people, five relatives, one visiting healthcare professional and 10 members of staff. This included nursing, care and ancillary staff as well as the deputy and registered manager.

We reviewed five care plans, two staff files, medicines administration records, mental capacity assessments and quality assurance records.

Following the inspection, we asked the registered manager to provide further information relating to care planning and the quality assurance checks completed by the provider which they did.

Inadequate

Is the service safe?

Our findings

Relatives told us there were not enough staff to meet their needs. One relative told us that, "Weekends always feel busier" whilst another said their loved one, "Needed the toilet but there was no-one [staff] around". At the previous inspection in February 2018 there was a breach of regulation 18 as there was not always suitable numbers of staff deployed to meet people's needs.

There were still not enough staff to meet people's needs which placed them at risk of harm. People were left in bed still waiting to receive their personal care at 12.30pm on the day of the inspection and staff told us this was a usual occurrence. One member of staff said, "There's too much stress on us" whilst another said people were "Staying in bed longer" when the staffing levels were lower. The lack of staff affected all areas of care including when personal care was given, how risks were managed and mealtimes. We found one person sitting in their room in their nightclothes holding an uncovered pillow covered with blood from a wound on their face. We had to find a member of staff to help them. At 11.25am one person wanted to get up but said they had been waiting a "Long time" for staff. At 11.45am another person was also waiting to get out of bed, have a wash and brush their teeth but staff had not been able to assist them. Again, we had to intervene and ask staff to attend to them.

People who were nursed in bed and required re-positioning to keep safe were not regularly turned as staff were too busy. People were heard calling out for help from staff however there were not enough of them to respond promptly. One person shouted loudly from their room throughout the day and required staff to sit with them to reassure them when they did this. Staff were too busy to sit with them and calm them. Another person in the nearby room told us the person calling out regularly was, "Not nice". They had a radio in their room to "Drown out the noise" but the shouting could still be clearly heard. Another person told us they had missed a visit to the local church the previous day as there had not been enough staff to take them. This person told us, "It would help me so much to get to church, it helps me it's important to me".

One member of staff told us on a normal day there were 10 or 11 staff but, "Even with that it's not enough." According to the dependency tool used by the registered manager to determine safe staffing levels, there should have been two nurses and 10 care staff in the morning, reducing to nine care staff in the afternoon. This included one member of care staff providing one-to-one support for one person. At night there should be one nurse and four care staff. These staffing levels were not met. From a review of the staffing rotas for a four-week period prior to the inspection these levels had not been met on 27 out of 28 days. On occasions there were more than two care staff short. At night there were 13 occasions when minimum staffing levels had not been met. Due to people's complex needs even if there had been the required numbers of staff working it was not clear that this would have been sufficient to meet the needs of people.

Failure to maintain sufficient staff numbers to meet people's needs is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider told us they would be increasing staffing levels by two care staff during the day and one at night.

At the previous inspection in February 2018 there was a breach of regulation 12 as staff had not always managed the risk of the spread of infection or other risks to people. These areas had not improved and the concerns remained at this inspection.

People, relatives and staff fed back about the uncleanliness of the service. One person told us the service needed to "Sort out its hygiene". One relative told us their daughter did not like to bring their children to visit because is meant they would have to walk and crawl on the floor which they "Know is dirty". One member of staff told us, "There is a problem with cleanliness".

People were placed at risk from poor infection control practice. The smell of urine that was identified at the last inspection persisted and had not been addressed. This unpleasant smell remained throughout the day. There were plans to replace the flooring but these had not been completed despite assurances after the last inspection in February they would be. The smell was particularly noticeable throughout the main communal area and other areas of the service. Rooms were dirty and had what appeared to be dried bodily fluids including faeces on the walls. Outside waste bins were kept next to the open kitchen window and were overflowing with clinical waste which had a strong smell coming from them. Cleaning staff told us that care staff would clean bodily fluids due to the infection control risk unless they were unable to. Not all staff were aware of this. There were spots and smears of blood on the walls leading from the first to ground floor that we asked staff to clean. This was particularly important as one person had a specific health condition that required strict infection control procedures to be applied to reduce the risks of cross-contamination to other people, staff and visitors. The ground floor sluice room was dirty and difficult to use as a vacuum cleaner and other equipment was stored in it. The shelves in there were covered in dust.

The laundry room was dirty and untidy and the floor had a build-up of grime with people's clean clothes in contact with the floor. The kitchen was dirty and the glass washer had a heavy build-up of limescale. A crash mat in one person's room was frayed with the foam showing which made it difficult to clean properly. One of the staff toilets did not have any soap for staff to wash their hands properly. Not all staff had completed their mandatory infection control training. The provider's audits had not identified any concerns in respect of infection control.

Risks to people were not always assessed or acted upon appropriately which was unsafe. There were occasions when call bells were out of people's reach, this had been raised as a concern previously. People who were at risk of developing pressure sores required regular turning to prevent their skin breaking down. Staff were required to complete a chart detailing the time they turned people. These were not always completed accurately and there were instances when they weren't completed at all. Four out of five pressure mattresses were set at the wrong weight which increased the risk of people developing pressure sores.

One person required thickened fluid as they were at risk of choking. Staff had left them with an unthickened fluid which was noticed by their visiting relative. No action was taken to investigate how this had happened. Care records were not always completed accurately. People at risk of dehydration did not have the amount they drank totalled each day and on occasions people's drinks were out of reach. Staff would not know whether they were drinking sufficient quantities of fluid.

Personal emergency evacuation plans (PEEPs) were not in place for two people living at the service whilst there were three PEEPs for people who weren't living at the service anymore. Emergency services would not have an accurate record of people living in the service should they need to be moved quickly. Two fire doors were left open all day despite having signs on them stating they should be shut securely at all times. Staff or emergency services would not have been able to access one person's room had they used their call bell as

their crash mat was placed near the door meaning that the door did not open fully.

Lessons were not learned as incidents and accidents were not analysed to identify trends or patterns. Records were kept of incidents including injuries, falls and people's behaviours. One person needed to have their behaviour monitored as it had been noticed they were becoming more agitated. These charts were not always completed so opportunities to understand potential triggers to their behaviour were missed.

Failure to maintain safe infection control practices, manage and mitigate risks is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises and equipment used by the provider was not clean, stored appropriately, properly used or maintained. Hoisting equipment was being stored in a 'lean-to' adjacent to the communal area. The equipment was dirty and covered in dust. The deputy manager told us this should be cleaned daily however this was not being done. The lift had not been working for a month and required replacing. People had been using a stair lift to get to the ground floor. At the bottom of the stairs where the stair lift was being used there was a nail that was sticking out at head height that put people of risk of an injury. We removed this immediately. Walls in people's rooms were chipped and dented. Crash mattresses were at times stored against the walls in people's rooms and there was a risk that these could fall on top of people. The upstairs sluice room could not be used as it was being used to store equipment. Fabric on the stools and chairs were stained and worn in all areas of the service and a radiator was hanging off a wall in a communal corridor. Two people had pressure mattresses but it was unclear why as they were not at risk of their skin breaking down

Failure to properly maintain the premises and equipment and failure to provide adequate storage is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were occasions when other risks to people had been assessed and managed appropriately. Where some people had been identified as being at risk of malnutrition this had been assessed and action taken to mitigate the risk.

People were not protected from the risk of abuse. The registered manager had not been notifying safeguarding incidents appropriately to the local authority. One person at high risk of choking had been given the wrong type of food by staff. This had been reported to nursing staff who had recorded the severity of the event as 'Mild' rather than 'Major'. Other than monitoring the person no other action had been taken. Another incident had occurred where a person had slapped another. Action had been taken to reassure the person who had been hurt and was reported to senior management however this was not notified to the safeguarding team. Due to the lack of staff it was not possible to speak to them to test their understanding of safeguarding procedures. It was clear from records that they would report incidents to the nurse in charge and managers however these were then not forwarded to the local authority. The registered manager agreed the incidents should have been reported in order to be appropriately investigated.

Failure to protect people from the risk of abuse is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they get their medicines when they needed. One person said "My medicine is always on time if it's been delivered. If not, they call and hurry them along". Despite this feedback medicine were not always administered safely.

One nurse was administering medicines at 10 am when they were prescribed to be given at 8 am. When

asked why they said, "That's what they do in hospitals". This is incorrect and medicines should be given as close to the prescribed time as possible. However, another nurse did administer three, time-critical medicines at the correct prescribed times. There were people who lived at the home who required patches to deliver pain relief. These required a body map to be kept guiding staff in making sure the patch is not applied to the same place without a gap. If this is not done and is applied to the same area it can cause irritation to the person's skin. When we read the leaflet in the patch packet together with the member of staff they said they had not been aware of the need to change where the patch was applied. This had put people at risk of suffering skin complaints and discomfort.

There had been a difficulty with getting the correct supplies from the pharmacy and this had caused delays in people receiving prescribed medicines. This was in the process of being resolved by changing the supplier.

One nurse said that since checks to medicines had started there were very few occasions when staff failed to sign that medicines were given. The medicines administration records (MAR) for the last two weeks did not contain any gaps in staff signatures. Staff administered medicines at lunch time and asked people if they had any pain and gave then pain killers if they requested them. Staff had guidance from protocols for PRN (as required medicines); these showed what a medicine was for, how often it could be given and at what time intervals. The nurse explained to people what their medicines were for and made sure they had a drink to take their medicines with.

Appropriate recruitment checks required some improvement. Staff recruitment files contained evidence that the provider obtained references, proof of identity and a Disclosure and Barring Service (DBS) certificate before staff started work. DBS checks identify if prospective staff have a criminal record or were barred from working with people who use care and support services. The nurses were registered with their professional body; the Nursing and Midwifery Council. However, one file did not have an application form in it detailing the staff member's history of working in social care and reasons for leaving previous jobs, as required.

Inadequate

Is the service effective?

Our findings

There was a mixed view on how effective staff were. One person said, "They need more staff that actually know what they're doing". A relative told us permanent staff were "good" but was "not sure" the agency staff were. Other people said the staff "seem to know what they are doing" whilst another relative said staff were "very good".

Staff did not always have the skills and experience to effectively meet people's needs. Prior to our inspection concerns had been raised by the local authority about staff practice in several areas including moving and handling and dignity and respect. We identified similar concerns on the inspection.

Staff received regular training in topics that were mandatory such as moving and handling, infection control, first aid and fire safety. Whilst training records detailed that most staff had completed these areas of training, observations of staff practice showed it was not always being followed. Other areas of training that the provider required staff to complete included record keeping, person-centred care, dignity and respect and pressure ulcer awareness. None of the care staff had completed this training and we identified there were concerns in all of these areas. There were people at the service that were living with dementia and other people that had a mental health diagnosis. 10 out of 15 staff had not received any training in relation to either of these conditions.

Staff told us they did not have regular supervisions on a one-to-one basis but instead had group supervisions. Nurses maintained their clinical practice by attending courses and holding clinical meetings with the clinical lead nurse. However, observations on the day of the inspection identified that these supervisions were not effective in ensuring good practice.

One person was being moved in a wheelchair without the use of footplates which placed them at risk of injury. We intervened and advised staff this was unsafe practice. Five minutes later we saw this was happening again and had to intervene again. When staff were moving someone using a hoist staff did not check there was the correct tension with the slings to ensure they were safe to proceed. One person required regular hoisting as they moved around the service frequently. Staff spent a long period of time trying to hoist them before realising they did not have a wheelchair to put them in. They left this person on the hoist for a period of time which was unsafe. Staff did not always follow safe infection control practice and did not notice areas of the service were unclean.

Failure to provide adequate training and supervision for staff is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a mixed view of the food available to people. Comments from people included, "The food is bad. The meals are often late", "The food is alright" and "The food is very good". One relative told us, "It is fine normally". One member of staff said "The food is alright. It could improve with a bit more variety."

People were not always supported to eat and drink appropriately. The registered manager told us that

mealtimes were 'staggered' with those requiring assistance eating at 12.30pm and the remainder at 1pm. The deputy manager told us there was one meal choice as people "kept changing their mind." The mealtime period was disorganised with staff struggling to cope with serving meals to people. The main meal was defrosted breaded chicken, mashed potatoes and vegetables with a white sauce. People on a soft or pureed diet had fish with tomato sauce which was mixed together by staff after it was served up. We suggested to staff that by keeping it separate it would be more palatable. The meals did not look appetising. One person was served their meal but said it was, "Revolting". Staff took their plate but did not offer another meal choice. Staff also did not have time to support people to eat and those that were supported by staff appeared disinterested. One person could eat without support however staff continued to assist them by putting food into their mouth and rushing them to eat. At 1pm people who were nursed in bed had still not received their meals.

The chef told us people did not have any allergies however one person's records showed they were allergic to nuts. There was no easy to read information available to the chef displayed in the kitchen about people's likes or dislikes or whether they had any specific dietary requirements. Some people were at risk of malnutrition and others were diabetic but information was not easily available to the kitchen staff. Following the inspection, we asked the provider to ensure that all allergies were shared with kitchen staff. The picture menu on display on the lounge also did not match the meal that was being offered on the day of the inspection.

The adaptation, design and decoration of the premises did not meet people's needs. Many people were living with dementia. There were no appropriate signs to hep orientate people or any areas of interest for them to use. Rooms were either not numbered, had two different numbers or the wrong number which was confusing for people. Memory boxes were not used to help people recognise their own rooms. The lift had been out of action for over a month which had meant that one person had been unable to come downstairs from their room on the first floor.

People's needs were not always assessed and care and treatment did not achieve effective outcomes. Detailed pre-admission assessments had sometimes been completed before people moved into the service however staff were struggling to meet some people's needs. One person needed input from specialist healthcare professionals who had recommended that behaviour charts were completed however these had been discontinued. Staff were unable to tell us why this had happened. Another person's behaviour had changed since they had returned from hospital and required specialist input but this had not yet occurred despite this being requested nearly two months previously. A third person was subject to a Community Treatment Order (a community treatment order allows a person to leave hospital and be treated safely in the community rather than hospital.) The registered manager had not sought a copy of the order when the person was admitted. This meant it would be difficult for them to know if they could effectively meet their needs, or support the person to abide by the conditions of the order.

Failure to assess and provide care based on people's needs and provide suitable design and adaptation of premises is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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 MCA was inconsistently applied and assessments of people's capacity were not always decision specific. One person who lacked capacity had a capacity assessment completed in relation to a range of care needs that required consent. The care plan stated their relatives were involved in their care and bedrails were provided but this had not been subject to a best-interests meeting or discussion, as required by the Act. Another person had a gate across their room which had been at the request of their relatives. However, the registered manager had not ensured the relatives had the legal authority to make this decision on the person's behalf.

Failure to consistently follow the MCA is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the lack of staff it was not possible to speak to them to test their understanding of the MCA however we did see staff seeking consent form people for day to day matters. In some care plans we saw that decisions were made appropriately.

There were occasions where people had access to external healthcare services such as GPs, community mental health teams, speech and language teams (SaLT) and the dentist. Relatives told us "[My relative] has seen the speech and language therapy team about the risk of choking and now has thickened fluids." Visits were recorded appropriately and action taken to follow the recommendations made. One visiting healthcare professional told us they felt that the care provided was "good" and staff "responded well" to one person who had a complex condition.

Inadequate

Is the service caring?

Our findings

People told us that staff were kind and caring. One told us, "The staff are lovely and very helpful" Relatives told us they thought staff were good. One said, "The staff are kind and patient" whilst another said, "It's very good here".

Despite these positive comments people were not always treated with kindness and respect and did not always receive the emotional support they needed. People were allowed to live in an environment that was unclean, smelled strongly of urine which affected most areas, people had insufficient staff to support them and risks to people were not managed effectively. These shortfalls are not indicative of a caring service. Staff were at times doing their best but they, and people, were being let down by the lack of leadership of the service addressing the shortfalls.

People looked unkempt and not well cared for. One person had long, dirty toenails that required cutting. Staff said the person could be resistant to personal care but the care plan did not contain any guidance for staff on how to manage this. There were several times we had to ask staff to assist people who needed help. One person in their room was shouting throughout the day but staff were seen leaving their room without speaking to or reassuring them. Another person had been anxious and upset during the morning however staff either ignored them or walked away when they required reassurance. One member of staff became frustrated with the personas a result.

People were not always treated with dignity or respect. There were staff that referred to people, as 'Grandma' or 'Grandpa' rather than their name. One person asked why they called them that but the member of staff did not respond and other member of staff did not question this either. Staff told us, "That is what we are told to do". Another person was asked by staff if they were "being a good boy today?" One person in bed asked us to pass them their glasses as they had been placed out of reach by staff. Their glasses were extremely dirty.

Another person required specialist help to have food, there was a sign outside of their room on their door that stated this which was undignified for them. One person who required one-to-one care sat with a member of staff. They wanted to eat their own dinner but were prevented by the care staff who rushed them through their meal. Pureed food was mixed together by staff which made the meals look unappetising and at times staff appeared disinterested and did not speak to people when helping them with their meals.

There were several instances where staff walked into people's rooms without knocking or introducing themselves. People's bedding was grey as colours and whites were not separated by the laundry. Some people told us their clothes sometimes went missing. One person said, "My clothes are always going missing. They aren't washed well, it's dreadful". None of the staff employed by the service had received any dignity and respect training despite this being raised as an area of concern by the local authority.

People were not supported to express their views about the care they received. The registered manager told us that they did not hold residents or relatives' meetings as they were not well attended. No attempt had

been made to engage with people or relatives although we were told a dignity and care survey had been circulated but had yet to be returned.

Failure to ensure people were treated with dignity and respect is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other staff were caring and kind and we saw examples of people being spoken to appropriately. One nurse was particularly reassuring and kind when they interacted with people, and one relative told us, "The nurses are lovely". One person was distressed and staff spoke softly to them to reduce their anxiety.

Requires Improvement

Is the service responsive?

Our findings

There were differing views from people and relatives about the activities on offer. Some said there were not enough activities but others felt there were. One relative said, "They could do with more activities", whilst one person said they, "Do dancing which I love".

We found that there were not enough meaningful activities for people which put them at risk of becoming socially isolated. For people nursed in bed there was limited interaction with staff throughout the day apart from when they were supported to eat their meals or when staff checked on them. For those that could participate in activities we saw them taking part in art and craft classes however for most people that were unable to communicate there was little to keep them occupied.

People spent large parts of the day sitting in the communal areas watching television or just sitting in their chairs without anything to do. Staff spent a lot of their time watching people rather than engaging with them. One member of staff told us, "Activities are very low" whilst another told us, "If I'm harsh there isn't enough stimulation. Without it people just fall asleep. Some people get cross." A relative told us there had been tea parties and someone would come in and play bingo or the piano. They said people went into the garden, "Quite often".

People did not receive care that was personalised. Information in care plans was not always complete and did not give a sense of who the person was. The focus was mainly on the person's diagnosis. There was detailed medical information however personal information was sometimes lacking. The registered manager told us that care plans were an area that they needed to improve. One person with complex needs did not have any personal information for staff to refer to. For another person with mental health needs staff did not understand their condition. One member of staff said, "I don't know much about her diagnosis."

Staff told us they did not always get time to read people's care plans and as a result did not always know people's needs or how they liked to be supported. The service used many agency staff most of whom were used regularly. In one care plan there was an 'At a glance' sheet which gave a summary of people's needs however these were not present in all the files we looked at.

Where people's needs had changed there had been referrals made to the appropriate healthcare professionals however action had not been taken to respond to these changes. One person had behaviour that staff had difficulty managing, rather than proactively care for the person they reacted to the times when they became difficult to care for. Similarly, with another person whose needs had changed and required more support the service had not addressed this or responded appropriately.

There was no-one on end of life care during the inspection so we looked at how the service prepared for this event. Some people had advanced care plans which stated what their preferences would be at end of life. These were not always completed fully.

Failure to provide person-centred care and meaningful activities is a breach of regulation 9 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints and concerns raised were not always addressed or responded to. One relative had complained two months prior to the inspection about the smell of urine in the main lounge. Whilst a record had been made of the complaint the response stated that 'Management had been informed and that the flooring would be changed but 'No date yet'.' There was no record of what action had been taken as a result. Other complaints had been recorded but in the outcome section it stated for most entries that this was 'On-going' rather than resolved. It was therefore not clear if appropriate action had been taken.

Failure to resolve complaints raised is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2018 records were not always being maintained or updated with accurate information. Management and provider quality checks of records had been ineffective at driving improvement across the home. This was the same at this inspection.

Following the last inspection we were provided with an action plan that set out how the breaches of regulations identified would be addressed. The action detailed that all areas would be improved by 23 April 2018. For the breaches of regulations 12, 17 and 18 the improvement actions included; 'Daily, frequent checks on all residents', 'Communicating with residents and relatives daily about their welfare and being', 'Check care plans are detailed and reflective to individual needs', 'Involve relatives during care plan reviews' and 'Daily review of staff rota to ensure staff numbers per shift is reflective of occupancy level and needs of residents'. None of these actions had been achieved.

People were being affected by the lack of leadership and direction at the service. Relatives told us that the registered manager was not always visible and we saw that on the day of the inspection staff needed direction and support and this was not being provided.

There was no clear vision to help deliver high-quality care. The provider's website stated that Holmwood Nursing Home is a 'Home from home.' It adds that people should experience a warm, safe and supportive environment with 'Excellent facilities.' The website lists, amongst other things, that pre-admission assessments to determine individual needs should be completed, a choice of freshly prepared, nutritious meals would be provided, and meaningful activities and access to local places of worship would be facilitated.

The organisational aims and objectives included to provide a high standard of care and support, maintaining people's dignity and self-respect, to empower people to make choices through the expression of wishes, feelings and preferences, developing their right to self-determination, to adopt a person-centred approach, ensuring the best possible support and providing a service specific to the needs of the individual and to make sure people had access to a wide variety of individual and group activities, both in their home and in the local community. This was not evident at our inspection where people were not always treated with respect and person-centred care was not provided. The provider was not meeting its stated aims and objectives which had a detrimental impact on the care people received.

Quality assurance processes were ineffective at driving improvement. The provider's own internal audits had been completed by an external quality assurance manager who checked different areas of the home. During the April 2018 audit they had identified issues with the laundry and use of old mop heads and rooms to be improved and painted. There was no mention of any concern about the smell in the home. Similarly, in May 2018 the quality assurance audit had identified the area for storing equipment was 'Untidy' and 'Shabby' but again no mention was made of the smell in the communal areas. In July 2018 the audit did reference the smell in the main communal area. It stated there was a 'High odour, which smelt of urine'. The report also mentions 'Arrangements were in place for a new carpet'. The registered manager told us they had been

trying for some time for new flooring to be provided but there had been issues with the contractors. He said that other improvements, such as new dining tables, would not be made until the flooring was replaced. It was not clear what the rationale for this decision was.

Some audits were completed by the registered manager and staff. The health and safety audits stated that there was an odour in the main lounge but no action had been taken to address this. In the health and safety and infection control audits in July 2018, there were no concerns noted in respect of the home. Other safety checks had either not been completed or the records were not available. Annual checks were not always completed. The last gas safety certificate was dated 2105 whilst a legionella audit was dated November 2013. There was no evidence of care plan audits being completed and it was clear from our inspection staffing levels were insufficient but this had not been identified by the registered manager or the provider through their own monitoring.

Relatives and residents' meetings did not take place so opportunities to seek feedback from them were missed. Staff received group supervisions and attended team meetings where important issues were discussed such as the concerns that had been raised by the local authority however these had not improved the standard of care provided.

As there was a lack of leadership, systems and processes were not established and operated effectively, and feedback was not sought to improve the service. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Significant events, accidents and safeguarding incidents were not always submitted notifications to CQC in line with their requirements of registration. These included safeguarding incidents.

Failure to notify safeguarding incidents is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was no evidence of how the service worked in partnership with other agencies. There were some positive comments made by one healthcare professional about the care and support one person received.

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 18 Registration Regulations 2009 Notifications of other incidents Safeguarding incidents were not appropriately notified to CQC

The enforcement action we took:

We issued a Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person-centred care. The environment and care planning was poor and activities for people were not meaningful.

The enforcement action we took:

We issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with kindness or respect and were not involved in the care they received.

The enforcement action we took:

We issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The Mental Capacity Act was not always been applied consistently.

The enforcement action we took:

We issued a Notice of Proposal

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 Risks to people were not acted on or managed well. There were poor infection control practices which placed people at risk.

The enforcement action we took:

We issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents were not acted upon or reported to the local authority appropriately.

The enforcement action we took:

We issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not clean and were poorly maintained.

The enforcement action we took:

We issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always acted upon.

The enforcement action we took:

We issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective quality assurance systems

Treatment of disease, disorder or injury	and a lack of leadership.

The enforcement action we took:

We issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to keep people safe or meet their needs.

The enforcement action we took:

We issued a Notice of Proposal.