Heritage Care Limited

Holmers House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

The inspection of Holmers House took place on 10 and 11 April 2018 and was unannounced. This was a scheduled inspection, which followed up breaches from the previous inspection when the service was rated inadequate and placed in special measures.

Following the last inspection, we met with the provider and asked them to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring responsive and well led to at least good. During this inspection we found some improvements had been made. However, we found a continued breach of regulation in relation to person centred care.

Holmers House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Holmers House accommodates 48 people in one adapted building. The service accommodates 16 people across three separate units, each of which have separate adapted facilities. All of the units specialise in providing care to people living with dementia. At the time of our inspection there were 33 people using the service.

The service requires a registered manager to manage the service. At the time of our inspection a registered manager was not in post. The service was being managed by a registered manager from another location.

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.

People we spoke with told us they felt safe living at Holmers House. One person told us, "I am grateful for a place like this, it is safe, no-one interferes and they leave you alone."

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

Records relating to recording of food and fluids were not always completed accurately. People on restricted fluids did not have their daily intake recorded accurately for staff to see how much they had received.

People were not always supported to have maximum choice and control of their lives; policies and systems did not support this practice.

Staffing levels were adequate to ensure people received care in a timely manner. Staff had received training in topics such as moving and handling, mental capacity and fire safety. Regular supervisions and reviews of performance had not been carried out in the past. However, there was now a system in place to ensure that staff received adequate support. Staff told us they felt supported by the management of the service.

Staff had received training in safeguarding and told us they knew what to do if they suspected someone was being inappropriately treated. We spoke with a member of staff who told us they had reported poor care practice in relation to medicine administration.

The provider had robust recruitment files in place to ensure only suitable staff were appointed. Files we viewed had proof that Disclosure and Barring Service checks (DBS) had been completed.

We found people's care was task-focussed and not person-centred.

One relative we spoke with told us, "Staff congregate in corners with no awareness of what is going on." The delivery of high quality care was not assured by the culture of the service.

People told us the food was good and they were given an option. People with swallowing difficulties had pureed or soft food.

People had no social stimulation and were asleep in lounges for most of the day. One relative told us they took their relative to a day centre to give them some form of social interaction. The relative told us, "Dad comes to life when he is there." There was no indication from any information and notices in the Home and from what people told us that people from the community visited Holmers House at all apart from a monthly church service.

Information about advocates was not present in the service. We did not see a comments or suggestion box for people, visitors and relatives to make any comments about the service. Systems were in place for managing complaints but information on how to raise a complaint was not available for people living with dementia.

People had access to other professionals such as community mental health nurses and the GP. These services were accessed when required.

The service employed domestic staff who were responsible for the cleaning of the home. We saw the home was clean and free from odour when we visited.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always available for people.

Risk assessments did not always highlight how staff managed risks.

Recruitment checks were robust to ensure only suitable staff were appointed.

Is the service effective?

Requires Improvement

The service was not effective.

Records were not always completed or accurate.

Person centred care was not evident.

Supervisions were not carried out on a regular basis.

Staff received training in topics relevant to the organisation.

Is the service caring?

Requires Improvement

The service was not always caring.

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

Staff did not always spend quality time with people.

Confidentiality was protected. People's records were stored appropriately.

Is the service responsive?

Requires Improvement

The service was not responsive.

Supplementary records were not always completed or accurate.

Complaints were responded to in line with the providers policy and procedure

Is the service well-led?

Requires Improvement

The service was not always well led.

The providers' quality assurance systems were not always effective in identifying shortfalls.

Staff felt supported and could voice their concerns to management.

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

Holmers House

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 April and was unannounced. The inspection was carried out by an inspection manager, two adult social care inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people and dementia care. An inspection manager and one adult social care inspector completed the second day of the inspection.

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

During our inspection, we spoke with twenty-one people who use the service, four relatives, and three visitors to the home. The visitors included a medic, a Chaplin and a community nurse. We spoke with the home manager, the regional manager, a deputy manager, two senior carers, the administrator, and six members of staff. We received feedback from commissioners of the service prior to our inspection.

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

Observations were from general observations and where people could not communicate with us, we used

the Short Observational Framework for Inspecting (SOFI). SOFI is a tool to help us understand the experience of care people receive who were unable to communicate with us.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in August 2017, the provider was in breach of Regulations 12, 13, and 15, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not managed appropriately. Some people had not received their medicines due to insufficient stock. People were not protected from abuse and improper treatment. Premises and equipment were not maintained to acceptable standards of hygiene.

We found during this inspection the provider had made improvements in relation to ensuring the premises were maintained to acceptable standards of hygiene and protecting people from abuse and improper treatment. We also found that the systems in relation to medicines had improved. The home had been supported by a visiting pharmacist who had carried out regular audits and reviews of medicine practice. We did however; find some areas still required improvement.

We found two instances where people's medicines were not available for a short period. We discussed these with the manager of the service, who was able to explain why these had happened and measures put in place to avoid these happening again.

We observed the administration of medicines during our inspection and found staff to be competent to carry out the role. We saw that one person had their medicines covertly. Covert medicine is the administration of medicine in a disguised form. This usually involves disguising medicine in food. As a result, the person is unknowingly taking the medicine. The person's care plan did not specify how much food to disguise the medicine in. We spoke to a member of staff and they told us they usually put the medicine in a pot of yogurt. However, the person may not eat all of the food and this would result in the medicine not all being taken. We discussed this with senior staff who said they would ensure the records were updated to specify the amount of food to put the medicine in to ensure the person received all of their medicine.

We received further information following our inspection to confirm the care plan now specified the amount of yogurt to put the person's medicine in. This would ensure all the medicine had been taken.

We looked at one person's topical medicines administration chart (MAR). The person was prescribed cream for their dry skin. Staff had handwritten on the MAR the times for the cream to be applied, but there was no information, which stipulated it was to be applied four times a day. Over a 22-day period, there was a variety of administration recorded by staff. On some days, the MAR chart was not completed at all. On other days, staff had correctly recorded the person refused the medicine (by using a code). Some day's staff had signed the cream was applied only once or twice a day. A lack of clarity in the records meant the person's medicine records did not indicate the cream was applied in a consistent way.

We recommend that the provider continues to implement the improvement plan in relation to medicines management within in the home in line with national guidance.

Staff we spoke with told us the indicators of abuse and what they would do if they had any concerns.

Records confirmed staff had received training in safeguarding people from abuse. One member of staff told us how they had reported abuse to the management in relation to poor practice. We saw the service had carried out investigations in relation to this and taken appropriate actions.

People who remained in bed (bedbound) had special air mattresses to help prevent pressure ulcers from developing. In addition to the mattress, a turn chart should be used to record how staff repositioned the person, what side the person is on, and how often the staff changed the person's position. For two people, the staff could not locate turn charts. This meant there was no record of the frequency of the persons reposition, which increased the risk of the person developing skin damage.

People we spoke with told us they felt safe living at Holmers House. One person told us, "I am grateful for a place like this, it is safe, no-one interferes and they leave you alone." Another comment we received was. "I didn't feel safe when I lived alone at my own home because I knew I was alone."

Recruitment procedures were found to be safe. The manager had reviewed the recruitment records held in the service and updated the staff files. The files were easy to navigate and demonstrated that appropriate checks had been made to ensure that only suitable staff were employed. This included proof that Disclosure and Barring Service checks (DBS) had been completed.

Through our observations and discussions with people and staff it was clear there were enough staff deployed in the units to meet people's needs. The home had found it difficult to recruit staff and there was a high reliance on agency care workers and a large number of shifts per week were completed by them. The manager and the provider acknowledged this and had an ongoing recruitment process in place. The provider also ensured consistent agency staff were employed where possible. We saw that many of the agency staff had worked at the home for long periods of time.

People commented they did not have to wait long for assistance. Comments were, "I press it (buzzer) only a few times, they tend to come around quite often anyway," "Yes they come fairly quickly," "I use the buzzer but not very often." We saw that in the lounges downstairs, there were buzzers inset in the wall.

People's care was primarily recorded within an electronic records system. Both the permanent and agency staff recorded information in the system. The computer recorded the date and time of the notes, and which staff member had entered the information. All people who used the service had relevant care records in the computer system. Computer records consisted of general information about the person, such as their social and family history, medical needs, various risk assessments, care plans and reviews.

Risks to people were recorded in a variety of standardised risk assessment forms on the computer. This included falls risks, medicines, moving and handling, pain management, nutrition and hydration and those specific to medical conditions, for example diabetes. Risk assessments were mostly accurate detailed and provided a clear overview of the person's needs for staff. Some risk assessments did not contain specific information to ensure the person was completely protected for harm. For example, we noted risk assessments about diabetes did not contain enough information about how to detect low and high blood glucose levels, factors that could influence blood glucose levels and the frequency of various medical checks associated with the disease. We pointed out the local area's best practise guidelines for diabetes to the home manager, and they were receptive of our feedback.

One person's fall risk score was incorrectly recorded. The computer risk assessment stated the person was at low risk of falls. However, they had sustained five falls in December 2017. Strategies to manage the risk of repeated falls were noted, but did not include referrals to community healthcare professionals such as a

falls clinic, optician, occupational therapist or physiotherapist.

Fire drills took place and people had individual personal emergency evacuation plans in place (PEEP) in the event of an emergency such as a fire.

We checked how the service assessed, mitigated and managed the risks from premises, equipment and the grounds. The provider leased the building and maintenance was carried out by the landlord and third-party contractors. This meant some required paperwork related to the building risks was not on site at the time of our inspection. The home manager had obtained some risks assessments since they commenced in their post. We wrote to the home manager after our inspection and they provided the requested documents. Checks were completed for fire safety, window restrictors, gas and electrical safety. Moving and handling equipment and portable appliance testing. A Legionella risk assessment was completed, but not all remedial actions were completed at the time of our inspection. In addition, a water sample had not been collected to check for the presence of the bacteria. The home manager organised this after the inspection.

All areas of the building were clean and odour free. We observed cleaners attending to various areas of the premises during our inspection. They followed national best practise (known as the 'cleaning code') which included using colour-coded cloths, mops and buckets for specific areas. Hazardous chemical were locked away. Cleaners kept records of the tasks they had completed on each shift. There were adequate facilities for staff to wash and dry their hands. Staff used disposable gloves and gowns when performing care. Waste storage and disposal was in line with the required regulations.

The service had a policy and procedure in place to review and monitor accidents and incidents. Accidents and incident reports had been completed as required when events occurred at the service. These were then reviewed by the home manager and measures taken to reduce the risk of them happening again.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection, the provider was in breach of regulation 14 and regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found during this inspection the provider was compliant with regulation 14 but was in continued breach of regulation 9 of the Health and Social Care Act 2008.

There were a limited number of paper records used for particular aspects of care, such as food and fluid intake, the use of topical medicines (creams and lotions) and elimination. Some staff were unaware which people were on specific paper-based charts. In addition, some people's charts could not be located, or were situated at inappropriate locations, or were not fully completed.

All people who used the service were on food and fluid charts. The home manager explained this was temporary until the recording of input was more consistent, after which this would be reduced to only people who had high risks for dehydration of malnutrition. Fluids were also recorded in the computer care system, although these were inaccurate. Staff did not always record the actual volume consumed by people and instead recorded that people drank the whole cup. One person who had a fluid restriction in place did not have excess fluids when we added up the volumes consumed over consecutive days. However, staff did not calculate how much fluid the person had in a 24-hour period and record this. That meant the person was at risk of having too much fluid in a given period, which could lead to deterioration of their existing medical condition. Other papers related to people's care were kept in a folder at the staff station. This included information such as letters from social or healthcare professionals, deprivation of liberty applications and authorisations, GP notes and blood test results.

Although there were sufficient staff deployed, some staff did not know people's needs well-enough. For example, in one unit we asked all four staff who had diabetes, insulin or was on warfarin. Only one member of staff knew these needs of the people. The lack of staff knowledge about people placed people at risk of receiving task-based, rather than person-centred care.

During the course of the inspection, we observed interactions between staff and people living in Holmers House. The quality of these interactions was variable. Some of the interactions were formal and minimal others were caring and showed an understanding for people's needs. During breakfast on one of the units everyone sat in silence, staff brought food in but we saw no one was asked what they wanted to eat. There were no condiments visible and no one was asked if they wanted them. We observed a member of staff ask one person who had finished their breakfast. "Do you want some more tea?" The person said politely, "No thank you I have finished." Shortly afterwards we saw the member of staff place a mug of tea in front of the person and walk away without comment. The person told us, "I didn't ask for this; I shall be going to the toilet all morning." This meant that people were not always supported to have maximum choice and control of their lives.

However, when we observed breakfast in another of the units the experience was very different. There was background music playing and staff interacted really well with the people. They were offered choice and we

observed a staff member supporting a person to leave the table following their breakfast in a very understanding and appropriate way. The atmosphere during the mealtime was pleasant and we observed that people seemed to be enjoying their breakfast.

We asked people what the food was like at Holmers House. Comments were, "It is okay," "I am given an option, there are different things on the menu". However, we saw menus were not clearly displayed for people to see and it would be good practice for a picture menu to be available for people. During one lunchtime observation, staff presented people with a choice of two meals that they had prepared and asked people to choose what they wanted. One person was tempted by sticky toffee pudding after refusing the main courses and alternatives offered. However, this practice was not consistent and in other units, this was not done. For example, one person asked, when they were offered cottage pie. "What is cottage pie?" and received an answer, "Mash mince and potato" the member of staff did not show the food to the person to help them make a choice. One thing we did note throughout our mealtime observations was that people ate good quantities of food and seemed to enjoy what they were eating.

One person said of the lunch experience, "It is quick, it is always quite." We observed one lunch was eaten in total silence with no interaction or conversation at all. Some people dropped food but ate independently, there were no napkins for people and we saw two people wiping their mouths on their clothing. We noted lunchtime lasted less than twenty-five minutes, by which time most of the attending people had left and the tables had been cleared. We noted not one member of staff sat down beside people during lunch.

In the electronic care records, there was a place to record people's allergies, including those to food and medicines. In addition, people's food allergies were noted in the kitchen on a paper chart. However, when we asked a staff member, they were unaware of any food allergies or where information about this was recorded. We pointed out the paper chart in clear sight on the wall. This meant people could have received food that was inappropriate for them. Care workers however did know people's food allergies when we asked them. Some people were at risk of choking on food or fluids. Their records reflected the texture of the diet they must receive to minimise the risk of harm. Care workers we asked knew some people's specific dietary requirements, but not others. There was a chart which detailed the food modifications, located in the kitchen for use by the chef and kitchen assistants. We noted that specifically modified meals were prepared in the kitchen and correctly served to people.

We saw one person asleep at the dining room table following their lunch and had their outdoor coat on. Two members of staff were engaged in conversation with each other, oblivious that the person was asleep at the table and required attention as they had a streaming cold and needed tissues. We discussed this during feedback with the management of the service. They said staff were still not providing person centred care. One visiting relative told us, "Staff congregate in corners with no awareness of what is going on." One person told us, "I know nothing and do nothing until I'm called for."

One person was wandering for most of the morning and walked aimlessly around the unit, we did not see one member staff talk to the person or engage with them. At lunchtime, the person was shown to her place and we saw them eating lunch. In the afternoon, the person seemed less anxious and was seated for a while until they started wandering again still no one interacted with the person.

In discussions with the home manager they were aware staff needed to improve their interactions with people and often staffs approach was task centred rather than person centred. The home manager showed us they had arranged training for staff to address this issue.

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

Regulations 2014.

The home manager had implemented a new supervision structure and we saw this was now in place. Supervisions in the service had not taken place on a regular basis but the home manager was monitoring the new system to ensure that staff were regularly supervised. The home manager also informed us that no appraisals had taken place for some considerable time and he would be addressing this once the supervision structure was embedded. Staff told us they could go to senior staff when necessary and felt supported by their seniors and the home manager. One senior member of staff told us, "[Name of staff] is really great, in terms of me, I feel really supported." A regular agency member of staff told us, "I think I have seen a lot of improvement, there is an element of team work." They went on to say…"We are treated the same even though we are agency."

Staff were required to shadow more experienced staff as part of their induction. Staff told us and records showed that regular training was undertaken to enable staff to meet the needs of the people they supported. Staff attended training in areas such as fire safety, safeguarding, food hygiene and moving and handling.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires that as far as possible people make decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Each person had a mental capacity assessment recorded. However, for people who had full mental capacity there was no need to complete a capacity assessment. The assessments completed were neither time nor decision-specific, which rendered them as mental state examinations, rather than mental capacity assessments

Policies and procedures were in place to guide staff in relation to the MCA and DoLS. Staff had completed training in this area and demonstrated an awareness of the act. Where decisions had been required to be made, we could see evidence that formal capacity assessments and best interest meetings took place with relevant parties. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had submitted applications to the local authority last year for a number of people who used the service. The service was waiting to hear the outcomes of some of these applications.

People received ongoing support from healthcare services such as GPs and specialist services. Referrals were made when required.

The service had recently undergone refurbishments. Communal areas and individual bedrooms were bright and well designed to provide people with a pleasant environment in which to live.

Requires Improvement

Is the service caring?

Our findings

During our previous inspection, we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. People were not treated with dignity and respect at all times. We found during is inspection the provider had made improvements and people were treated with dignity and respect.

We asked people and their relatives if they felt the service was caring. People were mostly positive in their comments about the care they received and most confirmed that staff were caring. We received comments such as, "I'm looked after", "I am cared for here", "They are all kind to me and try hard to make me comfortable", "I am looked after and I am happy here as long as I am in charge," "By and large I get on with the staff", "Most of them are pleasant people, there is the odd one of course that isn't."

From observations, relationships between staff and people were varied, some appeared formal, minimal and efficient. Others were caring and positive interactions and showed awareness for people's need. Staff were always polite but sometimes lacked spontaneity or any ongoing conversations with people.

Staff were able to describe the methods used to ensure people's dignity was upheld and respected. We saw that staff knocked on people's doors before entering. People were appropriately dressed and well kempt. However, we observed that several people had the same colour nail varnish applied, which was chipped and unsightly and had clearly been applied some time ago.

The service did not always involve families in decisions about their family members care needs or changes to their relative's condition. One family member told us, "A, doesn't tell B what they are doing. That is the thing that lets them down." The relative went on to say, "It all depends on what staff you have got on in terms of a caring attitude." Another relative told us how disappointed they were when they visited to find their relative suffering from a urine infection. They told us, "The home had not noticed or done anything." They also told us their relative was losing weight and not eating. The relative told us, "The carers are today in the lounge, but normally they are in the kitchen in groups and not looking at the residents."

Details of advocacy services were not available for people living at Holmers House. Advocates are people independent of the service who help people make decisions about their care and promote their rights. This meant people who required support to express their point of view about their care were not able to access independent help to achieve this. However, the person currently managing the service told us they were looking into this area and would source advocates for people if they were needed.

The Accessible Information Standard (AIS) is a framework in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service assessed and recorded people's cognitive functions, communication barriers and methods of ensuring meaningful information were provided. Information about how to communicate with people effectively was included in care records. This included any modifications to, or adjustments made for the way of ensuring people could understand information provided to them. There

was clear information about glasses, hearing aids and other methods of communicating with people. Signage throughout the premises was clear and in a large font. Bright colours were used to denote certain elements of the building such as doorways, bathrooms and toilets. Pictures were also used on some signs as a method of helping people with dementia understand information.

The rating poster was conspicuously and legibly displayed in the reception area of the service. Our prior rating was also displayed on the provider's website. This meant people could see the performance of the service from prior inspections.

Families could visit without restrictions. Records were kept securely within the service. Care plans could be accessed via computers, which required a password to access.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us the service was not responsive. One family member told us they had to remind the service when their relatives blood tests were due. They told us, "[my relative] has to have regular blood tests, but I have to remind them. The home fails to provide basic care for my [relative]. He is often without his dentures when we visit and more often than not, he has the same jumper on. We are in the process of looking elsewhere for a care home. But this worries me how this will affect him as his health is poor at the moment." We looked at the person's care plan during our visit and saw the person required regular blood tests to monitor their condition. We saw no confirmation when the next test was due. We spoke with a senior member of staff about this and they contacted the local surgery to request an appointment for the person's blood test.

We also noted in one person's care plan the GP had requested the service to monitor a person's drowsiness as the GP had stopped a medicine. We saw a letter from the GP stating, 'as discussed please stop trazadone and monitor if drowsiness improves' dated 4 April 2018. We did not see evidence this had been carried out. We spoke to a senior member of staff about this and they told us, "We have discussed the person's drowsiness when we have handover." However, evidence this had been discussed was not recorded in daily records.

One person, at times, exhibited behaviour that challenged staff and the service. During our inspection, the person was observed to be calm and friendly. A review of the person's needs was scheduled to occur with the multidisciplinary team. Staff were not aware of the review, but were requested to keep a record of the person's care using a "24-hour care diary". We looked at March and April 2018 records of the person's care. Staff recorded detailed information about the person's care, mood and behaviour. However, these records conflicted with information recorded in a separate document called the "behavioural chart". In the person's chart, staff used codes to record the person's level of agitation. This was designed to be completed hourly. On some days, there were large gaps where staff had not completed the form. On one day, the form was not completed for the entire 24-hour period. This meant that at the person's review, the multidisciplinary team would have a confusing view of how to determine whether the person's care needs were accurate.

Relatives told us they were not aware of care plan reviews and had not been invited to attend review meetings. However, some relatives told us they were contacted if their family member had a fall. We were aware the home manager had identified this and the service was in the process of sending out letters to invite relatives to care plan reviews.

Assessments and care plans were reviewed monthly. The computer system alerted staff when risk assessments and care plans required mandatory updates, but staff could also made ad hoc adjustments if a person's care needs changed during the course of a month. Some people's social history was not completed, meaning agency workers may not be able to read a summary about the person they had never cared for before.

Organised activities were not consistently provided for people at Holmers House. There was no specific

member of staff responsible for providing activities within the service. One relative told us they arrange for their family member to visit a day centre as, "There was nothing for them (family member) to do at the service." They told us, "[my relative] comes to life at the day centre." Another relative commented when their family member was admitted to hospital, "He was talking with the other gentleman on the ward; he really came out of himself then. They went on to say that, staff at Holmers House do not engage with their family member.

The lack of stimulation was evident in most of the comments we received from people. We asked one person if they would go to the lounge today. They replied, "I expect so." We asked what they would do when they were in the lounge. They told us, "Nothing; if you are really lucky something will happen." We asked other people what they would do today we received replies such as, "Oh probably sit here and look out of the window and see if anybody passes by", "I don't know maybe watch TV", "That's a good question, nothing I expect," "We don't get up to much here", "I'm happy doing nothing", "Nothing; there is nothing to do here".

We asked one person what they would like to do and they replied, "Nothing it's all miserable." One person told us, "I stay in my room nearly all the time. I don't go down because I feel uncomfortable and people look at you oddly." Another person told us, "There's not many here that can talk to me, I miss that, staff sometimes talk to me if they have time." This demonstrated the service failed to provide any meaningful stimulation for people and we saw most people remained seated, inactive, alone and immobile all day. However, we saw on one unit a member of staff played music and sang to people to engage with them.

A monthly church service was held; however, we were told people who wanted Communion no longer had this facility available. One person we spoke with told us they have asked the management to reintroduce the service.

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

Families we spoke with told us they knew how to make a complaint. Complaints were responded to either verbally or in writing depending on the complainant's preference. We saw there was one open complaint, which was sent on 4 April 2018. This was in relation to clothing being all 'lumped together' and not ironed.

The service supported people at the end of their life, which was overseen by the palliative care team and the GP. Do not attempt cardiopulmonary resuscitation (DNACPR) orders were in place for people which was signed by the GP and relevant others where required. At the time of our inspection, no one was receiving end of life care.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Effective systems were not in place to monitor and improve the quality and safety of the service. We found during this inspection the provider had made improvements and was no longer in breach of this regulation. However they were aware improvements were on-going and still needed to be made.

Audits were carried out to monitor the quality of the service. Audits of risk assessments, care plan, health and safety and medicines management were completed. Senior management of the service reviewed audits. However, the audits had not identified issues we found. For example, stock of medicine, reposition checks, and person-centred care. In addition, following advice given by health professionals and meeting the needs of people who require follow up appointments.

The service had implemented a system for ensuring that paper-based care records were correctly and fully completed. However, this required improvement. We looked at the "shift leader daily checks form" in two units. This was a form designed to be completed three times a day by the most senior staff member as a method of checking staff had completed necessary paperwork. On one day, shift leaders had completed checks on the day and evening shift, but not the night shift. The form showed four people's daily hygiene charts were not completed, however there were no notes that indicated what shift leaders did to remedy this. This meant some people's records were not completed to correctly record their care during that period.

At the time of our inspection, a registered manager was not in post. A registered manager from another location was managing the service. Staff told us the manager was easy to talk to and they felt supported by them. Staff told us, "There have been mega changes; we are now checking that checking has been done. We are definitely on the way up." Another senior member of staff said, "We are still in transition. It's been a hard journey."

We asked people if they knew who the manager was we received comments such as, "I don't know, "Pass", "No I have no idea". One relative commented, "Where's the stability in terms of management." Another relative told us they had been coming to the home for two and a half years and visit two or three times each week. They said they had been reasonably happy with the care provision. They told us things had improved in terms of decoration and furniture. They also said in terms of communication things had improved as they are now contacted if their family member is going to hospital. However, were more critical on other matters.. They also told us they did not know who the manager was.

We found that person centred care was not provided at Holmers House. The service did not work towards best practice in supporting people living with dementia. People were left without any form of activity or engagement to occupy them. Records were not kept consistently or accurately.

Relatives and residents' meetings had not been taking place, but we were aware the manager was

addressing this and sending out letters to invite people and their families to future meetings. Staff meetings were taking place on a regular basis. Feedback surveys were being implemented and were due to be sent out to people and their families.

The service had notified us of significant events that had occurred, in line with the relevant regulations. Staff told us they were aware of the whistle blowing policy and procedure. They told us they would not hesitate to report any concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service failed to provide person centred care that met people's needs and reflected their preferences.