City of Bradford Metropolitan District Council

Holmewood

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

Summary of findings

Overall summary

The inspection was undertaken on 6 November 2017 and was unannounced. At the last inspection in September 2016 we rated the service 'Requires Improvement' overall and identified a breach of regulation relating to 'Good Governance' as records of best interest decisions were not consistently kept. At this inspection, although we found action had been taken to address this breach of regulation, we found a new breach of regulation relating to 'staffing' as staff training and supervision was not kept up-to-date. We rated the service 'Requires Improvement' again.

Holmewood is a 'care home'. People in care homes receive accommodation and 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. It is registered for a maximum of 32 people within one adapted building split into four wings. The service specialising in care for people living with dementia. So that everyone can have a single bedroom the maximum number of people living at the service is 28. The home provides long term care, intermediate care and respite (short term) care. People living at Holmewood also have access to a day centre, which is attached. The home is in the town of Keighley. On the day of the inspection there were 28 people living or staying in the home.

A registered manager was not in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been recruited, had applied to become the registered manager and was going through the assessment process with the Care Quality Commission.

People said they felt safe and secure living in the home. Safeguarding procedures were in place and we saw these had been followed to keep people safe. Most risks to people's health and safety were assessed and staff had a good understanding of the people they were caring for. However more robust care planning and staff training was required to mitigate the risks of people living with diabetes.

The medicines management system was in the most part safely managed and people received their medicines as prescribed. Recording arrangements for topical medicines such as creams needed improvement to demonstrate these medicines had been consistently applied.

There were enough staff deployed at the service to ensure people received prompt care and regular supervision. Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable adults. There was a low turnover of staff which helped create a stable and experienced team.

Staff training was not consistently kept up-to-date. We saw many staff were overdue training updates in a range of subjects. Supervisions and appraisals needed bringing up-to-date.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent was sought and people were involved in decision making to the maximum extent possible.

People had access to a suitable choice and variety of food. People's nutritional needs were assessed and action taken to address any nutritional concerns.

The service worked in partnership with a range of health professionals to help meet peoples' needs. Health professionals reported good working relationships with staff and said that the multi-disciplinary team worked well together. Technology was appropriate used to compliment this approach.

Staff were kind and caring and treated people well. People reported good relationships with staff and staff demonstrated they knew people well. People were listened to and staff took time to comfort people and relieve any anxieties people had.

The service recognised the importance of helping people to maintain and/or improve their independence. Our observations of care and support showed this approach was embedded into staff practice.

People's care needs were assessed and a range of care plans developed. These were subject to regular review. People's likes, preferences and any diverse needs were taken into account.

People's communication needs were assessed and where people had sensory impairments, staff supported people to wear aids, and/or adapted their communication approaches.

People said they were satisfied with the service. Action was taken to address any complaints and concerns that people had.

People, relatives and staff spoke positively about the home and said they would recommend. We found the management team were friendly and approachable and committed to further improvement of the service.

Systems were in place to audit and check the service. Some of these needed to be more robust to prevent the shortfalls we identified from occurring. For example around staff training and documentation of topical medicines.

We found one breach of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this 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.

People said they felt safe and secure in the home. Most risks to people's health and safety were assessed and mitigated although work was required to ensure this was consistently the case, for example in relation to diabetes care.

Most medicines were given safely and as prescribed. However the recording of topical medicines such as creams needed improvement.

There were enough staff deployed to ensure consistent and prompt care. Staff were recruited safely to the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People praised the staff who delivered care and support and we saw there was a low turnover of staff. However required training was not kept up-to-date by the service. Supervisions and appraisals were not consistently completed.

The service worked effectively with a team of health professionals to help meet people's individual needs. Health professionals spoke positively about the service and said various agencies worked well together.

People praised the food in the home. People's nutritional needs were assessed and action was taken to address any risks.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People and relatives said staff were kind and treated them well. This was confirmed by our observations of care where staff

consistently treated people with a high level of dignity and respect. Staff provided companionship to people and it was clear they had developed good relationships with them.

There was a person centred approach to care and support. People were listened to and the service acted on their requests.

People's independence was encouraged by the service and we saw staff patiently assisting people to do tasks for themselves.

Is the service responsive?

Good

The service was responsive.

People, relatives and health professionals said good quality care was provided. People's care needs were assessed and plans of care put in place for staff to follow. People's likes and preferences were taken into account and staff were familiar with people and their needs.

People's communication needs were assessed and action taken to support people to communicate and understand information.

People said they were very satisfied with the service. A system to log and investigate complaints was in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were in place to assess, monitor and improve the service but these needed to be more robust to prevent the shortfalls we identified from occurring.

People, relatives, staff and health professionals spoke positively about the service and the way it was run. They said the management team was approachable.

People were listened to and their views and opinions used to make improvements to the care provided.

Holmewood

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 on 6 November 2017 and was unannounced. The inspection team consisted of two adult social care inspectors 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. In this case the expert-by-experience was experienced in the care of older people and people living with dementia.

During the inspection we spoke with 11 people who lived at the home, four relatives/visitors, five care workers, the activities co-ordinator, cook, manager and deputy manager. We also spoke with two health professionals who worked with the service.

We observed people being supported in the communal rooms and observed meal service at breakfast and lunch time. We used the Short Observation Tool for Inspection (SOFI) to observe how staff interacted with people. This tool helps us to understand the experience of those living with dementia who could not communicate verbally with us. We looked at elements of four people's care records and other records such as medication records, meeting notes, accident and incident reports, training records and maintenance records. We looked around the home.

Before visiting the home we reviewed the information we held about the service which included notifications sent to us by the provider. We contacted the local authority commissioning and safeguarding teams to ask for their views of the service.

We asked the provider to complete a Provider Information Return (PIR). This is a document which gives the provider the opportunity to tell us about their service and any planned improvements. All this information was taken into consideration when we rated the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and comfortable whilst staying or living in the home. One person said, "I feel safe here. I'm treated okay." Another person said, "I suppose I do feel safe." A third person said "Safe as houses. No trouble from the others, they're quite a peaceable lot really." A relative said, "Certainly seems to be safe here. They seem well looked after."

Staff we spoke demonstrated a good knowledge of safeguarding matters and how to identify and raise safeguarding concerns. They said they felt able to approach the management team with any issues. We saw the correct safeguarding procedures had been followed to keep people safe including making referrals to the Local Authority Adult Protection Unit. Safeguarding incidents were thoroughly investigated with people and relatives kept informed throughout the process. Measures were put in place to prevent a re-occurrence such as updating care plans and risk assessments with new strategies of care and support.

Risk assessment documents demonstrated that in most cases, risks to people's health and safety had been assessed in areas such as moving and handling, bed rails, falls and medication. Care plans were produced which provided guidance to staff. We saw these were in the most part detailed and contained appropriate information. For example, one person's medicines risk assessment indicated, 'If staff put [person's] tablets in [person's] left hand and give [person] verbal instructions [person] will take [person's] tablets with a glass of water.' We observed this was adhered to during our inspection with the staff member administering medicines confirming they were aware of this information. Staff we spoke with had a good understanding of the plans of care we asked them about which helped provide assurance they were followed to keep people safe.

However, we found the risks associated with diabetes were not consistently robustly assessed and mitigated. We saw one person's blood sugar level had been highly variable whilst they stayed in the home and had on one occasion been very low. They had a diabetes can plan in place but this did not provide suitable instruction to staff on how to support the person to stay healthy, for example through diet, and the personalised signs to look out for if they became hypoglycaemic or hyperglycaemic. Staff had not received diabetes training and we saw a comment recorded by a health professional in a recent survey which stated they believed better staff skills were required in this area

We recommend the service reviews the way it assesses and mitigates the risk associated with diabetes within the home.

Where people displayed behaviours that challenge, care plan documentation was in place to instruct staff on how to reduce distress. The manager told us staff had received Conflict Resolution training and an updated version of behaviours that challenge training would be provided in 2018. The home was divided into four small units of seven people. This helped minimise distress and altercations between residents. We found each unit to be calm and homely with staff supervising people appropriately. Staff understood people's behavioural triggers and were aware of what distressed people. One staff member said, "Sometimes when the TV volume is up, voices go up, and things can escalate. So we try and keep an eye on

the TV volume and reduce it to keep things calm." A visitor said, "They [staff] have a lot to deal with – seem to cope with it very well. They came quickly and calmed [person] down. They didn't leave [person] by herself – there was always someone close by, checking in on them."

The premises was safely managed and well maintained. People spoke positively about the home's environment. Safety features were installed on the building such as window restrictors to reduce the risk of falls and controls were in place on hot water outlets to reduce the risk of scalding. A maintenance team were employed which ensured any faults of defects were promptly repaired. Checks took place on key safety systems such as the gas, electrical and fire systems within the home. Health and safety checks of the premises were undertaken by the management team to help ensure the building remained in safe condition.

Personal emergency evacuation plans (PEEPs) were in place although these were not always in line with people's current mobility. For example, one person's PEEP indicated they mobilised with the aid of a walking frame whereas their updated mobility plan indicated they now used a walking stick. We raised this with the manager who assured us they would address.

Safe numbers of staff were deployed in the home. Six care workers were deployed during the day alongside a senior care worker and two care staff and a senior care worker at night. The deputy manager told us this could rise should people's dependencies increase. We looked at the staff rotas and saw these matched with what the deputy manager told us. People and relatives told us staffing levels were appropriate. One visitor said, "There's always someone sat with them" and a person said staff were "extremely good" at answering calls for assistance promptly. Staff also told there were enough staff. For example one staff member said, "To do the main things, caring, there's enough staff. Sometimes it has been a bit difficult due to service users and we have asked for and extra staff have been provided." During our inspection we saw staff were available to offer care and support and spend quality time with people.

Staff were recruited safely. We saw records of interview where previous experience was discussed and appropriate checks such as references and Disclosure and Baring Service (DBS) were obtained prior to employment. We saw the manager followed disciplinary processes if required.

Most medicines were managed safely and in line with prescribers instructions although documentation needed improving to demonstrate that topical medicines were consistently applied.

Staff administering medicines received training and had their competency assessed. Medicines were stored in a locked cupboard in the kitchen area of each unit. Medication Administration Records (MARs) for boxed medicines were well completed which indicated people received their medicines as prescribed. As part of our inspection we undertook a random check of boxed medicines and found tablet amounts correlated with the amount stated on the MAR providing further evidence these medicines had been given consistently as prescribed.

We observed part of the morning medicines round and saw medicines were administered in a calm and gently manner and staff wore tabards to indicate they were administering medicines and were not to be disturbed. The staff member administering the medicines did so with patience, taking up to 20 minutes with each person to ensure tablets were given safely. MARs were signed after people had taken their medicines. 'As required' protocols were in place which detailed when people should receive these types of medicines. This helped ensure these medicines were offered by staff in a consistent way.

Information about the application of topical ointments was located in a central file located in each wing.

Topical MAR charts (TMARs) were present, including body maps of where each cream was to be applied. We saw detailed information was present to ensure creams were administered correctly. However, better documentation of topical ointments was required since we saw gaps in the signature on a number of charts. There were no indications staff had not applied the creams and our observations and stock levels indicated these had been applied. We spoke with the manager and the staff member administering medicines on the day of our inspection and they told us they were aware of the concerns and were in the process of addressing them. For example, we saw documentation of creams had been an item on a recent staff meeting.

Medicine audits took place weekly and monthly to check the safety of the medicines management system with actions seen to be taken when any issues were highlighted. Where medicine errors had occurred we saw these had been recorded and investigated to help prevent a re-occurrence.

People said the home was always kept in a clean and hygienic condition. One person said, "The place is extremely clean. Decorations, the beds – which are most important." We saw staff had access to items to assist infection control such as gloves and aprons and these were used where required. We saw sanitising gel stations located in various areas throughout the building. A health care professional commented during a recent quality survey, 'The cleaning staff are always visible.' We saw this was the case during our inspection and saw nothing of concern relating to infection control during the inspection

Incidents were recorded, investigated and lessons learnt. We looked at incident records which demonstrated following safety incidents such as falls, medicine errors and behaviours that challenge, a full investigation was undertaken by the management team. Measures were put in place to prevent a re-occurrence, for example following falls the advice of health professionals had been sought and equipment such as bed rails and sensor mats obtained. Following medicine errors, letters of expectation had been sent to staff to help drive improvement. Incidents were analysed each month, and a lessons learnt log completed demonstrating the service was committed to continuous improvement of safety.

Requires Improvement

Is the service effective?

Our findings

People's care and support needs were assessed in a range of areas to help ensure their healthcare needs were met. This included physical , mental health and social needs. The service assessed people's communication needs, any disability, cultural and religious needs to help prevent discrimination. The service had utilised best practice guidance to develop the environment to help ensure it met the needs of people living with dementia and some staff were trained in Dementia Care Mapping. Dementia Care Mapping is an established approach to achieving and embedding person-centred care for people with dementia, developed by the University of Bradford. This helped promote person-centred care within the service.

People and relatives spoke positively about staff and the effectiveness of care. We found care was delivered by a stable staff team who knew people well and their individual likes and preferences. Staff spoke positively about the training they were provided with and said it met their needs.

Staff new to care that had not completed NVQ2 training were enrolled to complete the Care Certificate. This is a government recognised training scheme, designed to equip staff new to care with the required skills for the role. New staff also received an induction to the service and its ways of working and completed a period of shadowing.

A range of staff training was available for existing staff. Training methods were varied including face to face and on-line with questionnaires. However, we found staff training was not always kept up-to-date. For example, training records showed that 15 out of 36 care staff had not completed dementia care training, despite the service being a specialist dementia care service. Staff had not received diabetes training despite caring for people with diabetes. 27 out of 36 staff did not have up-to-date fire safety training and 33 out of 36 staff had not completed Mental Capacity and Deprivation of Liberty Safeguards (DoLS) training. 22 out of 36 staff did not have updated safeguarding training. The manager told us that it was likely that some staff had received further training updates but had not brought in their certificates. However, they acknowledged that some training was not up-to-date. They demonstrated they had plans in place to address this.

The manager told us supervisions and appraisals were not all up to date although they had actions in place to remedy this. We looked at the supervision and appraisal matrix which confirmed this. For example, the manager told us supervision should take place at least quarterly and their aim was for eight weekly supervisions to take place. We saw six staff in September 2017, three in October 2017 and six in November 2017 had received supervision out of a total of 54 staff. We saw supervision had been discussed at the management team meeting the week prior to our inspection and senior staff were to be given protective time to complete these.

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

People spoke positively about the food provided by the home. One person said, "The food is excellent. Not

had as good in some hotels. We get a choice of options." Another person said, "The food is okay. I can either say yes or no if they give it to me."

People were offered a varied and nutritious diet. We saw all units had a pictorial or written menu displayed on the wall in the kitchen area which showed what the meals were for the day. We saw people were asked what they wanted to eat prior to serving food and there was plenty of food available. For example, we saw one person was offered a second serving of fish for their lunch since they had requested more. If people did not want what was on the menu, an alternative was offered. Vegetarian options were available each day to ensure people who did not eat meat were not discriminated against. We saw hot and cold drinks were offered throughout the day and fluids were encouraged. We saw people's weights were recorded. Those deemed at nutritional risk had their food and fluid monitored and were referred to the GP or dietician.

We spoke with the cook who told us they received information each week on people's individual needs and care staff informed them of any changes. We saw a list was displayed of these in the kitchen. Our discussions with them confirmed they were aware of and catered for people's individual dietary needs. They told us they fortified food with cream, butter and full fat milk and used extra powered milk in milk shakes where required. We saw food was freshly prepared and home-made including soup and cakes prepared daily.

The service co-ordinated with other services to help meet people's needs. A number of beds in the home were determined 'flexi beds', which meant that people were moved into the home at short notice following a stay in hospital. Hospital staff visited the home to check and help meet people's healthcare needs. We spoke with one such professional who told us the care was well co-ordinated between various professionals including mental health nurses, physiotherapists and occupational therapists. We saw weekly multi-disciplinary meetings were held in the home involving hospital staff, the local GP and management of the home to discuss operational issues. A health professional said these worked really well. People had an "at a glance" care plan in place which provided concise information on their care and support needs. The manager said if the person was admitted to hospital this was sent with them to help ensure appropriate information for hospital staff to help meet needs.

Where people's health changed the service worked with a range of professionals including GP's and district nurses. The service used the telemedicine scheme run by a local hospital trust. Telemedicine provides remote video consultations between hospital nursing staff and the home. It helps support care outside hospital, including avoiding unnecessary visits and admissions to hospital. Staff were able to give positive examples of how using this had reduced distress and hospital admissions.

The building was suitable for its intended purpose, with adequate amount of communal spaces for people to spend time. The service was divided into four wings, which were all secure, homely and provided adequate seating for people to be comfortable. People and relatives spoke positively about the home. One person said, "The overall décor is much improved on the past. I'm very impressed" and a visitor said ,"It's very nice here. I like the relatively small lounges – separate wings – means they are in smaller groups. I think this place is fabulous." Another visitor said, "I'm very pleased with the rooms. How light they are, and clean and tidy." There were various points of interest, reminiscence materials and memories on display, and clear signage to help meet the needs of people living with dementia. A sensory room was in place and there was a pleasant, enclosed garden area which had a variety of seating and sensory attractions such as a water feature.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager had a good understanding of their role and responsibilities in relation to MCA and DoLS and the service had made and awaiting approval from a number of applications to the local authority. Two people had DoLS in place and we saw any conditions associated with these had been met. For example, one person's GP had been informed and they were encouraged to attend a local day centre and another person had had their medicines reviewed. The manager had compiled a document showing all DoLS applications, when these had been chased up with the local authority or reapplications made.

We saw staff asked consent before assisting people. We saw people were given choices wherever possible such as being able to get up when they wanted, sit where they wanted and choose what food they wanted to eat. Overall, we saw appropriate information in people's care records about their capacity to make decisions and evidence best interest processes had been followed. Each individual care plan had a section to record people's capacity to understand and consent to the plan of care and the support needed where they lacked capacity. Some of these sections needed further detail adding to demonstrate people's understanding and capacity had been fully assessed. We spoke with the manager about this and had confidence the care planning process would be made more robust.

Good

Is the service caring?

Our findings

People and relatives consistently said that staff were kind and caring. One person said, "They are all very, very kind." Another person said, "I have felt well cared for by the person here. I'm enjoying myself." A third person said, "They're all lovely – all very nice. No problem coming here. I'm hoping they'll adopt me." A relative said, "They are respectful and kind with her. There's no talking down to her here." A visitor said, "Staff here are very good. Always very polite. Probably slightly better than I'm used to." One relative had commented during a recent survey, 'Always feel welcome, whatever time of day.'

We observed care and used the Short Observational Framework for Inspection (SOFI). We saw staff were warm and friendly with people, consistently interacting positively with them. Staff were patient with people and calmed any anxiety or distress effectively. There was a calm and relaxed atmosphere throughout the service. Staff greeted people with a smile and chatted about a variety of subjects. It was clear staff knew people's care and support needs well. We observed a senior care worker administering medicines in the morning. They spent 20 minutes with one person, firstly chatting to them about their day, before offering the required medicine support in friendly manner, consistently talking to them to reduce anxiety and distress.

We saw staff had time to sit with people, chat with them and provide companionship. One person said, "They [staff] find time to talk to you, in amongst all the other stuff they do." Another person said, "Honest to God, they're all my friends here." Staff knew people well and it was clear they had developed good, caring relationships with people. A professional said, "The continuity of staff is good, and they really care. They are proud of the service, and concerned about quality." Information on peoples past lives had been sought to better understand them and help with the provision of personalised care. Staff we spoke with demonstrated they knew peoples past occupations and explained how this explained some of their behaviour within the home. This demonstrated a person centred approach to care.

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race. We saw the service respected people's diverse and individual needs for example around diet and beliefs. We saw staff adapted the way they communicated with people based on their sensory abilities. This helped ensure people were listened to and involved. We saw no evidence to suggest anyone who used the service was discriminated against and no one told us anything to contradict this.

People said they felt involved in making decisions relating to their care and daily routines. One person said, "I can get up and go to bed when I need" and another person said, "I should think I can go to bed when I want." We saw staff regularly checking on people, asking how they were, patiently listening to their responses. This included members of the management team. People were asked exactly how they wanted their drinks and toast and people were given choices as to where they sat and what they got involved in. Although the care plans of long stay residents were subject to regular review and people and relative were involved on an informal basis, there was a lack of evidence these people were involved in more formal recorded reviews of care. We saw this had been identified by the management team and a plan was in place

to begin formal reviews. Those in assessment and rehabilitation beds received face to face meetings to review their support plans.

People's independence was promoted. Care planning focused on encouraging people to do as much as they could for themselves. Staff were able to give clear examples of how they achieved this, for example one person helped with the washing up. At breakfast time, a staff member gently guided a person's hand to their toast, explaining what it was, encouraging the person to eat independently. One person had been encouraged by staff to mobilise more independently and was now able to walk with a walking stick rather than use a mobility frame. The staff member administering medicines on the day of our inspection took time to ensure people were supported to be as independent as possible with their medicines. They asked one person, "Would you like me to put it into your hand or do you want to pick it out yourself?" With another person, they tried a number of options, including putting the tablets onto a saucer so the person could see it more clearly and guiding their hand towards the tablets, saying, "Can you feel it?" This took several minutes and the staff member remained patient throughout, gently reminding the person about their medicines several times. This demonstrated the service recognised the importance of promoting and maintaining independence.

People were treated with dignity and respect and their privacy upheld. Staff were able to give examples of how they ensured people were treated with dignity for example during personal care. During observations of care we saw staff consistently treated people well and respected their right for privacy.

Good

Is the service responsive?

Our findings

People and relatives spoke positively about the care and support provided in the home. One person said, "Don't think you could get much better care if you were in a hotel." A health professional we spoke with said, "Really really good quality of care." People looked clean and well-presented indicating their personal needs were met by the service.

Care plans demonstrated people's needs had been assessed in a range of areas. These were detailed and personalised, for example they considered the exact nature of the support needed to help people maintain personal hygiene. Care plans were subject to regular review and were updated following changes to people's needs.

People's communication needs were assessed and care plans put in place detailing how staff were to support them to communicate effectively. We saw people wearing glasses and hearing aids in line with plans of care. Staff adapted communication techniques based on people's individual requirements demonstrating a person centred approach. Information on the menu and activities was presented in an accessible format to help make it more accessible, although work was required to care plans to make them more accessible to people. Environmental adaptions had been made to promote understanding, for example toilets were colour coded with a yellow door, so they were all easily recognisable. People's bedroom doors had their names and also their photo on the door, to help them find their room.

The service utilised technology to ensure it was responsive to people's needs. This included telemedicine's; a video consultation service with NHS nursing staff to respond to any changes in people's health. Pressure sensors had been utilised to reduce the risk of falls and a call buzzer system was in place to help people summon assistance.

People's spiritual needs were assessed and during the inspection we saw a member or religious clergy visit the home. The registered manager told us they were looking to further improve the accessibility of religious services to people and were undertaking a piece of work to make this happen.

People had access to a range of activities. A picture board was displayed within the lounge area of each unit, showing a range of activities planned for the week. This included games, exercises, pampering, sing-a-longs, crafts, outside entertainment and trips out. The service employed an activities co-ordinator who worked 30 hours per week, dependant on what activities were planned. We spoke with the activities co-ordinator who was preparing an activity for the upcoming week, based around Remembrance Sunday. They told us they were currently working within the adjoining day centre for some of the time, due to staff shortages in the day centre, but people at the service could come to this and take part in activities there if they wanted to. We saw some people had done this during our inspection. They told us of their plans to organise trips out using the minibus and Christmas activities such as a fair, parties and entertainment. We saw they had organised a bonfire quiz and party the previous evening, with hot chocolate, parkin and a fireworks DVD. The activities co-ordinator told us they made time to speak with people individually about their likes and dislikes and offered one to one activities with those who were unable to take part in group activities. For example, they

said they would spend time with people who were being nursed in bed, reminiscing or reading stories and poems.

If appropriate, people's end of life needs were assessed by the service. We saw permanent residents had advanced decision books in place which set out their preferences at the end of their lives.

A system was in place to log, investigate and learn from complaints. People said they were satisfied with the service and said they had no cause to complain. One person said, "If there was anything I was upset about, I would certainly tell them." Another person said, "It's well done here, so I can't fault it. I would be able to tell someone if I wasn't happy." We saw one complaint had been logged since our last inspection which included information about the complaint, actions taken and the outcome. The manager told us they were not aware of any complaints before they had started working at the service several months ago, but was keen to document both minor concerns and complaints moving forward. This showed us complaints were being taken seriously and people listened to. The service had also received a number of compliments and 'thank you' cards with comments such as, 'Holmewood picked [person] right back up again', 'The dedication, care and understanding shown to each resident, temporary or permanent is outstanding,' and, 'You have all gone above and beyond.'

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in place. The previous manager had deregistered in July 2017. A new manager had been recruited and they had applied to become the registered manager for the service. Their application was currently being assessed by the Commissions registration department.

We found the service had notified us of all required events within the service. This included deaths, safeguarding incidents and any serious injuries. This helped us monitor how the service was operating.

People, relatives and health professionals spoke positively about the service and said it provided good quality care. A person said, "I'm very happy here. It's a very nice place. Nicer than I thought it would be." Another person said, "It's been alright up to now. Never noticed anything go wrong. I haven't got any complaints about it." A health professional said, "good home, I would recommend, consistent staff, knowledgeable about people, staff friendly and kind and work well together."

We found the staff team to be friendly, approachable and knowledgeable about people they were supporting. Staff were confident in their ways of working and had clear roles and responsibilities. Staff spoke positively about how the service was run. They said morale was good and the management team were supportive of them. Comments included, "Feel we are working hard. They're (staff team) a committed bunch. Really working together. I feel enthusiastic about that," and, "I enjoy coming to work. The atmosphere's really nice. We all work together as a team. Morale is good. [Management team] support you; absolutely fabulous. [Manager] has been really god since she's here; really understood. Definitely feel supported." We saw the management team were visible throughout the day which helped them provide oversight of the home. For example, the deputy manager regularly walked around the home checked how things were operating and asking people how they were. Staff told us they would recommend Holmewood as a place to work and if a relative needed this type of service.

During the inspection we identified a breach of regulation relating to staff training as it was not consistently kept up-to-date. This demonstrated that the governance of the service needed improving. Systems should have been effectively operated preventing staff training becoming outdated. We also found shortfalls relating to topical medicines which should have been prevented from happening through the operation of robust systems of quality assurance. A range of audits and checks took place in other areas. This included medicines management audits, care plan audits and health and safety audits. Where action points were identified we saw these were worked through by the management team. The provider employed quality checkers, independent from the service who to help assess the quality often service and drive improvement. We saw a report from September 2017 which showed a range of areas had been looked at. The report had concluded the service provided good quality care and the staff were polite and friendly.

In addition, a service director regularly came in and audited service on a regular basis. The findings of this helped shape the service improvement plan to continuously improve the service. We looked at the plan which demonstrated a number of improvements had been made in recent months with further improvement initiatives planned over the coming months. This led us to conclude the service was

committed to further improvement and development.

Staff meetings were periodically held and were an opportunity for any quality issues to be discussed following feedback from people, staff, health professionals or audits undertaken.

The service sent out and requested feedback about the quality of the service from a number of sources including people who used the service, staff, relatives, and healthcare professionals. We saw most comments were positive and where concerns were raised, actions had been taken which showed people's voices were listened to. Most comments were very positive about the service. For example, one comment read 'Cannot fault anything over the past 18 months. Has exceeded my expectations of elderly care,' and, 'Communication is effective between the services. It is a pleasure to visit Holmewood,' from a health care professional.

The service worked in an open and transparent way with a range of health and social care professionals. Regular multi-disciplinary team meetings were held in the home to discuss and continuously improve the effectiveness of working arrangements. This included staff from the local hospital trust, community nurses and the local GP practice. The service liaised appropriately with other agencies such as the local authority safeguarding team. Information was effectively shared by the home with the relevant agencies. Two health professionals we spoke with said there was good joined up working and the current arrangements were effective.

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 18 HSCA RA Regulations 2014 Staffing (2) People employed to carry out the regulated activity were not always provided with regular training and supervision.