Meridian Healthcare Limited

Holme Lea

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out over three days on 26 and 28 January and 1 February 2016. Our visit on 26 January was unannounced.

We last inspected Holme Lea on 13 August 2014. At that inspection we found the service was meeting the regulations we assessed.

Holme Lea is one of 31 care homes owned by Meridian Healthcare and is situated in the Stalybridge area of Tameside. The home provides care, support and accommodation for up to 48 people who require personal care without nursing. Holme Lea is a 3-storey, purpose built care home and all rooms provide single accommodation, many of which are en-suite. Communal bathrooms and toilet facilities are available throughout the home. Bedrooms are located over the ground and first floors and they can be accessed via stairs, stairlift or passenger lift. The home is divided into three units, two on the ground floor and one on the upper floor; each unit consists of a lounge, dining area and kitchen facilities. The laundry and main kitchen are located in the lower ground floor. There is a conservatory and an enclosed garden and patio area at the rear of the building that is accessible to people who use the service. There is also a designated smoking room for people who wish to smoke.

At the time of our inspection there were 43 people living at Holme Lea.

The service did not have a registered manager in place. 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. A new home manager had been in post since December 2015 and had not yet submitted an application to register with the Care Quality Commission (CQC) as the registered manager for Holme Lea. The previous registered manager had moved on three months previously, but had not yet deregistered with the CQC at the time of our visit.

We identified 13 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People, their relatives, and staff spoke highly of the service; one person's relative told us "It's a lovely place" and "The manager is approachable, all the staff are." Visiting professionals were also complimentary of the service and one person told us that they had seen a vast improvement in the home recently and told us "they are working with us a lot more".

During this inspection we found that there were not always enough staff available to meet people's needs. There was evidence of a dependency tool in place which should support the service to identify appropriate staffing numbers. However, whilst the dependency of residents was documented, this information was not

used to calculate staffing numbers. Instead the staffing was based on a ratio of 1 staff to 8 people on day shift and 1 staff to 15 people on night shift. People did not always receive the care and support they needed in a timely way. Relatives and people using the service who we spoke with felt that there were not enough staff on duty during the day and night. One person told us, "There is nowhere near enough staff on at night." Another person told us that they would like to have a bath, but staff say they do not have time.

The staff files we looked at showed us that safe and appropriate recruitment and selection practices had not always been used to ensure that suitable staff were employed to care for vulnerable people.

Staff we spoke with were aware how to safeguard people and were able to demonstrate their knowledge around safeguarding procedures and how to inform the relevant authorities if they suspected anyone was at risk from harm.

Documentation at the home showed that people received appropriate input from other health care professionals, such as dentistry and podiatry, to ensure they received the care and support they needed from community healthcare services. However, plans put in place by health care professionals were not always being followed, for example, we saw that documentation was not always fully completed.

Care files we looked at, showed comprehensive plans and risk assessments documenting people's specific care and support needs. These were detailed plans outlining how people needed to be cared for in an effective and safe way. The plans included a photograph of the person and some information around their preferences, but did not have information about the person's family or history. Additionally, we saw that these care files were not always reviewed in a comprehensive way; meaning that information in the files was not always current and up-to-date and could lead to people not receiving the correct care and support.

During a tour of Home Lea, we saw that some areas of the home were not clean and there was an unpleasant odour as we entered the home each morning during our site visits. The outside patio/garden area required tidying and cleaning, and we found a number of safety concerns with the general home environment, such as broken bins and unsecured radiator covers.

Audits for safety of the building and care delivery were in place; however these were not always effectively acted upon.

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.

Insufficient numbers of staff meant that people did not always receive care and support in a timely way.

Risk assessments were in place; however, these were not always followed and effectively reviewed to ensure people's care needs were kept up to date.

Staff spoken with demonstrated a good understanding of safeguarding and the types of abuse that people may be at risk from.

Safe recruitment practices had not been followed to ensure that suitable staff had been employed to care for vulnerable people.

The environment was not always clean and well maintained.

Accidents and incidents were not comprehensively recorded and acted upon.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive the required nutritional support prescribed for them by health care professionals.

Meal times were not flexible and people were not involved in decisions around meals. Choices were very limited around food and drink for people who lived in the home.

Care records and observations during the site visits showed us that people received input from other health and social care professionals, such as, district nursing, podiatry and GP.

We found that the home manager had identified 11 people as requiring a Deprivation of Liberty Safeguards (DoLS) authorisation that had not be submitted to the local authority; this was completed during our inspection.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service and their relatives were complimentary about the care they received from staff.

We saw that people were sometimes treated in a caring and respectful way; however, we also saw that people were not always treated with privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints system in place but there were inconsistencies with timely responses to complaints.

A customer satisfaction survey was displayed in the reception from 2014 along with information about a relatives group run by one resident's relative.

There was an activities programme and part-time co-ordinator. Activities were decided by the co-ordinator with no one to one personalised support offered.

People were not always treated with dignity and respect as their choices, preferences and needs were not always met.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager had not yet completed their registration with the Care Quality Commission (CQC).

Staff, people who live at Holme Lea and their relatives, along with visiting professionals, were all complimentary about the positive changes made by the new manager.

Audits for safety of the building and care delivery were in place; however these were not always effectively acted upon.

Care records and personal information was not kept secure and confidential.

Holme Lea

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.

This inspection took place on 26 and 28 January and 1 February 2016 and day one was unannounced. The inspection was carried out by two adult social care inspectors on days one and three, and one inspector on day two.

Before we visited the home, we checked information we held about the service including contract monitoring reports from the local authority and notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

On this occasion, we had not asked the service to complete a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We walked around the home and looked in all communal areas, bathrooms, the kitchen, store rooms, medication room and the laundry. We also looked in four people's bedrooms and outside the building; in the garden and patio area.

During the three days of inspection, we reviewed a variety of documents, policies and procedures relating to the delivery of care and the administration and management of the home and staff; including three people's individual care records, the administration of medication records and four staff personnel files to check for information to demonstrate safe recruitment practices, training and regular supervision had taken place.

As part of the inspection process we observed how staff interacted and supported people at lunchtime and throughout the three days of our visit in various areas of the home. We spoke with four people who use the service, seven relatives and four visiting health care professionals. We also spoke with the home manager, a

manager from the head office of the organisation, one senior carer, the cook, and two care staff members; one of whom was also the activities co-ordinator and one who was also the laundry assistant.

Inadequate

Is the service safe?

Our findings

The people and relatives we spoke with during our inspection told us that they felt safe living at Holme Lea. One relative told us, "Without a doubt, we feel she is safe", another relative said that they felt less stressed now their relative was in Holme Lea and told us, "I feel like he is safe". Another relative we spoke with told us that although they felt their relative was safe, they were concerned about staffing levels, particularly at night and the use of agency staff, as they felt that their relative was being cared for by people who did not know them.

Holme Lea uses a dependency tool to assess and calculate how many staff are needed to ensure that people receive the required levels of care and support. The number of staff had been decided through a ratio of one staff to eight people (1 to 15 at night) and the tool stated that this was the minimum numbers required. However, using this dependency tool did not reflect the differing levels of dependency of the people and we saw no evidence to show that this tool accurately reflected the dependency of the people currently using the service.

Staff we spoke with told us that usual staffing levels would be two care staff upstairs, two care staff downstairs and one "floater" to work wherever was needed within the home. We requested information about staff rotas and details were emailed to us. However, from the information we received we were unable to accurately ascertain what the actual staffing levels within the home had been over the four weeks previous to our inspection. The rota documentation was not accurate because the names of staff who had left the service were included as being on shift. This meant that we were not able to check that Holme Lea had the required staffing levels that adhered to their own staffing dependency tool.

People we spoke with and their relatives felt strongly that there were not enough staff around within the home and it was clear through our observations during the site visits that people were placed at risk. One relative told us, "I don't think there is enough staff, if there are emergencies then staff have to leave residents in the lounge on their own". Another relative told us, "There isn't enough staff…staff are running around" and "The girls work so hard, but are spread too thinly". We were told by one relative that they felt that there were poor staffing levels.

We observed several periods of time where units were left unattended by staff; in one instance at lunchtime, one staff member was alone in one unit and assisting several people to sit at the dining tables when another resident in the lounge was agitated and required assistance and stood up unaided, leading them to fall backwards into the arm of the chair. This person had also fallen the day before and the home manager requested a visit from the general practitioner. Also during our lunchtime observations, one person was served their lunch and it was left in front of them without comment, this person was unable to cut up their food and pushed their plate away in an agitated state. Staff did not attend to this person until we intervened and requested assistance.

The staff members we spoke with told us they felt that there was not always enough staff to cover each unit as the dependency levels of the people were increasing and told us "some people fall a lot". Staffing levels

were a particular problem when agency staff needed to be used as staff told us "they do the bare minimum" and staff told us it was difficult to cover the units when staff took sick leave or holidays. We asked staff how the unit was supervised if someone needed personal care and required the assistance of two staff and we were told that they had to request assistance from other units to cover. This meant that people on the other units within the home were being placed at risk as they were then left without adequate staff cover.

Our findings during the inspection identified that Holme Lea did not have sufficient numbers of staff to ensure that people received the care and support they needed in a safe and timely manner.

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

Suitable arrangements were in place to help safeguard people from potential abuse. There was a safeguarding adult's policy and procedure in place and when asked, staff spoken with were fully aware of this procedure demonstrating a good understanding of the subject and were able to tell us about the different types of potential abuse and what steps to take to report any concerns. One staff member told us that if they ever saw or heard anything that could be potential abuse that they would go straight to the manager as she is approachable.

During the inspection we looked at four staff personnel files to check that safe recruitment practices had been undertaken. One of the staff files was incomplete as this person was suspended from duty and was under investigation by the organisation; paperwork had been removed to aid this investigation. In one staff file, we found that their last employment had been a care home and the reference would only confirm that the staff member had worked there. The manager of Holme Lea stated that she had followed this up and spoken personally to the previous employer, however, this was not documented in the staff file. In another staff file, we found that one person had been working for the last three months without a full check from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable to work with vulnerable adults. We brought this to the attention of the home manager and a risk assessment was put in place. In this same staff file, we found that a reference had not been obtained from the most recent employer. We found in all three staff files that vital information around previous work history was missing or that gaps had not been accounted for. This meant that the home manager had not received satisfactory assurances and that robust and safe recruitment practices were not followed to ensure that suitable staff had been employed to care for vulnerable people.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Included in the individual care records that we reviewed, we saw that comprehensive risk assessments had been completed covering many aspects of people's care and support needs. Examples of risks assessed included; mobility, moving and handling, falls, personal hygiene, bathing, choking, pressure care and weight loss. We found that reviews did not contain contemporaneous information, for example, we noted that one person was at a very high risk from being underweight and had continued to lose weight since the last review and the latest risk assessment review had also noted no changes. This meant that although risk assessments were detailed and in-depth, they were not being accurately reviewed. Therefore, they were not providing the most up to date information to enable staff to safely and effectively provide care personalised to each resident and their health and safety was put at risk.

We also found that six of the radiator guards were either loose or could be completely removed from the

walls. This created a potential risk of accidents due to the instability of the guards. As this identified risk was high, we asked the home manager to arrange to have them fixed securely to the walls as a matter of urgency.

We saw that fire safety signage was in place and fire doors were clear and were alarmed. There was a general fire evacuation procedure. We asked the home manager if people, who lived at Holme Lea, had an individual personal emergency evacuation plan (PEEP). This is an escape plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire. The home manager told us that a no-one living at Holme Lea had a PEEP in place. This meant that individual risks had not been assessed regarding the individual safe evacuation of people who use the service in the event of an emergency and appropriate individual measures identified to ensure people were safe and supported.

We examined records of accidents and incidents and found that records were incomplete and had information missing, such as, the time of the accident or incident, or the location. Accidents and incidents were recorded on specific documentation and kept in files in unlocked cabinets on the units. We looked at the files kept on Heather unit. We asked the home manager how this information was investigated, analysed, monitored and acted upon and we were given a print out of an analysis report. We found that some of the accidents recorded in the accident file on Heather unit were not included on the overall analysis report. We did not see evidence that the analysis report information was being actioned to minimise the risks to people and reduce the number of accidents and incidents. This meant that vital information was not being monitored and acted upon in order to identify specific patterns, such as accidents occurring in specific areas of the building or at certain times, or if certain people needed a referral to the falls team.

The above examples demonstrate a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at the way in which medicines were managed at Holme Lea. We found that there was a relevant policy in place and system used for stock control and most medication was delivered by a local pharmacy in prepared blister packs. People who had recently moved in to the home or were staying at the home temporarily had their medication stored in individual, named baskets. Medicines were administered by senior care staff using a lockable medicines trolley and medication administration record (MAR) sheets in individual file records documenting known allergies and a photograph of the person to identify that the right person was receiving the correct medication. We checked a sample of these records and found them to be in order. We saw that the home manager conducted monthly medication record audits to check for accuracy and to provide extra checks on the safe administration of medication.

We observed that people's medication, including controlled drugs (CDs), was recorded and stored appropriately and securely in a locked medicine store room and medicine fridge, we saw that these were temperature checked regularly for storage safety. However, this store room was not kept in an orderly fashion and we found a number of items, such as old MAR sheets, that needed to be tidied away or destroyed, to ensure that the potential for mistakes were minimised. Additionally, we identified items stored in the fridge that had not been labelled with the date they were opened, although these items were dated by the pharmacist's label, they should also be marked with the opened date as an extra safety check to ensure their safe administration and disposal. We brought this to the attention of the home manager and these issues had been rectified when we checked on the second day of inspection.

We looked around the home and found that it was not always clean. The kitchen areas on all three units were worn and had food splashes on walls, floors and units. We looked in two fridges and found that these

were not clean and contained uncovered jugs of milk that spilled onto the floor on opening the fridge door; we also found uncovered and unlabelled items of food. None of the fridges we looked in had a thermometer for checking safe temperatures. In one drawer we found 2 syringes that had some liquid residue inside, when we asked staff why these were in the drawer, we were told that they had been used for giving someone a drink. We found that microwaves on two units were not clean and contained food debris, chairs in the dining area and integral lounge were not clean and had stains and food debris. Each of the units required a thorough clean and some soft furnishings required replacing. We found the outside patio area to be particularly untidy and requiring substantial cleaning. We saw that the paved area was littered with many discarded cigarette ends and the paving flags had moss growing on them causing a potential slip hazard. We fed these findings back to the home manager at the time of our inspection and we were told that they were waiting for a refurbishment start date from the head office of the organisation that owns Holme Lea.

This was a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Whilst on our tour of the home, we found one sanitising hand gel dispenser was empty and one relative told us about the hand sanitiser near their relatives room "it's been empty for a week". We asked other people and their relatives for their views on the cleanliness of the home. One person told us "cleanliness is not to my standard" and one relative told us that they thought their relative's room was dirty and untidy. Another relative told us that they felt the home was clean. One visiting health professional told us that they thought cleanliness had improved but said "there's room for improvement" and another said "the odour has improved, but it's still here".

We checked communal bathrooms and toilets throughout the home; we found that some were clean and had accessible personal protective equipment (PPE) for staff to use when assisting people with personal care, however, we found some bathrooms and toilets to be unclean, soiled and without access to PPE. Many of the pedal bins in the bathrooms and toilets were broken and lids had to be lifted manually. The hydrotherapy bathroom was not clean and in another bathroom a standing hoist and ambulift over the bath were not clean. We found two toilets to be particularly soiled, one where we also found some hardware stored, a bin overflowing with continence items and our feet stuck to the floor. We brought this toilet to the attention of the home manager at the time of our inspection and this was addressed.

As part of our inspection, we looked in the laundry room, which is situated in the basement and is accessed by stairs or a passenger lift. We were accompanied by the laundry assistant who showed us how the laundry system was managed. The laundry room was segregated for clean and dirty linen and had a separate door for entry and exit in line with current Department of Health infection control guidelines. This meant that the risk of cross contamination of clean and dirty linen was minimised. This area was well ventilated and PPE was available to protect staff whilst using the laundry. We found the laundry room to be untidy with bags of dirty linen either on the floor in bags or in uncovered plastic baskets ready to go in the washing machine. There was an item of underwear soaking in the hand-washing sink and the trolleys used for transporting baskets were not clean.

During our inspection we observed poor practice by staff in relation to the prevention and control of infection. We did not see staff wash their hands during our inspection, either before or after giving care or serving lunches. The sink on Heather unit did not have hand washing facilities; staff told us they had to leave the unit and wash their hands in the toilets or bathroom. We saw that staff did not always use PPE when necessary and in the appropriate way. We spoke to one member of staff, who told us that PPE was not always accessible within the home and this meant leaving a person using the service alone, as often they needed to walk quite far to get the appropriate equipment from the PPE storage area. We saw three

occasions where staff did not use PPE appropriately; we saw one staff member carry soiled bed sheets from a person's room to a laundry bin in the corridor whilst not wearing any PPE, another staff member was assisting a person in the toilet and came out wearing gloves specifically for personal care and proceeded to handle several walking frames in the lounge whilst wearing these gloves, before returning to assist in the toilet. We passed a staff member walking down the corridor carrying a soiled continence product whilst not wearing any PPE. This meant that unsafe infection control practices by staff members were putting people at risk of cross contamination by not wearing appropriate, disposable protective equipment.

The above examples demonstrate a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The home manager showed us documents relating to keeping people safe within the premises, such as, water safety tests, fire equipment monitoring and electrical testing. This showed us that contracts were in place to maintain equipment safely.

We reviewed the business continuity plan for Holme Lea, this is a corporate policy for all care homes owned by the provider. The business continuity plan sets out what plans are in place if something significant occurs to affect the running of the care home, for example, a building fire, an outbreak of influenza or financial insolvency of the provider. This means that robust systems were in place to protect the health and safety of residents in the event of an emergency situation.

Requires Improvement

Is the service effective?

Our findings

The two staff members we spoke with had been working at Holme Lea for several years and told us the new home manager was approachable. One staff member told us that training was available to them and found it helpful and said "I feel adequately trained to do my job". They also told us that training helped them keep up to speed and "I feel supported to improve". One relative we spoke with told us that they felt that staff were adequately trained

Holme Lea had introduced a new electronic training system several months previously, known as 'Touch', and the new manager was in process of updating training files. This meant that evidence of staff training was not organised and readily accessible to us. There were two separate training matrixes that required updating, and staff training certificates were not available for us to review. This meant that we were unable to ascertain if staff had received the relevant training in order to ensure that all staff were suitably qualified, competent and skilled to effectively meet people's care and support needs within the home. Of the three staff personnel files we reviewed, one contained training certificates for fire safety, basic food hygiene, infection control, pressure care, mental health awareness, dementia awareness, six care values and promotion of a care centre. The other two staff files did not have any evidence of training certificates. We requested confirmation and evidence that the three staff members, whose files we were reviewing, had received a full induction programme and had the required training in place. This information was not produced for us during the inspection. This meant that staff may not have received the necessary training to ensure safe and effective care and the home manager was not able to verify this with us.

We reviewed, in depth, three care staff personnel files looking for evidence of a robust system of induction, regular supervisions, development and a comprehensive training schedule. One file was for a staff member who commenced working at Holme Lea three months previously, one had been with the organisation for a few weeks and the third was for a staff member who had been working at the home for seven months. We did not find evidence of induction, supervisions or development in these individual staff files. Staff supervision records were kept in a separate file in the home manager's office. On reviewing the most recent documents within the supervision file; we found that there was no evidence of regular, effective supervisions or appraisals held to discuss staff development or any issues that staff may like to bring to the attention of the manager. We found that information in this file was incomplete and mainly consisted of "situational supervision" reports where staff had been given a reactive supervision session in response to a particular instance or occurrence. This meant that staff were not regularly supported to discuss any concerns regarding staff or residents, or their own development needs.

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

During our inspection we saw that staff mostly sought consent from people before providing care and support. One person told us, "staff always knock on the door before they enter the room". We observed instances where staff asked people if they would like to come and sit at the dining table or what they would like to drink whilst seated at the table. One staff member told us how they would promote independence by

encouraging people to put on their own clothes after asking them to choose for themselves what to wear. However, we did observe one incident where someone was seated at the dining table and another person was being brought through the room on an ambulance trolley. To assist with access for the trolley one staff member came behind the person seated at the table and quickly pushed their chair forward further under the table. This person was unaware this was going to happen and was startled at being pushed forward without warning; the staff member did not speak to this person before or after they had done this. This meant that consent was not sought before moving the person without warning and showed poor care practise.

The care plans we reviewed during the inspection showed us that people had signed consent forms to show that they had agreed their plan of care and to have their photograph taken by staff. This showed us that people had been involved in decisions about their care and support.

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 made in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We looked at whether Holme Lea was working within the requirements of the MCA and DoLS. We found that people's liberty was being deprived and the required authorisation request to the local authority had not been submitted for 11 people. The home manager was aware that this was an outstanding requirement and told us that the applications for authorisation would be made that day. This meant that people living at the home were being deprived of their liberty without the legal safeguards in place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We asked two members of staff about their understanding of consent and their knowledge of DoLS and they told us they only knew a little bit about this subject although they had previously had training. This meant that staff needed refresher training in this area to enable them to safely and effectively provide care and support within the legal framework of the Mental Capacity Act 2005 (MCA).

We reviewed the staff meetings file and saw that these meetings were not conducted on a regular basis. We looked at recent staff handover notes for Heather unit and saw that these were not detailed and gave little information between staff shifts to ensure effective continuity of care. This meant that regular information sharing between staff was not consistent and vital information about service users' care and support needs may be missed.

During this inspection we reviewed people's personal care files to check if people were supported to maintain their health and well-being. We saw that staff at Holme Lea supported people to have assistance from other health care professionals, such as district nurses, dentists, opticians and dieticians. These visits

or appointments for people were also documented in the home manager's medical intervention file. We spoke to one visiting health care professional who told us that they had seen a vast improvement recently, especially around skin care and pressure relief. They told us they felt much more positive about the care people were receiving and said about staff, "they are working with us a lot more".

We identified in one care plan where staff had noticed and recorded, that one person was not well during the night and they had promptly organised for a doctors to visit. One relative told us they were confident that staff would act appropriately if they thought someone was unwell and said, "his chest had been a bit off, but they got go-to-doc out to him straight away". Another relative told us the service had referred their relative to the continence service when their symptoms got worse. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

We saw in people's care plans and other files held on Heather unit that people, who were at risk from specific health care issues, such as pressure care, fluid intake and dietary needs, were monitored in a separate file for each condition. However, we found that these records were incomplete and inconsistent, for example we saw that one person was being monitored on the unit to prevent pressure sores and these records had only been filled in at certain times and there were very large time gaps in the recordings. This meant that people were not receiving the identified care and support they had been assessed as needing and processes were not being followed.

We saw that Holme Lea kept a folder to monitor people's healthy weight ranges. This folder contained information around Body Mass Index (BMI), the procedures for how and when to weigh someone, and information on nutrition and weight loss. Information stated that people should be weighed on admission and weekly for four weeks afterwards. Specific people had been identified within this file as requiring enhanced input and monitoring to ensure their health and wellbeing needs were being met.

We found that people were not receiving the necessary nutritional support that had been prescribed for them by a nutritionist. Records showed us that one person had been identified on admission, as being very underweight and their nutrition risk assessment showed that they were at a very high risk. Risks assessments in this file also showed us that this person required a stage 3 diet as they were at risk of choking. A stage 3 diet means that people need to avoid specific foods and have their food prepared to a mashed or minced texture. We saw that this person had two separate visits from the community dietician and had been prescribed specific ways in which food must be served in order to add extra calories to prevent continued weight loss. We did not find any evidence that any of the prescribed actions were being carried out and the nutritionist's action plan was not being followed. The cook and care staff that we asked were not aware of this person's prescribed dietary requirements and we saw that at teatime, this person was offered sandwiches, thin soup and a chocolate éclair cake and they refused all but the soup and had only a small amount of this. This person was also given a hot drink in a large mug, which they found difficult to hold and had to use two hands to pick it up due to their frailty. We did not see any staff member offer any encouragement or prompting or offer any assistance or an alternative meal as per this person's dietary plan. This person's relative arrived later and made a hot drink in a small cup commenting that it was so that the person could pick it up, they also retrieved a yogurt from the fridge and a left over chocolate éclair from the food trolley. With prompting and encouragement from their relative this person ate most of the food and had the hot drink. We asked two members of staff present on Heather lounge what was in place for this person to help improve the amount they ate and increase their calorie intake. They told us that they would offer this person some chicken soup; however, this does not follow the nutritionist's diet plan.

We reviewed this person's Food Intake Chart for the last nine days and found that the documentation was incomplete on four days and we found that over three days the chart had no entries. The entries we

reviewed did not follow the nutritionist's prescribed plan and there were no explanations as to why the plan was not followed. We found that this person's Hydration Chart had not been completed since November 2015. We also looked at weight recording charts and found that this person was only put on weekly weigh charts on the second day of our inspection and had not been weighed for three weeks prior to this change. Records showed us that this person had lost 14% of their body weight in 7 months. The last care plan review in December 2015 documented in this person's care file stated "no identified changes" despite continual weight loss. This meant that records did not accurately reflect an up to date account of people's nutritional needs and placed them at significant risk of not having their nutritional needs met. We brought this to the attention of staff and the home manager, who told us that the person did not like to eat certain foods as per the nutritionist's meal plan, but we did not see any evidence where other choices had been considered or plans put in place to try to accommodate preferences whilst ensuring essential nutritional needs are being met.

A person who used the service told us that they were unhappy with the food at Holme Lea and that they had lost weight since coming to live at the home. They told us that they get family members to bring in food for them as every teatime is only sandwiches and soup and lunchtimes are the same every day and are too close to breakfast. This person told us that they have breakfast at around 9.45 am and then a cooked lunch is served at noon, followed by sandwiches and soup at around 5pm.

As part of our inspection, we observed lunchtime on the first day of our site visit and we saw that people were offered a choice of fish fingers or cheese and onion pie, the accompaniments were mashed potatoes and baked beans. There was one pudding option. We saw that one lady said she didn't like mashed potato and beans; the staff member just brought some fish fingers on a plate and we intervened and asked if there was something else this person could have with the fish fingers and it was agreed that some bread and butter could be brought so that a fish finger sandwich could be made. Another person was served cheese and onion pie by a staff member who placed the food in front of the person without comment; this person was banging the top of the pie with a knife and was unable to cut the pie, they pushed the plate away and did not eat anything. The staff did not return to this person throughout the lunchtime period when we drew attention to the fact they had not eaten anything. We saw that some people were offered assistance; however, we also saw where people required help and did not receive it.

We spoke to the cook about nutritional needs and preferences of the people who lived at Holme Lea. The cook knew that certain people were diabetic and had some knowledge around what the different diet stages meant. People with certain health conditions require their food to be prepared in a specific way to ensure they can eat their food comfortably and safely, for example, stage two meant that food needed to be pureed. When asked about people's preferences, the cook knew that one person did not like white meat and they told us about "resident of the day", where one person is chosen and asked what food they like in particular, however, this had not been happening over the last few weeks due to staff shortages in the kitchen. We did not find robust information held in the kitchen to show the specific dietary needs of everyone who required special attention to their diet and the cook did not have up to date knowledge or information to hand. For example, the cook was not aware of, or had information, around the person who had a nutrition care plan in place from the community nutritionist and what this entailed during the preparation of their food. This meant that people were at risk of not receiving their food safely; as prescribed by health care professionals.

The above examples demonstrate a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

During another lunchtime observation, we saw that people were asked if they would like a napkin and if they

would like their food cutting up; this showed us that people were being offered assistance and choice during this particular lunchtime.

One care staff member we spoke with, was able to identify certain people who lived at Holme Lea who required prompting or assistance with eating and they knew to offer alternatives if necessary and they were able to tell us who required assistance with eating and drinking. They told us they would check that someone had enough to eat and drink and would encourage someone to eat, they told us, "If I noticed someone was not eating, I would inform the senior". However, we did not see these actions from other care staff in practice during our observations whilst on inspection.

On the first day of our inspection we spoke to two relatives who told us that their relative required to have their food pureed and this is sometimes served so that each food item is placed separately on a plate like a normal meal, but sometimes the food comes all pureed together in a bowl; they told us they call this, "the brown gloop". They said that no options are given; they just get whatever everyone else is having but served pureed. They also told us that often at weekends because it is a buffet their relative did not get any food sent up to their room and they have bought some jars of pureed food so that they have some supplies for when this happens. They spoke of seeing the food served to other people on the units and said, "it doesn't look nice…we see people push their plates away".

We spoke to the cook and they told us that meals were on a three week rota and meal choices were already pre-set as the menus that came through from head office and people were not consulted on choices. Daily menus were displayed on whiteboards on each unit, however, these were not changed in a timely way and each day we could only see what had been served the day before. Cooked meals were given at lunchtime because kitchen staff finished their shifts early afternoon. This meant that people did not have choice to have a light lunch and a more substantial meal at teatime as the only options were to have food at teatime that had been pre-prepared and left for care staff to serve from food trolleys; this was sandwiches and soup every day and sometimes a hot option was available that had been kept in the bain-marie, such as chips. Choice was very limited and the times and types of meals was rigid. This system did not take into account people's preferences and choices around when they would like to eat.

One person told us, "the gap is too small between breakfast and lunch".

The cook told us that they had a cold buffet every weekend, including sandwiches, sausage rolls and pork pies. We asked what people ate between meals and the cook told us that fresh fruit was offered to people in the afternoons; however, on the first day of inspection this did not happen as no fruit was available that day as they had run out three days previously. We saw that during the afternoon people were offered a biscuit from a storage jar of mixed biscuits. The cook told us that every night for supper the people were served jam sandwiches and crackers; we asked if there were any alternatives if people did not like these two items and we were told that staff could make some toast. Each day people were offered tea or coffee at mealtimes and set times during the day, and had the option of cordial served in a plastic cup.

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

On the ground floor of the building we saw that some attention had been paid to making the home conducive to people living with dementia; there was a reminiscence room containing items from previous decades, and some rooms had photographs and names of people whose room it was. We saw one blue toilet seat on the first floor to provide assistance to differentiate items for people living with dementia. However, we did not see any other alterations to the home to make it dementia-friendly, such as contrasting

doors and we noticed that carpets had thick dark borders in places and lighting was low on Heather unit. This meant that people living with dementia may confuse the carpet with holes in the floor and may not easily be able to differentiate doorways and navigate their way around the home.

Requires Improvement

Is the service caring?

Our findings

People told us that they were well cared for in Holme Lea. One person told us, "staff have been amazing… always got time for you" and another person told us, "everybody looks after you". We spoke to one relative who told us about their relative who lives at the home, "they couldn't be looked after better…would recommend it".

We saw that people were mostly treated in a caring way. We observed one carer sitting with a person using the service and the person was stroking the carer's hair and they were talking about the colour and softness of her hair. We observed some staff kneeling down to eye level and talking kindly to people, and we saw that one carer had noticed one resident was cold so they asked if they would like them to go and get a cardigan for them. Another carer was talking nicely to residents in the lounge area of the unit and we saw the home manager helping one person to move seats whilst chatting and providing reassurance.

One visiting health care professional told us that they like how staff take people to their rooms for privacy if they need to have blood taken and stay with the person. They told us that staff "speak to residents properly" and that they are, "a good set of staff". Another visiting health care professional told us that they had spoken to people and their relatives about the care they receive at Holme Lea and they had given positive feedback; one person had been staying temporarily at the home and had decided they would like to move in permanently because they liked the care they received.

We saw some positive interactions between staff and people who use the service however, many interactions between staff and residents were task-led and any discussion was around what was happening there and then, for example, asking if they would like tea or coffee with their lunch. We did not see staff talking to people about their family, past history, the weather, or just having a general chat with people. When talking with us, one member of staff referred to people who required assistance with eating as "the feeders". This comment regarding people, demonstrated a lack of respect to people living at Holme Lea. We found that, although most staff were caring towards people using the service, the atmosphere in the home was rushed and task-led, and staff had little time to spend with people.

We saw that photographs of people living at Holme Lea had been put together in collages and displayed on the walls, showing a number of social events at the home. During the inspection we saw that the home manager had accommodated a person using the service and their spouse to have a meal together in the reminiscence room to celebrate their wedding anniversary. This meant people were supported to celebrate events in their lives that were important to them.

One person's visitor told us that they felt that their relative always looked clean and had their hair done every week and they found the new home manager, "approachable, listens and seems caring". Another visitor told us, "in the last three or four months the care has become tip top". Another relative that we spoke to named four members of staff who they felt were particularly caring and felt that the new home manager "had improved thing a lot".

Requires Improvement

Is the service responsive?

Our findings

People's care plans contained comprehensive information around the person's support needs, but had relatively little about the person, for example, their family history, previous work experiences, preferences and aspirations. We found a photograph and some basic information around what people like to do, for example, in one person's file there had been recorded that they liked painting, but we did not see any evidence that this preference had been accommodated. We also noted that this person liked to have two pillows; we visited the person in their room as we were told that they had decided to have a lie-in that day and we found that they had two pillows on their bed.

One person who lived at Holme Lea had their relative visit them every day and they were very involved in caring for the person. We did not see that the relative was included in the person's care plan; relatives who are very involved in caring for the person can contribute positively to effective care delivery and this can be incorporated into their care plan.

During our inspection, we looked in four people's bedrooms. Three of them were on the ground floor and were clean and tidy with evidence of personalisation, showing that people had been able to add their own personal items, including one person who had ornate decoration put up their en-suite room.

We saw some examples of positive interactions between staff and people who use the service, but the majority of the time staff did not have time to be attentive or notice when people required assistance. For example, we saw more than one instance where people needed help with their meal and did not receive it. There was little choice with food and drink options and we saw one care staff put on a film in one of the lounges, but no-one was asked if they wanted to watch it. We noticed that cleaned items in the laundry that were waiting to be returned to people's rooms, were hung up on rails, but some items were creased and would not have looked smart when worn. We observed that when one person's relative arrived to visit them, they commented, "those are not your trousers" and mentioned this to a staff member. This person's care plan stated that they "like to be smart"; however, the staff member did not offer to go and assist the person to change into their own clothes. We observed another person had a wet patch on the front of their trousers and when we saw them again some time later, they were still wearing the same trousers.

We spoke to one person who told us that they were mostly independent, but required assistance to have a bath or shower. They had not had a bath for several weeks and had requested one five times and this request had still not been fulfilled as staff say they did not have time. We reviewed the bathing file on Heather unit and found that records for January 2016 showed us that people were not being offered or having regular baths or showers. Records evidenced that some people had not had a bath or shower for a whole month and some people had had one bath or shower in the month. This meant that people were not having their basic needs met nor their choices and wishes respected.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

In the Heather unit section of the building, we found that there were a total of three call bells located on the walls. One was located in the dining area and was accessible to people sat at the dining tables. However, we saw that two call bells were inaccessible; one was hidden out of view behind a lounge chair and the other call bell was out of reach behind a hat stand. None of the call bells had the attachable cord fixed in. This meant that people could not easily summon assistance if they needed help.

Holme Lea had part-time activities co-ordinator employed to provide mental and physical stimulation through a programme of activities. We spoke to the activities co-ordinator and they told us that they offered regular activities throughout the week, for example, jigsaw, knitting and occasionally people were taken out for a pub lunch. We were told that around five people would be taken out at a time and this was often the same people who would participate, however, we were told that everyone would be asked. Fundraising events would sometimes also be put on at the home and we saw that in the reception area there were prizes displayed for a valentine's day raffle.

On the second day of our inspection, we asked what activities were on that day and we were told that it was parachute/skittles, a film and nibbles, and building blocks. We observed one lady was seated with a staff member in at a dining table on Tulip unit with the building blocks, which are useful for mental stimulation in the elderly, however, only one person was involved and everyone else was seated in the lounge area not participating in any activity. We did not observe any other activities that were happening during our three day inspection.

We saw that there was an activities programme notice board in the reception area showing that the hairdresser was visiting that week and Wednesday night was "bingo and games". The only other information was an advertisement for Sky TV installation. This showed us that attention had not been paid to giving up to date and comprehensive information to people using the service about the activities programme to enable them to make a choice around what they might like to join in with that week.

We asked about the people who preferred not to participate in the pre-planned activities and we were told that a staff member may go and have a chat with them. We asked how decisions were made around what activities would be included in the activities programme; we were told that the activities co-ordinator would decide the programme. People had no input into the planning or decisions around what activities were on offer and no individual options were available to those people who did not want to participate in the predetermined activities. This meant that people's preferences, choices and personal opinions had not been sought or considered as part of their right to participate in making decisions about their daily choices.

This was a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care

There was information on the wall in the reception area giving information on how people could complain about the service. We reviewed the service's complaints file and saw that there was a complaints procedure in place and the home manager had responded to most complaints; carried out an investigation and acted upon the outcome, for example, we saw that staff had undergone additional training in response to one substantiated complaint. This showed us that the manager had been responsive to complaints about the service and implemented improvements. However, we saw that there were two serious complaints that involved safeguarding investigations by the local authority and these two complaints had not been responded to in line with the service's own complaints procedure and responses from the home were still outstanding. The home manager told us that these complaints would be responded to as soon as possible.

We saw that the views of people and their relatives had been sought and published in a customer

satisfaction survey report, which was on display in reception. This report had been carried out in 2014 and the manager told us that they were currently in the process of updating this information. We saw that information detailing a new Holme Lea family support group being set up by a relative. This had been organised by the family members and facilitated by the home. As the group was currently in its infancy, no meetings had yet taken place.

Requires Improvement

Is the service well-led?

Our findings

At the time of inspection the home manager had not yet applied for their registration with the Care Quality Commission (CQC).

People, relatives and visiting professionals were complimentary about the home manager and felt that improvements had been made in the six weeks that they had been in post at Holme Lea. Several people and their relatives described the home manager as approachable and one visiting professional described them as "more hands on". One relative told us that the home manager had "improved it a lot".

During the inspection, we found that systems and procedures were in place as Holme Lea was a care home owned by a corporate provider and had existing quality assurance systems. We found that these policies and procedures were not always being implemented or followed by staff to ensure the effective and safe delivery of care. For example, accidents and incidents were not being comprehensively recorded and meaningful analysis was not being made of these records to ensure effective monitoring and safety of the people. We also saw that procedures put in place to ensure safe and effective delivery of care were not being followed or completed, such as, nutrition and hydration charts and prevention of pressure sore charts. Care plans and risk assessments were not being comprehensively reviewed with accurate information to ensure up to date care delivery. The manager was not aware of these failings in the recordings and did not have an overview of this situation to enable suitable action to be taken.

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

Personal information around people who lived at the home was not kept confidential and systems did not adhere to the Data Protection Act 1998. Personal information, such as, care plans and risk assessments, stored on units in unlocked drawers meant that this private information was accessible and not kept secure. The home manager had a large whiteboard on the wall in their office with the full names of each person living at Holme Lea. This information included details of room number and if they were on pressure relief, nutritional support or end of life care. This is a useful tool for managers to enable them to see vital information about a person quickly, however, this whiteboard was visible to people who lived in and visited the home and included person identifiable information that needed to be kept confidential. When we looked at the information displayed on this board we found information to be incorrect and required updating. This meant that out of date information could result in unsafe care and support being delivered.

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

Audit checks were in place for a number of areas within the care home. Checks we reviewed included; monthly medicines audits, infection control, equipment tests, fire safety checks and we checked that Holme Lea's smoking room had a risk assessment in place. Despite these checks, we found that the environment was not always clean and safe. We saw that the manager had recorded daily walk round notes and told us

about "flash meetings" that they held in order to give staff updates on people's current care needs. However, we found cleanliness and safety concerns throughout the building as found during the service walk around, for example, insecure radiator covers, a disorganised medication room, a lack of easy access to Personal Protective Equipment and infection control risks in the laundry. A robust environmental audit would have identified these areas and help minimise the risk of the potential for future incidents. Additionally, we found that staff personnel files were incomplete, training information was missing and safe recruitment of staff had not taken place. This meant that the provider did not operate effective systems to monitor the safety, quality and risk of services to people within the home.

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

The home manager was visible around the home and people we spoke to told us they were approachable and caring. It was clear that the new home manager was making improvements within Holme Lea and establishing positive relationships with people who lived at the home, their relatives and staff. However, we identified a number of shortfalls, as detailed in this report, that were endemic throughout the service and this meant that people who live at Holme Lea were not always receiving high quality care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use the service were not having their nutritional needs, choices and preferences met. People's preferences, choices and personal opinions had not been sought or considered as part of their right to participate in making decisions about their daily choices.

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 because they did not receive assistance to have a regular bath or shower.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not receiving care in accordance with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards because 11 people were being deprived of their liberty without the required application/authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

People who use the service were at risk of not receiving the prescribed nutritional support

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that accurate complete and up-to-date records were kept in respect of each person. The provider did not ensure the security and confidentiality of information relevant to carrying out the regulated activity and did not adhere to the Data Protection Act 1998. The provider did not have sufficient and effective systems in place to ensure a robust overview of the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe and effective recruitment procedures were not in place and appropriate checks had not been made on staff to ensure safe and effective care delivery.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's risk assessments were not effectively and accurately reviewed. There were no personal emergency evacuation plans for people who used the service. Accident and incident reporting was inconsistent. Investigations were not carried out and effective monitoring was not in place to identify, address and remedy accidents and incidents. The environment was not clean to adequately protected against the risks associated with not effectively preventing and controlling the spread of infection.

The enforcement action we took:

Warning Notice to provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to ensure the safe and effective delivery of care. People did not receive care from staff who had benefitted from effective induction, training, development, supervision and appraisal necessary to carry out their duties.

The enforcement action we took:

Warning Notice to provider