Care Expertise Limited

Holmwood Nursing Home

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

Summary of findings

Overall summary

Holmwood Nursing Home provides nursing and care for up to 48 people most of whom have dementia. Care and support are provided on two floors. Each bedroom has en-suite toilet and washing facilities. There were 37 people living here at the time of our inspection.

Communal areas include two large rooms, one of which leads out to the secured gardens.
Holmwood Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present during the inspection.

People and their relatives gave positive feedback about the home, and its staff. However we noticed that aspects of care and support had dropped in quality since our last inspection.

People were not always safe at Holmwood Nursing Home. Risks of harm to people had not always been identified so clear plans and guidelines were not always in place to minimise these risks.

Staff deployment around the home needed to improve. At times people at risk of harm, or in need of support, such as to access the toilet, were left in areas unsupervised by staff.

The effectiveness of the systems to monitor the quality of care and support that people received had declined since our last inspection. Quality assurance records were not all up to date to show that the provider had checked on important aspects of the management of the home. The registered manager had not ensured that accurate records relating to the care and treatment of people and the overall management of the service were maintained.

People had access to some activities; however these were not always focused on supporting people living with dementia. Access to outside trips and visits to the local community were limited for some people who live here.

People had enough to eat and drink, and received support from staff where a need had been identified. People's individual dietary requirements where met. Overall people were happy with the quality of the food; however they felt the choices dropped when the chef was not there. The registered manager and staff team were working with an outside agency to improve people's diets.

The staff were kind and caring and treated people with dignity and respect, but peoples experiences were inconsistent. Staff took time to sit and talk with some people and encouraged them to take part in activities. However others were left on their own for periods of time and did not receive as much positive interaction from staff. Caring interactions were seen throughout the inspection, such as staff holding people's hands. The staff knew the people they cared for as individuals.

People received the clinical care and support as detailed in their care plans, however the care plans were not always person centred, and there were gaps in information. This gave a risk that staff became task focused, with little work being done around people living their lives to the fullest. People and relatives were involved in reviews of care to ensure it was of a good standard and meeting the person's clinical needs.

Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or the police.

People received their medicines when they needed them. Staff managed medicines in a safe way and were trained in the safe administration of medicines.

People would be protected in the event of an emergency. Each person had a plan which detailed the support they needed to get safely out of the building in an emergency. Appropriate safety checks were carried out on equipment and fire safety systems.

Staff induction and ongoing training was tailored to the needs of the people they supported. Staff received regular support in the form of annual appraisals and formal supervision to ensure they gave a good standard of safe care and support.

Staff recruitment procedures were safe to ensure staff were suitable to support people in the home. The provider had carried out appropriate recruitment checks before staff commenced employment. They had also checked to ensure staff were eligible to work in the UK.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them. People's health was seen to improve due to the care and support staff gave.

People knew how to make a complaint. When complaints had been received these had been dealt with quickly and to the satisfaction of the person who made the complaint. Staff knew how to respond to a complaint should one be received.

During the inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff deployment around the building left some people at risk as they were unsupervised and staff were not always present when they needed assistance.

Risks to people's health and safety were not always managed in a safe way. Control measures to support people at risk of dehydration were not well documented. Infection control processes were not sufficient to reduce the risk of infection. Areas of the home had malodour where peoples support needs had not been adequately met.

People felt safe living at the home. Appropriate checks were completed to ensure staff were safe to work at the home.

People's medicines were managed and stored in a safe way, and they had their medicines when they needed them.

Is the service effective?

Good

The service was effective

Staff said they felt supported by the registered manager, and had access to training to enable them to support the people that lived there.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and had specialist diets where a need had been identified, although records management needed to improve.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health was seen to improve as a result of the care and support they received.

The environment suited the people that lived here, and the registered manager had a plan in place to upgrade it to take on board best practice for people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

The failure to manage the malodour in parts of the home, and the lack of effective support to people at all times meant that peoples experience of care was inconsistent.

Staff were caring and friendly, however the interaction people had with them was inconsistent. We saw good interactions by staff that showed respect and care.

Staff knew the people they cared for as individuals. People were supported to follow their spiritual or religious faiths.

People could have visits from friends and family whenever they wanted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred. They did not always give up to date information about the support needs of people. People were involved in their care plans, and their reviews.

People had access to some activities; however these did not always take into account the specialist needs of people living with dementia. Some people had little opportunity to go out into the local community.

There was a clear complaints procedure in place. Staff understood their responsibilities should a complaint be received.

People were supported at the end of their lives to, as much as possible, have a pain free and dignified death.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Quality assurance checks were not all up to date and had not been effectively used to drive improvement throughout the home. Completion of records inconsistent across the home.

Staff felt supported and able to discuss any issues with the manager.

People and staff were involved in improving the service. Feedback was sought from people and ideas and suggestions were acted on.

The manager understood their responsibilities with regards to the regulations, such as when to send in notifications.

Holmwood Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 05 February 2018 and was unannounced. Due to the size and layout of this home the inspection team consisted of three inspectors, and a nurse specialist.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The inspection had been brought forward due to concerns so the provider had not been requested to complete a 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. This information we did have was reviewed to see if we would need to focus on any particular areas at the home.

To find out about people's experience of living at the home we spoke with six people and seven relatives. We sat with people and engaged with them. We observed how staff cared for people, and worked together as a team. We also spoke with eight staff which included the registered manager. We also reviewed care and other records within the service. These included six care plans and associated records, six medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Holmwood Nursing Home. When asked if people felt safe one relative said, "Yes, my family member feels safe here. When we return to the home (after being out) he seems to relax and I know that he trusts the staff." One person said, "Of course, I feel very safe here." However we found areas around infection control and staff deployment that needed to be improved.

There were not always sufficient staff deployed around the home to keep people safe and support their health and welfare needs. One person said, "I don't think there are enough staff as I have to wait too long sometimes for staff to respond to my call bell." Another person said, "Sometimes staff seem to disappear after lunch and leave residents needing the toilet. On this basis I don't think there are enough staff as residents regularly don't get to the toilet quick enough." We observed this happen during our inspection. After lunch we noticed one person's face showed discomfort and they were holding their stomach. The person next to them put their hand in the air for attention, but no staff were around to see. We had to intervene and find a member of staff to come and help the person be taken to the toilet. In addition during the day there were at least three times where staff were not present in a communal room to support another person as detailed in that persons care plan, with needs relating to their behaviour. This could put that person and others at risk if staff were not present to manage behaviours that may challenge. Staff were assisting people in other areas of the home. One person summed up the situation when they said, "Staff are sometimes over stretched. If you get a character acting up, there is not always the one to one support to help."

Staffing levels were based on people's dependency needs, and the numbers of staff present did match these assessed needs on the day of our inspection. However the staff deployment around the large building left some areas unstaffed and people at risk of not receiving support when they needed it. Staff confirmed that they felt there were enough staff to support people; but at times the nurses or the deputy manager had to step in to help out with basic care and support tasks.

As there were not always suitable numbers of staff deployed to meet peoples identified needs, this was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and safety were not always managed in a safe way. Where people were at risk of dehydration guidance to support the person's needs was not always clear, or was not followed by the staff. Hydration care plans stated that staff should document the person's fluid intake and observe for signs of dehydration. The care plan instructed staff to call the person's GP if they had concerns. However, the care plan did not describe what these signs were. One person's review stated "drinks (are) just not enough and staff to continue to encourage". However, we found little mention of staff doing this in the person's daily records. The person's fluid intake was recorded but no record of actions taken to increase the intake were kept in the care plan. People who stayed in their rooms were also at risk of dehydration as they may not be able to drink without aid. The daily records did not clearly show when they had been supported to drink, or how much they had drunk. The clinical manager explained they felt this was an issue around record keeping rather than people not receiving fluids. They explained that staff are instructed to visit people who stay in

bed on an hourly basis. However records of these checks were inconsistent. Fluid charts were not routinely completed at the time people were supported to drink. These were completed later when the information could be forgotten or confused between people.

Staff had not always managed the risk for the spread of infection. During the inspection there was a persistent odour of urine in the large communal area. Two bedrooms also had strong smells of urine present. The registered manager explained that the people who lived in these rooms had a behaviour that made it difficult to keep the rooms clean and free from odours. This demonstrated that the risk to people from the prevention and controlling the risk of the spread of infection was not currently safely managed. This also linked to the issue with the deployment of staff, where staff were not always present when people need support to access the toilet. People's mattresses were not checked regularly. Tears or punctures can lead to ineffective cleaning and malodour. One of three mattresses we checked was found to be like this.

Failure to do all that is reasonably practicable to mitigate risks to people's health and safety was a breach in regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of the home were clean, with no malodours. The kitchen was also well organised and clean. The cleaning staff had a schedule they followed and we observed them effectively cleaning other areas of the home and other people's bedrooms over the day of the inspection. Equipment used by staff, such as hoists and wheelchairs, were also subject to regular cleaning to reduce the risk of spreading infection.

People were protected from the risk of abuse. Staff had received safeguarding training and could tell us about the various forms of abuse and what they would do if they suspected or saw that it was taking place. Staff described appropriate actions they would take, like making a referral to an agency, such as the local authority safeguarding team or police. Information for staff about whistleblowing was also clearly displayed in the registered manager's office.

People were not restricted from doing things because it was too 'risky' which demonstrated that staff respected their independence. People with limited mobility, were not prevented from moving around and were actively supported by carers, when available, who ensured their safety.

Some assessments had been carried out in areas such as mobility, and behaviour management. Measures such as specialist equipment to help people mobilise around the home had been put in place to reduce these risks. Risk assessments had been reviewed to ensure that they continued to reflect people's needs. Staff understood their roles in keeping people safe. For example, when helping people to mobilise with a hoist, there were always two staff present.

People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the registered manager to look for patterns that may suggest a person's support needs had changed. For example where an issue had been identified with a person entering other people's rooms, action had been taken to reduce the risk of this happening.

People received their medicines in a safe way, and when they needed them. Staff followed best practice recommendations from the Royal Pharmaceutical Society, for example by using a minimal handling technique when dealing with medicines in dosage cassettes or loose boxes. This reduced the risk of errors.

For 'as required' medicine, such as pain relief or medicine to help people who may be anxious, there were guidelines in place which told staff the dose, frequency and maximum dose over a 24 hour period. For

homely remedies, such as cold and flu medicines which can be 'bought over the counter', the GP had drawn up a clear protocol for each medicine with dosage and interval between repeats.

Staff that administered medicines to people received appropriate training, which was regularly updated. Staff who gave medicines were able to describe what the medicine was for to ensure people were safe when taking it.

The ordering, storage, recording and disposal of medicines were safe and well managed. There were no gaps in the medicine administration records (MARs) so it was clear when people had been given their medicines. Medicines were stored in locked cabinets to keep them safe when not in use. The nursing staff carried out daily checks of the temperatures of medicine storage areas. This was to ensure medicines were stored in line with the manufacturer's guidance.

People's care and support would not be compromised in the event of an emergency. People's individual support needs in the event of an emergency had been identified and recorded by staff in personal emergency evacuation plans. Information on what to do in an emergency, such as fire, was clearly displayed around the home. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. There were also copies of other relevant documentation including character and professional references, interview notes, proof of identification such as passports, to show eligibility to work in the UK.

Good

Is the service effective?

Our findings

People's needs had been assessed before they moved into the service to ensure that their needs could be met. Assessments contained detailed information about people's care and support needs. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility.

People were supported by trained staff that had sufficient knowledge and skills to enable them to care for people. The induction process for new staff was robust to ensure they would have the skills to support people effectively. Regular refresher training had also been provided to keep staff up to date with current best practice. This included health and safety, moving and handling people, and food hygiene. Our observations of staff practice over the course of the day showed their training had been effective in these areas. Safety checks had been completed on equipment used to mobilise people; correct lifting techniques were used to minimise harm to people; and food was stored and prepared in a safe way.

Staff were effectively supported. Staff had regular one to one meetings (sometimes called supervisions) with their line manager, as well as annual appraisals. This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people. One staff member said, "I have a supervision every three months, it's a chance to tell them about my opinions, and if I want more training."

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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had complied with the requirements of the Mental Capacity Act 2005 (MCA). Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were effectively followed.

Staff had an understanding of the Mental Capacity Act (2005) and were seen to work within the legal framework of the act when supporting people. Staff encouraged people to make decisions by explaining the choices. Staff listened to peoples' wishes and respected their decisions. One person said, "They do ask my permission before they do things for me." People had received mental capacity assessments where this was appropriate and staff had sought the consent of people with capacity before acting. Where a person did not have the capacity to make decisions, up to date mental capacity assessments were in place, in addition to evidence of best interests meetings with relevant parties.

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). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had

made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible. These referrals were 'decision specific' and outlined clearly why authorisation was being sought.

People had enough to eat and drink to keep them healthy. One person said, "I lost a lot of weight in hospital and now they make me eat – in a nice way." Throughout the day we saw that people had access to drinks and staff were heard to encourage people to drink throughout the day. People were given support with food and liquids when needed. Staff that assisted people were calm, patient and understanding of people's needs.

Feedback about the quality and choice of food was varied, with one person saying, "The food is beautiful here." Others felt there could be more choice in the evening, or when the chef was not on shift. The registered manager said they were in the process of working on the menus with the aid of the clinical commissioning group. Everyone we spoke with agreed that the chef was approachable and listened to people's likes and dislikes, and tried to accommodate them.

People's food and drink preferences, special dietary or cultural needs were met. Where a specific need had been identified, such as food presented in a particular way to aid swallowing. This was done in accordance with the guidance given by the health care professional.

People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating enough to stay healthy. People's risk of malnutrition was regularly reviewed, and any changes were effectively supported. People's weights were monitored and they received appropriate support to maintain a healthy weight. The nursing staff were working with the clinical commissioning group (CCG) to make improvements. Actions from a recent CCG diet audit were in planning stage.

People received support to keep them healthy because staff worked effectively with other healthcare services. People and their relatives told us that the GP and other health professionals visited regularly. People with health concerns were referred to the relevant professional. People had access to a range of medical professionals including chiropodists, doctors, an optician and district nurses. This enabled staff to receive advice and guidance to ensure people received the best possible care. One person said, "I couldn't walk when I came here but they got me walking."

People who had nursing support needs were effectively cared for by staff. People's health was seen to improve due to the care and support of staff. People cared for in bed all had pressure mattresses and these were routinely checked to ensure they were set correctly to give effective protection. The daily nursing care notes recorded that wounds were regularly cleansed and dressed. The entries showed the involvement of the tissue viability nurse (TVN), so people had received appropriate care and support.

People lived in a home that had some adaptations made to meet their individual needs. The home was not purpose built, so corridors were narrow, however the provider ensured clutter was kept to a minimum to reduce the risk of trips. The registered manager was in the process of reviewing the decoration to take into account the needs of people living with dementia or whose eyesight was failing. Different parts of the building were painted different in colours and different decorations to aid people in identifying where they were in the home. Signage on doors was also clear to help people orientate themselves.

Requires Improvement

Is the service caring?

Our findings

We had positive feedback about the caring nature of the staff. One person said, "The staff are very caring and friendly. I went to hospital recently and I couldn't wait to get back to them." A relative said, "The staff are really kind and caring. I have nothing but praise for them." However the issues we found around the home such as the malodours, and the lack of effective risk management demonstrated that although individual staff were caring, the service as a whole needed to make improvements.

The variation in the interactions that people had with staff was also inconsistent. Some people had a good level of interaction. Those people with lower support needs and high levels of communication tended to receive more positive interaction, than others. This resulted in periods of time where those unable to communicate well were left in areas with little or no interaction.

We recommend the provider reviews the level of staff interaction with people across the home to ensure those with greater support needs receive the same level of attention from staff.

There was a calm and inclusive atmosphere in the home. We observed many instances of genuine warmth between staff and people. On these occasions, staff took time to explain their actions in order to minimise people's anxiety. Many times carers were seen holding hands with people or sitting with them in the lounge, talking. People were supported by staff that knew them as individuals. Throughout the inspection it was evident the staff knew the people they supported well, by the way they spoke with them, and the conversations they had.

Staff treated people with dignity and respect. People looked well cared for, with clean clothes, tidy hair and appropriately dressed for the activities they were doing. For example, ladies were fully dressed, such as wearing tights and shoes and also wore jewellery and makeup if they wished. When supporting people to eat, staff sat with them and engaged them in conversation, putting the person at the centre of the activity. People's privacy was respected by staff knocking on doors and waiting for a response before entering.

Staff involved people in their support during the inspection such as explaining what they were planning to do and asking the person if that was okay. When giving personal care staff ensured doors and curtains were closed to protect the person's dignity and privacy. Staff encouraged people to maintain their independence, and do as much as they could for themselves. People had access to different types of cutlery and cup types to maximise their independence at meal times.

Staff were knowledgeable about people. The care plans had been compiled in conjunction with people and their families and contained information staff could use to help build relationships. Staff were able to tell us a lot about the people they supported without access to the care notes, including their hobbies and interests, as well as medical support needs. Care records recorded personal histories, likes and dislikes, and matched with what staff had told us.

Staff communicated effectively with people. Staff communication with people was warm and friendly,

showing caring attitudes during their conversations. When providing support staff checked with people to see what they wanted. Staff spoke to people in a manner and pace which was appropriate to their levels of understanding and communication needs.

People told us that they were asked about their care and that staff did listen to them. They were actively involved in making decisions about their care and staff understood the importance of respecting people's choices and supporting them to live their lives as they wished. People told us they had control over their daily routines and were free to choose when to get up and go to bed and how to spend their leisure time. Although sometimes they had to wait for staff to come and assist them.

Family members were able to keep in regular contact and visit whenever they liked. Relatives we spoke with were positive about the welcome they received form staff whenever they visited. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs and people had access to services so they could practice their faith.

Requires Improvement

Is the service responsive?

Our findings

People were involved in their care and support planning. One relative said, "My family member is unable to plan their care themselves, so it's myself and the person who has power of attorney that do this. Staff keep us updated and we are always able to speak to staff about his care."

People's choices and preferences were inconsistently documented so it was difficult for staff to evidence that those needs were seen to be met. The care files were not all well organised so information about people and their support needs were not always easy to find. Care plans did not always contain sufficient information to 'see the person' in them. For example, one person's personal history section contained a staff entry stating they were unable to get further information about the person's background. However, elsewhere in the care plan staff stated the person "enjoys the company of their family". There was no evidence in the care plan why information about the person was not obtained from family members.

The care plans were not always concise and up to date. Most were very large and on examination, contained documentation which should have been archived. For example, we noted one person's care plan contained letters from 2015 and 2016 which were no longer pertinent to the person's care. This is relevant as their continuing presence meant it was more difficult for staff to access up to date information related to people's current health status. Daily records were also staff focused and task oriented; an insight into people's daily quality of life could not be obtained by reading them.

Some of the care plans we looked at did contain relevant and up to date information. One person was prone to developing pressure sores. The provider had undertaken thorough and relevant risk assessments regarding this situation. For example, we noted there was a tissue viability care plan in place which outlined the risks of skin breakdown associated with prolonged immobility. The care plan also contained an up to date body map and a wound assessment chart. There was also a nutritional risk assessment care plan in place. This contained clear guidelines for staff concerning the need for good nutrition and hydration in order to promote good health.

People had access to activities, some of which focussed and promoted peoples well-being, physical and mental health. For example encouraging people to carry on hobbies such as arts and crafts. However resources and activities specifically for people living with dementia were limited. Some people were supported to go out into the local community if they wished, such as meals out with family. However others had little opportunity to go outside the home on activities.

We recommend that the provider review the activities provision to ensure people have equal access to activities to suit their individual needs and interests.

People were supported by staff that listened to and responded to complaints or comments. All of the people we spoke with confirmed that the managers were approachable and they all felt confident that they could make complaints. One relative said, "They (staff) are intuitive and before things become a problem they sort it." They also felt that if they raised concerns these would be considered and listened to by both senior

managers at the home. There was a complaints policy in place. The policy included clear guidelines on how the registered manager should respond and when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission.

There had been two formal complaints received at the home in the last 12 months. Where complaints had been received these had been clearly recorded and responded to in accordance with the provider's complaints policy. Action had been taken to address the concerns raised, such as carrying out maintenance tasks. Many compliments about the care provided were also received in the same period of time. These were on display for staff and others to see.

People were supported at the end of their life to have a dignified and as far as possible pain free death. The service had recently been awarded the 'Gold Standards Framework' (GSF) in November 2017. The GSF is a systematic evidence based approach for staff to follow to optimise care for people who are approaching the end of their life. People and their family were actively involved and consulted. Relatives also had the opportunity to stay over with their family member as they passed away.

Requires Improvement

Is the service well-led?

Our findings

Records were not always being maintained or updated with accurate information. For example, where people were at risk of dehydration records of the fluids taken and passed were not all up to date or had gaps meaning staff were unable to demonstrate that care had been given as required. In addition areas of risk to people were not always clearly documented. We identified a number of incidents that should have prompted an update or creation of a risk assessment to give guidance to staff. Some information was later found on the manager's laptop, but had not been available in the care plans where staff would look for them.

Checks on the quality of service provided to people were inconsistently completed. This resulted in some areas of the service provision that needed to improve. Infection control audit records were not available for the last 12 months. Good practice checks, such as monitoring condition of mattresses were not in place. This had an impact to people as certain areas of the home had a malodour which made them unpleasant to be near.

Management and provider quality checks of records had been ineffective at driving improvement across the home. The system of internal audits used to ensure cleanliness and infection control process were safe had not been recorded since December 2016. They had not identified the issues with missing information in some care records, or gaps in daily record keeping. One staff member said, "We have to keep knocking in the nail about documentation. I see staff have given someone a drink and I ask them have they written it down, it is very frustrating." They had also not identified where important checks such as infection control had not been completed for some time.

The failure to effectively assess, monitor and improve the service, and the lack of effective management of records meant there was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a positive atmosphere within the home, between the people that lived here, the staff and the registered manager. Visitors were made to feel welcome. People felt secure and were very happy to share thoughts about their life at Holmwood Nursing Home with us. Staff were also happy working here. One of them said, "We are a good team and I would say that I'm well supported by the manager and deputy." The management of the home had a positive attitude as they accepted that there were always ways of improving service, and that they were open to new ideas.

People experienced a level of care and support that promoted their wellbeing because staff understood their roles and were confident about their skills and the management. Staff told us the registered manager, "Supports us very well" and they could approach him or the deputy at any time. Staff felt supported and able to raise any concerns with the registered manager, or senior management within the provider. Where this had happened the provider had investigated and taken action to correct the concerns, such as taking disciplinary action where deficiencies in staff performance had been highlighted. A record of provider management visits to the home was kept, and showed these were carried out on a regular basis. This gave

the opportunity for people and staff to talk to them, and for senior manager to have an understanding of how the home was being managed.

People and relatives were included in how the service was managed. There were regular resident and relative meetings, as well as surveys asking for feedback about various aspects of the service. People and relatives had the opportunity to discuss any improvements they felt needed to be addressed. Comments about the quality of care were also collected by use of a suggestion box. Staff were involved in how the service was run and improving it. Regular staff meetings took place across the staff teams. These had been introduced to share information to ensure staff were up to date on people's needs.

The registered manager and deputy manager were visible around the home on the day of our inspection, supporting staff and talking with people to make sure they were happy. This made them accessible to people and staff, and enabled them to observe care and practice to ensure it met the home's standards. Both the managers had a good rapport with the people that lived here, staff and visitors and knew them as individuals.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home, so they would know what to do if they had any concerns.

The staff worked in partnership with other agencies. They were working with the local clinical commissioning group to make improvements around the home. This covered areas such as staff training, dietary planning and implementing best practice projects. One such project was the 'red bag' project that had been successfully introduced in the London region. This was a system to ensure that when people transferred between services important information and items were transported with them. The home was going to be used as one of the initial services to use the system in Surrey.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff had not always documented or managed the risk of harm to people's health and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always being maintained or updated with accurate information. Management and provider quality checks of records had been ineffective at driving improvement across the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always suitable numbers of staff deployed to meet peoples identified needs.