Age Concern Manchester

Holmfield Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Holmfield Care is a residential care home in Didsbury in south Manchester. It does not provide nursing care. It is registered to accommodate up to 29 people. At the date of this inspection there were 26 people living in the home. Three people were single occupants of the three double bedrooms, which meant there were no vacancies. The home is converted from two adjacent houses with a link between them. There are three adjoining lounges and a dining area.

This inspection took place over two days on 27 and 28 September 2016. The first day was unannounced, which meant the service did not know in advance we were coming. The second day was by arrangement.

The previous inspection took place in November 2013. At that inspection we found minor breaches of three regulations. These related to infection control, safety of the premises, and the Statement of Purpose not being updated. The provider submitted an action plan in February 2014 stating actions had already taken to remedy the breaches. At this inspection we checked and saw that those issues had been rectified.

Holmfield had a registered manager who had been in post for two years. 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. There were also two assistant managers and there was always at least one manager on site during office hours and at weekends.

People living in the home told us they felt safe and the building was designed to minimise the risk of falls. There had been no serious injuries so far during 2016. Falls were recorded and analysed with a view to improving safety.

People were protected against the risk of fire. Individual evacuation plans needed to be improved to give a summary of people's mobility. This was done during the inspection. The building and equipment were serviced regularly. The home was clean and smelled fresh.

Staffing levels were adequate. Agency staff were never used. Recruitment methods were robust to ensure that suitable staff were employed, but there were a few points of detail to attend to. The registered manager used effective disciplinary procedures.

Staff were trained in safeguarding and knew what procedures to follow. There had been no safeguarding incidents within the past 12 months. Risk assessments were carried out. Medicines were managed safely.

People enjoyed the food. Daily pictorial menu sheets were produced. Meetings were held at which people could express their views about the food. There was a nutrition lead who together with the chef ensured that people got the food they needed and wanted.

People's weight was monitored and action taken when required. People's health needs were met.

Training was thorough for both new and established staff. A variety of training methods was deployed. There was regular supervision of staff, and annual appraisals took place.

The service was complying with the Mental Capacity Act 2005 and ensuring that consent to care interventions was obtained. The registered manager understood the legislation relating to the Deprivation of Liberty Safeguards (DoLS). Applications were made when needed. However, the registered manager had not notified the CQC about four DoLS authorisations. This was done immediately during the inspection.

The environment had some adaptations for people living with dementia.

People living in the home were happy with the care provided and with the staff. Families also expressed satisfaction with the home.

Staff were patient and thoughtful when helping people with physical tasks, and they showed empathy with their emotional needs. We observed kind and considerate interactions.

Staff maintained people's dignity, and respected their privacy. Care records were kept confidentially.

Staff were well trained in end of life care. People's preferences to stay in Holmfield at the end of life were adhered to where possible.

Effective assessments were carried out before people moved into Holmfield. Then detailed care plans were created. These were personalised and gave sufficient information to enable care to be delivered effectively. They were reviewed monthly and any changes recorded.

There was a keyworker system so that staff were especially aware of the people they were keyworkers for. People were given 'personal time' where the member of staff would spend time only with that person. Residents' meetings were held regularly.

Different activities took place every day. We observed am engaging armchair exercises session which people were thoroughly enjoying. There were occasional trips out.

There was a policy on complaints. Minor complaints were dealt with informally. There had been one formal complaint in the last 12 months which had been dealt with promptly and sympathetically.

People living in the home and their families, and visiting professionals, told us they thought the home was well managed and the registered manager was approachable. The registered manager shared responsibility with two assistant managers. They had defined areas of responsibility but worked together well.

Staff expressed confidence in the management team and in each other. There were regular staff meetings where staff could contribute their views.

The service had an up to date Statement of Purpose. A range of audits were carried out. The registered manager's line manager visited the home regularly and reported on their findings, so there was outside scrutiny of the management of the home.

There was an annual survey of families and the results were collated by the provider.

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 always safe.

The building was well maintained and provided a safe environment. People were protected against the risks of fire but individual evacuation plans needed to provide information about people's mobility.

There were enough staff. Recruitment methods were effective but some minor improvements were needed.

There had been no recent safeguarding incidents. Medicines were well managed.

Is the service effective?

Good

The service was effective.

The chef took pride in providing food which people enjoyed, and adapted menus to meet people's wishes.

People had access to healthcare services. There was a good programme of training for all staff.

The service was compliant with legislation relating to mental capacity.

Is the service caring?

Good

The service was caring.

People living in the home, their families and professionals all spoke very highly of the quality of care. Staff were kind, patient and considerate.

People's privacy and dignity were respected.

Staff were trained in providing care at the end of life and enabled people to stay in the home until the end, if they wanted to.

Is the service responsive?

Good

The service was responsive.

Care planning was thorough and person-centred. Care plans and risk assessments were reviewed each month.

Activities were varied and engaging. We saw an armchair exercise session which everyone enjoyed.

Complaints were handled effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager delegated some responsibilities to two assistant managers. They worked well as a team, and were well regarded by people living in the home and their families.

Staff enjoyed working in the home and felt supported by the registered manager and by each other.

There was an effective audit system and regular scrutiny by the provider.
The registered manager had not reported all notifiable events to the CQC.

Holmfield Care

Detailed findings

Background to this inspection

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

The inspection was carried out over two days on 27 and 28 September 2016. The first day was unannounced. The second day was by arrangement.

The inspection team comprised an adult social care Inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had experience of caring for someone in their family.

Prior to the inspection visit we gathered information from a number of sources. We looked at the Provider Information Return (PIR). This 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. Services are required by regulations to notify certain events to the CQC. We looked at the notifications sent to the Care Quality Commission by the registered manager. We contacted the relevant contract officer of Manchester City Council about any recent monitoring visits.

During our inspection we spoke with 11 people using the service, two visiting relatives, and six staff, including an assistant manager and the registered manager. We spoke with two visiting district nurses and a health care professional. Following the visit we also contacted health care professionals to seek their views. We looked at three care records. We also looked at records relating to staff, medicines management, building and equipment maintenance and the management of the service.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe. One person said, "You're with other people. If you want help you only have to press the buzzer." Another person said, "I've got other people around me." A third person said, "I just feel safe and comfortable." Another person said, "I feel reasonably safe because people help you." Both visitors felt their relatives were safe. One said "Yes, because of the way things are and the way they are looked after." The other visitor voiced concerns about their relative's bedroom door being left open all night, because it was a fire door. We mentioned this later to the registered manager who explained that the door was open because this was the preference of the person in the room. She explained that there was a door guard which would close the door if the fire alarm sounded.

The environment and layout of the building were designed to be safe for people with limited mobility. Care had been taken to minimise trip hazards. At the last inspection we identified two minor risks. The provider had rectified these immediately. At this inspection we saw that those risks had been removed. We had not received any notifications of serious injuries within the last three years. All accidents and falls were recorded, and falls were transferred into a falls matrix each month, and then into an annual summary. This enabled the management and the provider to see if there were any particular trends, for example locations or times of day, where falls occurred more often.

People were protected against the risk of fire. The fire risk assessment was reviewed annually. Fire alarms, fire doors, extinguishers and emergency lights were checked regularly. There were fire doors throughout the building which closed when the fire alarm went off. We saw a demonstration of how this system worked. A file was kept by the front door with a register of the names of people living in the home, to give to the fire service in the event of a fire. However, this list did not contain any information about people's mobility needs. Such information is often known as a personal emergency evacuation plan (PEEP) and assists the fire service to evacuate people more efficiently. The registered manager agreed that PEEPs would save valuable time in an emergency, and added the information to the register immediately, so that it was complete by the time the inspection finished.

We saw evidence that the boilers were serviced regularly. Electrical systems were checked, and portable appliance testing (PAT) was being done on the first day of our inspection. The water system was checked for the presence of legionella every six months. Water temperature was tested. The lift was maintained regularly. The home also had a stairlift on one of its staircases. We were informed this was not used regularly but was available if the lift should ever break down. This meant that people would still be able to get to and from their bedrooms in the event of lift failure.
We also saw that the hoists and the adapted bath were serviced every six months.

We saw the latest infection control report, from July 2015, which gave the home a high score. Actions following that report had been undertaken. One of the assistant managers was designated infection control lead. They checked that the cleaners had completed their tasks and ensured there was a system for doing 'blitz' cleaning of rooms in turn. At our previous inspection we had noticed some areas where infection control could be improved. We found these had all been addressed. All the rooms and communal areas we

saw were clean, as was the kitchen. We saw that tongs were used to hand out biscuits in the lounge. This reduced the risk of infection.
The home had a pleasant fresh atmosphere.

We considered that staffing levels were adequate. Staff told us and the rotas confirmed that four staff were on duty each day from 7am, three in the evenings from 6 till 9pm, and at night three waking staff (i.e. staff who stayed awake through the night). In addition there was always at least one manager on duty in office hours, and a manager on call outside those hours. Holmfield never used agency staff. There were bank staff who could be called on when needed. They were used in the event of holidays or planned sickness, or alternatively staff might be asked to do extra shifts. If someone was sick at short notice, the registered manager would try to find a replacement or if necessary one of the managers would fill in. Staff told us they were happy with this system and they had never been asked to work excess hours.

We looked at records of recruitment for three recently recruited staff. We found that the application form only had a small space to record previous job history, and did not include a request to account for any gaps in the applicant's career history. These details are important to verify that the applicant does not have a criminal record or anything untoward in their history. We drew these aspects to the attention of the registered manager. They told us that these details were requested at interview if there was anything uncertain on the application form. Notes of the interview were retained. We saw that all other necessary checks had been done. One applicant had named their own uncle as a referee, and a reference had been obtained. We mentioned that this might not be the most objective reference. Part of the job interview was to spend time with people living in the home, and their comments on the prospective staff were recorded and formed part of the decision.

We saw that a certificate from the Disclosure and Barring Service (DBS) had been obtained before new staff started work at the home. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. We noted that the original DBS certificate (or a copy) was kept on personnel files. The correct practice is to keep only a note of the number of the certificate. The registered manager assured us they would do this from now on.

We saw that the registered manager employed disciplinary procedures where necessary. These related mainly to attendance. She had told us in the Provider Information Return (PIR) that six staff had been dismissed in the previous 12 months. When we enquired about the reasons behind this figure, she explained that five of these had related to poor attendance of recently recruited staff, and the sixth was someone whose visa was not renewed. These dismissals therefore did not give cause for concern about any risk to people living in the home.

Staff told us they had received safeguarding training. The record of training confirmed that all care staff, including bank staff, had received safeguarding training, with the exception of the most recent recruit. Holmfield's policy was that this training should be renewed at three yearly intervals. Staff we spoke with had a good understanding of the different types of abuse that might occur in the home. One member of staff said they would look out for any change in behaviour or mood of the person. They described the action they would take to keep people safe from harm. They said they would report any concerns to the registered manager immediately, and if necessary also to the police and to the CQC. They told us they would have no hesitation in blowing the whistle if they suspected a colleague was abusing a person living in the home. One member of staff said that they had not witnessed anything that concerned them while working at Holmfield. They felt confident the registered manager would investigate thoroughly and deal with the issue.

No safeguarding issues had been notified to us within the last 12 months, either by the registered manager or from any other source.

We saw that a range of risk assessments were present in people's care records in order to protect them from risks. These included Waterlow risk assessments (which assess people's vulnerability to pressure sores), and risks in relation to malnutrition, falls, bathing, and moving and handling. We saw monthly reviews of these risk assessments in all files.

We looked at whether medicines were being ordered, administered, stored and disposed of safely. We saw an up to date medicines policy was in place. The senior care assistants and several other staff were trained in administering medicines. They told us they had regular competency assessments. The treatment room where medicines were stored was on the ground floor. We saw there was a locked cabinet inside the room, for storing controlled drugs. These are drugs which by their nature are required to be kept more securely than others. There was a controlled drugs book which was signed and countersigned by two members of staff. We checked three drugs and saw that the quantity recorded in the book as remaining matched the actual amount still in stock.

We saw that Medication Administration Records (MARs) were signed after each person had received their medicines. If a PRN (as required) medicine was prescribed, information was attached to each person's record about when to give it and what signs to look for, for example if someone was in pain. One person was receiving their medicine crushed. This was by agreement with their GP.

Good

Is the service effective?

Our findings

The majority of people we spoke with enjoyed the food. One person told us they were choosy about what they ate and the chef gave them something different. Another person was not sure about that. They said, "On the whole it's quite good. If I didn't like something I've not asked them to make something else, but I don't think it would happen."

We asked whether the portions were large enough. One person said, "I never have to ask for more, we get plenty." Another person said, "It's okay, I'm always satisfied." Someone else said, "The food is lovely, we have a choice." Another person said, "The food is okay, but we don't get a cup of tea or coffee after lunch, we have to wait until 2 pm." One visitor said, "Sometimes my relative says she's not had very much, hence I bring in a supply of biscuits. It seems ridiculous there's nothing after 7.30 p.m. Sometimes they get a jam sandwich." The staff told us, however, that people could ask for food at any time. Another visitor said, "The food seems a bit stodgy, but she never says she's hungry."

Daily menu sheets were produced with attractive pictures of each dish, and the choices available. These were placed on the tables at lunchtime. We noticed the font was quite small and some people had to put it very close to their faces so they could read it. We discussed whether putting lunch and tea on separate sheets might make it easier for people to use.

Everyone said they were given enough time to eat their meals. We spoke with the chef who said they always monitored the meals and checked if anyone had not eaten and recorded it. They added that they had made changes as a result of comments by people in the home and their own observations. For example, people generally did not want a cooked meal at tea time so mainly sandwiches and soup were provided. The chef added, "For me, mealtimes are important. I've got to make mealtimes enjoyable for them." They added that after requests they were going to start doing full English breakfasts once a month.

Each person had a 'resident food profile' which recorded dietary requirements as well as likes and dislikes. Some people required a soft diet. One person could not eat certain foods for religious reasons. One of the senior care assistants was the nutrition lead, and worked closely with the chef to maintain the nutrition file which recorded these details. The chef consulted the profiles and told us they were careful to ensure everyone got suitable food.

We joined people for lunch, the television was turned off and the radio (Smooth FM) was switched on. People could sit wherever they wished and some chose to stay in the lounge.
There was not a lot of conversation at the tables. The fish was served with mashed potato, butter beans and carrots. There was no sauce served or offered and it was very dry. The majority of people had the cottage pie which was served with gravy, and they told us they enjoyed it.

Everyone was weighed monthly, or more often if needed, and if weight loss was a concern people were referred to medical professionals. We saw on care records that people had regular access to healthcare professionals to look after their general health needs. Records were kept of visits to or from healthcare

professionals including the district nursing team, opticians, GPs, chiropodists, the mental health team, physiotherapists, speech and language therapists, and dieticians. People also went regularly to the dentist. A hospital information form was kept on people's records to ensure that essential information was made available about people transferring to hospital.

We looked at records of training and supervision to see how well staff were supported in their roles. New staff did a week's shadowing as part of their induction training. This meant they observed how other staff were working and learnt from them. New staff's training needs were assessed individually, and training prioritised according to their previous experience. The provider had an in-house trainer who could deliver training to an individual new starter or to a small group. For example the most recent recruit was booked in for food hygiene, infection control and safeguarding training. New staff were also enrolled on the Care Certificate. The Care Certificate is a nationally recognised induction programme for staff new to care.

In addition to the in-house trainer, the registered manager herself delivered dementia awareness training for all staff. Some distance learning was used. Topics such as fire awareness, health and safety awareness and stroke awareness were delivered by an external provider. Health and safety awareness was scheduled for October 2016 and fire awareness for November 2016.

Staff felt they had enough training to keep people safe and meet their needs. They told us the training was thorough, and that they had been provided with specific training to meet people's care needs, such as dementia awareness, first aid and training relating to people's specific health conditions. They told us that when training was due it appeared on their rota and they were allocated time to do it. The registered manager sent us a record of training completed by staff and the timescales when it needed to be renewed. The record was well maintained and up to date. This helped to ensure staff had up to date skills and knowledge to effectively support the people who lived at the home.

Supervisions took place every three months. Supervisions provide an opportunity for line managers to meet with staff, feed back on their performance, identify any concerns, and offer support, assurances and learning opportunities to help them develop. Supervision was given either by the registered manager or an assistant manager. The supervision record showed the dates these had taken place in 2016, and staff confirmed they had happened. Up till now supervisions had been recorded on a 'Holmfield appraisal form' but the wording was being changed to 'supervision'. Staff told us they did not complete the form prior to supervision. This might be an opportunity for them to raise issues they wanted to discuss, and allow the supervision to be more of a two-way discussion. Different supervision forms were used for senior care assistants, including space for comments on their skills in managing others.

We also saw the recorded dates of annual appraisals which all staff had received. These were opportunities for staff to discuss the previous year and look ahead to assess longer term development needs and career aspirations.

We looked at how well the service was applying the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

All the care staff apart from recent recruits had received training in understanding mental capacity.

We observed staff asking for people's consent prior to them providing any care or support. One staff

member told us, "We always ask for their consent and give them time to respond." Staff also explained how if someone declined support, they would leave the person and try again later, or another staff member would try. People's ability to consent to aspects of their care had been recorded in their care plans. These judgments were not always supported by a formal mental capacity assessment. Where people were unable to give consent, we saw the service had taken time to look at what was in the person's best interests and a decision was made in consultation with people who knew the person well.

The registered manager understood her responsibilities in relation to the MCA and understood when staff needed to consider making a best interests decision, and was providing additional support to staff through staff meetings.

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

The registered manager supplied the provider's policy on the MCA and DoLS which gave guidance on when to apply for a DoLS authorisation. She also showed us a Screening Tool produced by the Association of Directors of Adult Social Services, which highlighted criteria which made DoLS applications more or less urgent. The local council recently had supplied this with a view to receiving fewer applications. The registered manager told us she had submitted a dozen or so applications, but in most cases had not heard back from the local council, known as the supervisory body. This showed that the registered manager was aware of the need to apply for a DoLS authorisation if the service needed to deprive someone of their liberty in order to keep them safe. She told us that there were currently four applications which had been authorised. These DoLS authorisations had not been notified to CQC as required under the regulations. We pointed this out and notifications were sent immediately, before the end of the inspection.

We looked to see whether the environment was suitable for the needs of people living with dementia, as over half the people in the home had a diagnosis of dementia at different stages. Staff wore purple uniforms and badges which meant they were immediately recognisable. Toilets and bathrooms were clearly identified with large pictures. We saw evidence that when the lounge carpet had been replaced in 2015 care had been taken to install a plain carpet which would not cause visual disorientation for people living with dementia. People's bedrooms had pictures of the person who occupied that room, but no other distinguishing features such as painted doors or boxes containing memorabilia. Some of the posters and illustrations on the corridors, especially upstairs, included a lot of text in tiny characters, which would not be accessible to people living with dementia. The registered manager agreed these could be replaced with more appropriate items.

Good

Is the service caring?

Our findings

We asked everyone what the staff were like. Comments included, "On the whole very good", "Very nice and kind", "The staff are lovely, you can't fault them, they put up with a lot and deal with it professionally." Another comment was, "Excellent, they're totally dedicated." A visitor said, "They seem very nice, they've all been very pleasant."

We saw a file of thank you cards received by the home. One person using the service had written, "Thank you to all the staff for making me welcome and getting me better." A relative said, "Thank you for caring for [name] and being patient and understanding." Another family had written, "[our relatives] were very well looked after whilst staying at Holmfield. This is due to your dedicated staff. We as a family cannot fault the care given to them both and won't hesitate to recommend Holmfield to everyone."

There was also a comment by a student who had spent some time in the home: "You have a fabulous friendly and caring ethos and it really does show."

We saw that staff were kind, patient and considerate when supporting people and meeting their needs. One person was becoming quite upset as they sat in the lounge. A member of staff stopped what they were doing and went over to console them, saying, "Don't get anxious, no need to be upset. We're all here." They then offered a cup of tea and the person became calmer. This was a good example of understanding an individual's needs and how to meet them.

At the start of the day we watched staff helping one person transfer from an armchair into a wheelchair so that they could get into a taxi to visit hospital for an appointment. The staff calmly explained what they were doing and helped and encouraged the person. There was one rather impatient comment by a member of staff, who said, "The taxi's going without you." However, this was said in a joking fashion and as far as we could see did not cause the person any distress.

Some of the people at Holmfield were living with dementia and unable to express their thoughts and feelings to us. To understand their experience we conducted an observation to watch how well they were cared for. We saw that care assistants had developed close relationships with the people in the home. Staff talked to people with kindness and encouragement. Some people were dozing in their armchairs but staff checked from time to time to see if they were comfortable. We saw that staff ensured that people had drinks. Staff adjusted the stool that someone was using to rest their feet on. We observed some considerate interactions between staff members and people during the lunchtime period. Those who needed help or encouragement to eat were given it in a gentle and patient manner. This meant that the care assistants treated people with dignity and respect.

The laundry was in the basement, and the laundry system was explained to us. Clothes were labelled and sorted so that people would receive back their own clothes. People told us of one or two occasions when they had been given the wrong clothes, but these were not common. One person said, "On the whole I get my own clothes back." But someone else said, "Half of it doesn't come back sometimes. Some of my clothes

went missing, a bra went missing and when it came back it was discoloured, so I threw it in the bin." All the other people we spoke with said they had not had any problems. Everyone we saw was smartly dressed and well presented. This meant that people's dignity was maintained.

Staff were careful to ensure that privacy was respected, especially when providing personal care. We observed staff knocking on doors and waiting for an answer before entering. One of the senior care assistants was the 'dignity and dementia champion' and promoted dignity within the home. At each residents' meeting people were asked about whether they felt they were treated with dignity. Staff explained to us that people could get up in the mornings when they wanted. If they needed assistance they pressed their call buzzer and staff would then help them get up. This meant that people had choice.

One person had an advocate appointed. The registered manager explained the provider's policy was to ask for an advocate to be appointed if the person had no family members to represent their interests.

We noted that all care records were kept securely in lockable cupboards. We saw that when staff were working on the files in the lounge, they were careful to ensure that the files were overseen by another member of staff if they were called away. This showed that they respected the confidentiality of the information in people's files.

Training in end of life care had been provided through the 'Gold Standards Framework' (GSF), a provider of training for care for people approaching the end of life whether at home, in hospital or in care homes. The home was accredited by the GSF. One of the senior care assistants was the GSF lead and helped to cascade the training to all staff. Staff had maintained their skills and knowledge of end of life care. There had only been one death reported in the first nine months of 2016, but nine during 2015.

Most people had an advanced care plan on their care file, which was reviewed every six months. This is a document which sets out people's wishes in advance for the end of life and funeral arrangements. It had either been written by or with the person themselves, or when necessary in consultation with relatives as a best interests decision. This meant that people, and their relatives, could be confident that their wishes would be met. Only one person currently had a DNACPR in place. This is a form which instructs paramedics and staff not to attempt cardiopulmonary resuscitation. The registered manager explained that it was her practice not to obtain such a form until someone was known to be near the end of life.

Staff were knowledgeable about end of life care, and the local district nurses would provide nursing care to enable people to stay within the home if that was their preference and it was medically appropriate. We saw from death notifications in 2015 that this had generally happened. This meant that the home was equipped to provide dignified and safe care to people reaching the end of their lives.

Good

Is the service responsive?

Our findings

A pre-admission assessment was always done before someone came to live in Holmfield. The registered manager told us it was very important to ensure that the home could meet a person's needs before they moved in, both for the sake of the person themselves but also for the existing people living in the home. One of the three managers and a senior care assistant would visit the person and conduct the assessment. We were told this quite often resulted in a decision not to admit the person.

We looked at two care files in detail. After the contents page there was a one page profile which gave basic details about the person, with a photograph, and included what is important to them, their interests, what those who know the person best say they like about them, and "How we can best support them." This page enabled new staff to see at a glance significant details about the person, and so helped them to deliver person-centred care. We saw that a one page profile in exactly the same format had been created for every member of staff, and placed on a notice board in a hallway downstairs. This showed that the person-centred ethos of Holmfield applied to staff as much as it did to people living in the home.

The care plan was arranged in a clear way which was easy to follow. There were separate sheets for each aspect of care. Each sheet set out what the care needs were and how staff were to meet them, and a risk assessment. The information was brief but sufficient, with no unnecessary detail. It enabled all staff to get a clear picture of a person's needs. We saw that in some cases the care plan had been signed by the person it related to.

At the end was a care plan review sheet which recorded that the care plan had been reviewed every month. Any changes that had been made were recorded on this sheet so that staff could see them at a glance. There was no record to show that people who used the service or their relatives had been involved in care plan reviews, and the two visitors we spoke with told us they had not been.

All the people living in the home were allocated to a keyworker. Their role was to get to know the person particularly well and to ensure all their needs were met. The keyworkers were full time members of staff who each had a maximum of four people they were responsible for. This meant they had the opportunity to get to know those people well.

Residents' meetings took place every three months and we obtained minutes of the three meetings held in 2016. These recorded people's comments about meals, activities and trips, the décor of the home, and about how they were looked after. Some people mentioned individual matters which were immediately addressed. One person told us that at these meetings, "They want to know our opinion of the entertainment, if we don't like them they won't book them again." It was recorded that staff thanked people for attending the meeting. These meetings allowed those people who took part to contribute to the running of the home.

There were also monthly food review meetings led by the chef and the nutrition champion. These allowed people to comment on the food and make suggestions for additions. At the latest meeting people had

suggested some additional items for the menus which the chef had promised to include. One person had suggested having a takeaway occasionally and staff said that they were welcome to order one. These meetings showed that people were involved in developing the food on offer at the home.

Individuals were given 'personal time' for a morning or afternoon once a month when one member of staff would ask them what activity they wanted, which might be a trip or something within the home. If the person could not communicate a choice the staff member would stay with them and try to engage them in an enjoyable activity. When we asked two members of staff if there was anything they thought could be better, one said, "Nothing at all." The second said, "I sometimes think I spend all my time looking after the physical needs of the residents. I wish I had more time to just sit with them, be friendly and chat." This showed that the member of staff was conscious of the need to meet all a person's needs, including their emotional needs.

We asked people how they spent their time during the day. One person said, "I like to read the paper and have a snooze. We have activities, singers, arts and crafts, chair exercises to music." Another person said, "I like to set the tables for lunch, talk to the other residents and reminisce. We have arts and crafts and singers, they're good." Someone else said "I like watching TV in my room. I enjoy the activities. I don't get bored." Someone else said, "Sometimes I'm bored, but I've got puzzle books to do." Another person said, "I spend my time just sitting in here and watch the telly. I chat to other people and I do a lot of reading."

We saw a daily activity schedule which showed different activities each day except at weekends. The registered manager explained this was because relatives were more likely to visit at weekends. We checked that those activities were happening on the days we were there. One of the assistant managers was responsible for activities. On the first day there was banner making for 'National old people's day' which was about to happen. Chair exercises led by an outside entertainer took place every week and we observed part of the session on our second afternoon. Appropriate songs were played to encourage people to join in. By the end several people were dancing, some of them with staff. Others were singing or banging their maracas. One person had an imitation microphone made from an ice cream cone and tin foil, which the chef had made for them specially. The majority of the people in the home were taking part in this activity with obvious enthusiasm and enjoyment.

We asked the residents if they went out on trips. One person said, "We went to Knowsley Safari Park and I think we're going to Blackpool lights." Another person said, "I have twice been to Blackpool lights, the safari park and to a hotel four times for a meal." In the minutes of residents' meetings we read about an annual trip on a canal boat, which people had been looking forward to.

We obtained a copy of the provider's policy on complaints. The policy was readily available for people living in the home and their families. This set out the process for dealing with both informal and formal complaints. All the people we spoke with apart from one told us they knew how to complain. Only one person had made an informal complaint, that their bed had not been made, which they said was sorted out very quickly. One of the visitors had made an informal complaint, and it had been dealt with swiftly.

There had been one formal complaint recorded within the last year. We saw this had been thoroughly investigated by staff in the provider's head office. The file did not contain a copy of the complaint itself, but only of the response, which made it difficult to assess whether it was a full response to the complaint. The response was, however, sympathetic and timely.

Requires Improvement

Is the service well-led?

Our findings

We asked people living in the home and their visitors for their views on how well the home was run. Several people told us they thought the managers and the care staff worked well together as a team. People knew who the registered manager was, although not everyone knew her name. The visitors we spoke with told us the registered manager and assistant managers were approachable and always available. They said, "There's always one manager in the office, up to six o'clock."

We saw that the system of having one registered manager and two assistant managers was working well. The assistant managers had well-defined areas of responsibility, but liaised with each other effectively. The registered manager maintained oversight of all areas. They shared the on-call rota which meant that a manager was always available during night shifts. A manager was present during both days at weekends so they would be available for visitors.

One member of staff told us, "The staff team here are really good. We work well together. We have a good connection with residents, and the management are supportive. I can't think of anything I would like to improve. I am happy in my work." Another member of staff said, "We all get on well and everyone pulls their weight."

We talked with a community psychiatric nurse (CPN) who was making a monthly visit to one of the people in the home. They had been coming for several years and spoke highly of the management and the care provided. They said, "People are looked after very well here. They really understand and manage people well. They are quick to report any deterioration in mental states. I am pleased when families choose Holmfield. Our team really value this home." We also met a district nurse who visited the home daily, who said "It's good management, they are really on the ball."

We discussed with the registered manager the requirement to report certain incidents to the CQC. These include deaths, serious injuries, safeguarding incidents and the outcome of DoLS applications. We had not received any notifications during 2016. The registered manager confirmed that there had been no deaths or serious injuries up to the date of inspection. Some safeguarding incidents had been reported prior to 2016, so the service was aware of the requirement to report. We have mentioned that four DoLS authorisations had not been notified to us, but were notified to us before the end of the inspection. We have written to the provider to inform them any future failure to submit required notifications will result in enforcement action.

At the last inspection we found that the provider had not updated the Statement of Purpose for Holmfield and had not put a date on it. A Statement of Purpose is a document that all registered providers are required to produce for each service, setting out the aims and objectives of the service and other information useful to people using the service. The provider updated the Statement of Purpose in January 2014. At this inspection we saw an updated version dated March 2016. The document was succinct but contained all the expected information. This meant the service was now compliant with the relevant regulation.

Staff meetings took place regularly. We obtained minutes of the meetings held in 2016. Some meetings had

been held with groups of staff, for example night staff, the domestic staff and senior care assistants. The registered manager used the meetings as an opportunity to get a message across, but we also saw that staff were encouraged to raise issues and come up with ideas and solutions. Staff had the opportunity to contribute items for the agenda in advance of the meeting.

Regular audits were carried out to monitor the quality of the service. There was a weekly medication check by a senior care assistant checking that the quantities matched the records and that MAR sheets had been filled out correctly. A monthly medication audit was done by one of the assistant managers, which covered all aspects of medication, including the ordering and supply of medicines, storage, administration, recording, handling of controlled drugs, training, monitoring of staff, and policy and procedures. At the end was space for "actions taken"; on the audits we saw that box was left blank.

Care plans were monitored and reviewed thoroughly once a month by the other assistant manager. We saw that those reviews were done on each care record, and any changes to the care plan noted.

In terms of the building and equipment, the senior care assistants did a daily check of all the bedrooms, and one of the managers did a weekly walk around the building every Sunday, looking for maintenance issues. There was a weekly cleaning spot check and a check of any slip or trip hazards. The provider had staff who could attend at short notice for minor repairs. There was a monthly mattress audit and a quarterly audit of all bedrooms to check whether any new furniture was needed.

The range of audits helped to ensure that the building remained safe and comfortable.

The registered manager's line manager conducted periodic visits to the home, some of them unannounced and some to provide supervision to the registered manager. We saw reports of these visits. We saw two reports from August 2016, one in May 2016 but prior to that a gap since July 2015. The registered manager told us however that the visits took place every three months. The line manager's reports had commented on a challenge caused by difficulty recruiting staff, and commended the registered manager for taking a strong disciplinary approach towards staff whose attendance was unreliable. We saw evidence of this on staff files. The line manager reported about the registered manager, "She is a very effective manager and provides strong leadership to the team at Holmfield." The registered manager told us she felt well supported by her line manager and by the organisation.

An annual quality standards questionnaire had been issued to families in the summer of 2016 and we saw ten completed questionnaires which had been returned mainly in August 2016. The boxes ticked were mainly 'good' or 'very good', and there was space for comments. One person had written, "The home has a very good friendly atmosphere and all the carers are very approachable and the managers also. I am extremely satisfied with Holmfield." Another person had written "Management and staff are super at Holmfield."

In previous years a report on the surveys was compiled. The report summarised the responses from relatives and representatives, and from health professionals, and drew comparisons with previous years. In this way the provider could maintain an overview of how the service was regarded, and identify areas for improvement.