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Holmwood House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 22 January 2015 and was unannounced. The previous inspection of Holmwood House was on 27 June 2014. There were five breaches of the legal requirements at that time. These related to:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Management of medicines
- Assessing and monitoring the quality of service provision

Improvements had been made in some areas, but further improvements were needed to meet the regulations.

Holmwood House is a care home with nursing for up to 41 older people. There were 14 people living at the home at the time of this inspection.

The home did not have a registered manager. 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 last registered manager had left the home in August 2014. A new manager started in October 2014 but had not applied for registration at the time of this inspection.

Summary of findings

We found there were shortfalls in a number of areas. Improvements were needed to ensure the service kept people safe and protected their rights. Four regulations were not being met.

People's rights were not protected because the appropriate procedures were not being followed in relation to mental capacity and compliance with the Mental Capacity Act 2005. People could not be confident that decisions were being made in their best interests.

Suitable arrangements for supporting staff had not been in place since our last inspection in June 2014. People were not cared for by staff whose performance and development were being regularly monitored.

Improvements to the safe handling of medicines had been made since our last inspection. However the recording of medicines was not always in line with current guidance.

There continued to be shortcomings in the planning and monitoring of people's care. There were risks to people arising from a lack of appropriate information about their care.

The provider was not operating an effective system for assessing and monitoring the quality of the service. This had an impact on people in a number of ways. For example, the service was not always safe for people. Policies and procedures were not always followed consistently or updated to reflect changes in practice guidelines.

For the most part, care was provided by staff who were friendly and treated people with dignity and respect. People living in the home and their relatives were kept informed of changes and developments at the home. Since our last inspection, the lounges and a dining room had been redecorated and some new furniture obtained. This had improved these areas for people.

We found four breaches of regulations during our inspection. Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

Summary of findings

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.

A range of checks were carried out although these did not ensure that all the facilities were safe for people. Fire doors, for example, were being held open in an unsafe way.

People received support from staff which helped them to be safe, for example when they needed help with mobility.

Staff worked in a flexible way and were readily available to assist people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not protected because the appropriate procedures were not being followed in relation to mental capacity. There was a risk of decisions being made which were not in people's best interests.

People did not always receive care from staff who were well supported through training and supervision.

People said they enjoyed the meals. Staff helped people to ensure they had enough to eat and drink.

People had access to a GP when required to ensure their healthcare needs were followed up promptly.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us the staff were friendly towards them. Staff spoke about the importance of being patient and understanding with people. However not all aspects of the service reflected a caring and personalised approach. People were not always referred to in a way which maintained their dignity.

Visitors were made to feel welcome at the home. A meeting had taken place with relatives to ensure they were well informed about developments involving the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A system was in place for the planning of people's care. However there were shortcomings in how this was being implemented. A lack of appropriate information about people's care meant there was a risk that their needs were not being met.

Summary of findings

People had the opportunity to take part in some in-house activities which they enjoyed.

Is the service well-led?

Inadequate

The service was not well led.

The arrangements in place for quality assurance were not effective in ensuring that suitable standards were being maintained.

The provider's policies and procedures were not all being adhered to or updated to reflect changes in practice guidelines.

Holmwood House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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 22 January 2015 and was unannounced. The inspection was carried out by two inspectors and a pharmacist inspector.

The inspection also followed up the actions the provider had taken to meet the legal requirements following the last inspection where five breaches of regulation were found.

Before the inspection, we reviewed the information we had about the home. This included notifications we had received from the service. A notification is information about important events which the provider is required to tell us about by law.

We spoke with six people who were living at the home. We made observations during the day in order to see how people were supported and their relationships with the staff. We spoke with five staff members, two visitors and with the home's manager. We looked at four people's care records, together with other records about people's care and the running of the service. These included employment records, audits, meeting minutes and records relating to medicines. We were provided with further information following the inspection. This included records of staff training and copies of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We had found shortfalls in the safety of the service at the three previous inspections of the home.

At this inspection a range of safety checks and actions had been undertaken to keep people safe. However people were not fully protected from risks associated with their environment and equipment. We saw fire doors being held open in an unsafe way. The lounge and dining room doors were wedged open. The manager told us she didn't expect the wedges to be there and commented "I keep moving the wedges and they keep reappearing." We saw other doors with 'keep shut' signs on them that were being held open by items such as a chair and a bedroom cabinet. This included bedrooms that were not occupied at the time.

We saw a hoist stored by a fire exit where it could prove to be an obstacle if people needed to leave the building. Other hoists were kept in a conservatory which the manager told us was not used in the winter months. Labels were attached showing that the servicing of the hoists was up to date.

There was a regime in place for checking the water supply and monitoring water temperatures within the system. This helped to ensure the water supply was safe for people. However, we saw that a shower was available to people with an adjustable temperature dial which did not provide the same level of safety. A notice by the shower stated 'Do not turn to more than six'. The manager told us they thought this meant that the water "gets too hot" if the temperature dial was raised above that number. There was a risk that the hot water from the shower would not be maintained at a safe level. The Health and Safety Executive advise that where vulnerable people are at risk there are additional controls in place to ensure the temperature is maintained at a safe level.

We found that various checks relating to health and safety had been carried out since our last inspection. Records showed that items of equipment, such as profiling beds, were being checked as part of a programme of audits. 'Spot checks' had also been undertaken. For example, the condition of the sluicing facilities had been checked in December 2014.

A range of hoists and aids were available to help people with their mobility. We observed one person using a 'stand aid' to move from their wheelchair to a lounge chair. Two staff assisted the person to ensure they were safe and well positioned. A care plan for mobility confirmed that this form of support was meeting the person's needs and promoted their independence in a safe way.

Staff told us people had their own hoist slings to use in their rooms. This helped to avoid the risk of cross-infection which arises when slings are shared by people. We saw staff following safe practice by wearing disposable gloves and aprons and replacing these between tasks. Staff, for example, put on new aprons before serving meals to people in the dining room.

Staff worked in a flexible way and were seen to be readily available to assist people in the lounges and the dining room. At lunchtime, for example, it was the nurse who served people's meals from a hot trolley. Care staff helped to serve the meals to people. They also supported people to take part in activities that were arranged during the day. They told us there were enough staff to meet people's current needs and to ensure their safety.

The manager said a system was used to calculate the number of staff required to meet people's needs. They told us there was a consistent staff team in place and that the home was well staffed at the time, as the number of people had recently reduced without a corresponding reduction in staffing numbers. We were told a staff member had not been able to work as planned on the day of the inspection but had not been replaced because there were a sufficient number of care staff to manage in their absence. The deployment of staff was confirmed in a written rota and we met with these staff during the day.

People spoke positively about the staff who provided their care. Their comments included "They are all very good to me" and "they are fine".

Where new staff had been employed, we found that checks had been made to ensure they were suitable to work in the home. Records showed that applicants' personal details and backgrounds had been verified. References had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with adults. The manager told us they had recently checked that the nurses were correctly registered with the Nursing and Midwifery Council. A record had been kept to confirm this.

Requires Improvement

Is the service safe?

People were protected from harm because staff understood their responsibility to safeguard people from abuse. Staff said they had received training in safeguarding adults and they knew the correct action to take if they had any concerns about people being at risk. This was confirmed in written guidance which was prominently displayed for the attention of staff. Records showed that the manager had discussed safeguarding and whistle blowing in individual meetings with staff. This helped to ensure staff were knowledgeable about these subjects and their role in protecting people.

We saw that a record was being kept of any accidents and incidents. The manager kept a monthly log of these so that any trends could be identified and further action taken where necessary.

Improvements to the safe handling of medicines had been made since our last inspection. There were shortcomings in relation to the recording of medicines. Records were kept of the receipt of medicines into Holmwood House. However the date of their receipt was not always recorded. Arrangements were in place for the safe disposal of unwanted medicines. However records of the disposal of medicines were disorganised and there was no record of when medicines had been removed from the premises. This meant there was not always a clear audit trail to show that medicines had been used and disposed of safely.

Suitable systems were in place for ordering medicines. The current records showed that people's medicines were available for them. Although we did see that one person's skin treatment for washing had not been available for 11 days in January 2015. The manager told us she had met with the pharmacist to discuss problems with supply.

Qualified nurses looked after and gave people their medicine. We saw some people being given their lunch time medicines in a safe and respectful way. People who had been prescribed pain relieving medicines to be given 'when required' were asked if they needed them.

Information kept with people's medicines administration records included a photograph of the person, any medicine allergies they had and brief details about how they liked to be given their medicines. This helped to ensure people were given their medicines safely.

Staff recorded when they had given people their medicines and recorded the reason if a regular medicine was not given. When people had been prescribed a medicine with a variable dose, staff recorded the amount given. So there was a clear record of how much medicine the person had needed. Records showed that people had been given their medicines as prescribed for them.

Medicines were stored securely. Suitable storage was available for controlled drugs, which need additional security. Records showed these medicines had been looked after safely. A medicines refrigerator was available. Records showed this was kept at a safe temperature for storing medicines.

We recommend that the service consider current guidance on recording the receipt and disposal of medicines and take action to update their practice accordingly.

We recommend that advice is taken about the fitting of appropriate mechanisms which enable fire doors to be safely kept in an open position.

Requires Improvement

Is the service effective?

Our findings

We had found shortfalls at three inspections since July 2013 in how people's rights were protected when they lacked capacity to make decisions about their care and treatment.

People's rights were not protected because the appropriate procedures were not being followed in relation to mental capacity and compliance with the Mental Capacity Act 2005. We found that records in relation to consent and mental capacity were not sufficiently detailed and contained inconsistent information. In one person's record they had consented to receiving care and, if required, treatment. However they were assessed as having 'an impairment serious enough to prevent them from making informed decisions about key aspects of their life'. Another person's record also stated they had consented to receiving care, although it was recorded in their care plan that they had limited mental capacity to make informed decisions about their care.

Information in people's records raised questions about their mental capacity, rather than showing this had been assessed in relation to particular decisions. Where it was indicated that a person lacked capacity, this was not followed up as part of a 'best interests' decision making process. For example, a relative had signed a form to consent to the use of bed rails, rather than a mental capacity assessment being undertaken and where necessary, a decision being made that was in the person's best interest. This meant that people who used the service could not be confident that decisions were being made in their best interests or that their rights were being protected.

There were shortcomings in the assessment process relating to the Deprivation of Liberty Safeguards (DoLS). DoLS is the process by which a person in a care home can be deprived of their liberty if this is agreed to be in their best interests and there is no other way to look after the person safely. The manager told us that applications to the local authority for DoLS authorisations had been made for all except two people at the home. However, these applications were not based on assessments of people's mental capacity, which the manager said had not been completed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records showed that decisions had been made in relation to resuscitation and the majority of people had 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders in place. We had looked at this documentation at the last inspection and reported on a lack of clarity in some records about the process being followed and who had been involved in making the decisions. We discussed this with the manager who told us that one person's situation would benefit from review. This would be appropriate given the inconsistent information we saw in relation to consent and people's mental capacity.

Details of people's DNACPR status were included with other information on a daily handover sheet which was used by staff. A symbol was used alongside a person's name to indicate if they had a DNACPR order in place. This was not a safe way of recording the information and the number of people with DNACPR orders as recorded on the handover sheet did not match the number reported by the manager and as recorded on the DNACPR forms. There was a risk that people's rights in relation to end of life care decisions would not be upheld.

Staff we spoke with had an understanding of how mental capacity affected people's ability to make decisions on a daily basis. They said they talked to people and provided information which helped people to make decisions about their daily routines. This was important in ensuring that people were able to exercise choice in their lives, for example about what clothes to wear and how they wanted to spend their time.

A number of staff had completed training in mental capacity. Staff told us about other training they had received, for example in moving and handling and in health and safety. Records showed that training included a range of topics, although certain subjects relating to people's care were not covered. Some staff had not undertaken training in certain subjects. For example, fewer than half the care staff and only one nurse had undertaken 'dementia awareness' training. This meant people at the home living with dementia received care from staff who may not have knowledge and understanding of their specific needs.

Staff said they had met individually with the new manager to discuss their work and felt supported by them. The provider had a policy and procedure which set out the

Is the service effective?

support staff could expect during the year. This included formal supervision on average every eight weeks and a skill set and behaviour assessment twice a year. We found that the implementation of the policy had lacked a planned approach. However the manager told us they were planning to introduce annual staff appraisals and a more consistent approach to staff supervision. This would help to ensure that people received care from staff whose performance was being well monitored. Following the inspection we were told it was the manager's intention that the requirements of the policy will have been met by late June / early July 2015. We will be following this up with the provider.

This was a breach of Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received good feedback about the support people received from a local GP surgery. The manager said a GP visited the home regularly. This enabled any concerns about people's health to be brought to the GP's attention at an early stage. One person had a dentist's appointment on the day we visited. The manager and staff said that other health services were available to people when required. We were told there were no concerns about being able to meet people's day to day health needs at the present time.

Staff we spoke with were aware of the need to ensure people had sufficient to eat and drink. Drinks and snacks were offered to people during the day. The system for assessing people's needs included identifying those people at risk because of poor nutrition and hydration. In one person's record we also saw that the risk of choking had been considered and guidance produced for staff about how to reduce this risk. At lunchtime we saw staff were aware of the risk to this person and the person's meal was adapted to meet their needs. The manager told us that nobody needed any nursing interventions in relation to eating and drinking, for example by having to take their food and fluids by non-oral means.

People told us they enjoyed the meals. Staff told us the chef had met with people to find out the type of meals people liked. Before lunch, people we asked said they did not know what meal they were having. However, staff said people had chosen earlier from two main courses which included a vegetarian option. The people we saw were having a meal with chicken and a variety of vegetables. Staff talked to people about their meals and people's wishes were taken into account, for example about the size of the meal and whether they wanted anything to be left off the plate. Most people were able to eat their meals independently although staff encouraged people at times and provided individual support to two people. This helped to ensure that people maintained their nutritional and fluid intake.

Requires Improvement

Is the service caring?

Our findings

We had found shortfalls at three inspections since July 2013 in how people's privacy and dignity were respected.

At this inspection we found that actions had been taken to make improvements in this aspect of people's care. However, not all had been fully implemented to help ensure people always experienced a caring and respectful approach. Action plans received after inspections in 2013 and 2014 had referred to the role of 'dignity champion' as a means of promoting good practice by staff. However, the role had yet to be established. The manager told us a staff member had been appointed and was researching the role, but had not yet been involved with the staff team. A staff member we spoke with was not familiar with this role at the home.

We heard staff using people's own names, although there was a time when a person was referred to as "what's his name" in their presence. At lunchtime, there were also two occasions when a person was called to from across the room by staff and told to "eat slowly". These comments were in contrast to others which showed a more personal and respectful approach. For example, we heard staff complimenting people on their appearance, which was appreciated by them and produced a positive response.

At lunch time, staff mostly engaged well with the people they were assisting with their meals. The staff sat next to people and spoke with them in a calm manner. However, we saw one person being supported in a way which lacked dignity and looked rushed. They were being offered spoonfuls of their meal while still chewing the food they had been given earlier.

On a number of occasions we heard staff talking with people in a friendly and respectful way. Any terms of endearment were used appropriately. Two health care professionals told us that when visiting the home they had observed staff to be polite and respectful to people.

People spoke positively about how staff approached them. Staff were described as "fine" and one person told us "they are all very good to me; the staff are very friendly and none of them have an easy job." Another person said the home's activities organiser was "Lovely and always comes in with a smile on their face." Staff talked about the need to be patient with people and one staff member told us "You try and understand people and you need to give them love."

Staff talked with people so they felt involved in the care and support they received. When the stand aid was being used, staff spoke with the person in a reassuring way. A staff member told us they liked to involve people in their care and commented "Every time you do something, you talk to the person about what you are doing." Another staff member said "We talk to people and ask them how they are feeling." One person told us they liked to "Stay up late and to get up late", which they were able to do.

Staff asked people if they wanted to take part in the activities that were taking place on the day.. Information had been displayed about the home's weekly activities programme on a notice board with other items of interest to people and their visitors. However, there was a lack of confidentiality with one notice we saw, as it named a person and described their personal routines, interests and religion. We brought this to the manager's attention.

The information available in the home had been updated since our last inspection. A copy of the most recent inspection report for the home was on display and there was information about services that could be arranged, such as advocacy. More information was available about the home's CCTV system and the purpose of this. It was reported in an action plan produced following the last inspection that a policy had been updated to include CCTV and letters sent to relatives about the use of CCTV. We were shown the letter that had been sent, but a policy on CCTV was not initially available. Following the inspection, we were sent a policy and procedure for CCTV which was based on the contents of the letter.

Visitors we met with told us they were made to feel welcome at the home. The manager said they had held one meeting with people's relatives, in November 2014, to keep them up to date with developments affecting the home. The manager told us they had not used other means to gain feedback from people about the service.

In people's records, we saw information had been obtained about their interests and lifestyles. The manager said relatives helped to inform staff about people's likes and dislikes and the things that were important to them. We were told however that people's wishes in respect of end of life arrangements had not been obtained and care plans for end of life were not in place. The manager said they wanted to address this through a discussion about the subject as part of the initial assessment process when somebody moved into the home.

Requires Improvement

Is the service responsive?

Our findings

We had found shortfalls at the two previous inspections in how people's care and treatment were planned and delivered to meet their needs.

During this inspection we found there continued to be shortcomings in the planning and monitoring of people's care. The manager said there were training issues for staff which affected how well the system of care planning was used. The system was designed to provide a means of creating assessments and care plans, as well as a record of the care and treatment people received to meet their needs.

We were told by the manager that not all aspects of the system were being used with each person. This meant that, where sections had not been completed, it was difficult to assess whether this was because the information had not yet been added, or there was nothing significant to record about that aspect of a person's care. We also heard that some staff were not confident in using the system and there had been occasions when information had not been recorded as expected. A notice in the home's office reminded staff of their responsibilities about this.

The care planning system enabled care to be planned and documented from the initial assessment of a person's needs through to the production of a care plan and the details of the care provided. However, the documentation did not provide a clear record to show that people's pressure area care had been well managed. The manager told us that two people had very recently developed grade two pressure ulcers. A grade two ulcer is when the outer surface of the skin or the deeper layer of the skin is damaged leading to skin loss.

There were risks to people arising from a lack of appropriate information about this aspect of their care. One person had been assessed as at high risk, using a recognised pressure ulcer risk assessment tool. They did not have not a care plan for tissue viability although this was an option on the care planning system. The last entry in this person's care record was dated 20 December 2014 and stated "no skin breakdown this month". We saw that a body map with instructions for staff about this person's care had been started on 21 January 2015, once the grade 2 pressure ulcer had been identified. There was a lack of appropriate information about the care given in relation to tissue viability prior to 21 January 2014 to ensure this person's needs were met.

Another person was assessed to be at very high risk on 14 December 2014 and 1 January 2015 using the pressure ulcer assessment tool. They also did not have a care plan for tissue viability. Some actions had been identified as part of the assessment tool action plan. These included 'regular inspections of vulnerable areas' and to 'introduce a repositioning schedule'. The guidance was changed to 'position to be changed 2 – 4 hourly' after 15 January 2015 when the grade 2 pressure ulcer had been identified. Records before and after the 15 January 2015 showed the timing of repositioning had not been consistent. For example, the person had only been repositioned on two occasions on 14 January 2015 and on three occasions on 19 January 2015.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The care planning system included an initial assessment of people's needs, although the manager said nobody had moved into the home since our last inspection. However, the needs of people who had lived in the home for some years were being reassessed. The manager told us for example that one person was due to see a consultant in connection with their mental health. We also heard about steps being taken to obtain a more specific diagnosis in relation to one person's learning disability. The provision of day activities for this person was also being reviewed to ensure these were appropriate. This showed that action was being taken to look at people's needs in a holistic way and to assess how well the service was responding to these.

A weekly timetable of activities and events taking place in the home was displayed. The manager told us that people received support from an activities organiser who was employed for 20 hours a week. Some people were taking part in a craft activity during our inspection. One person told us that on the previous day they had enjoyed making lemonade with the help of the activities organiser. A 'memory tree' was displayed in the home and the manager said the activities organiser had recently run a reminiscence session with people. This was particularly relevant to those people at the home who were living with dementia.

Requires Improvement

Is the service responsive?

We were told about steps being taken to develop opportunities for people outside the home. The manager told us that day centre provision was being looked into for one person as it was thought that this would better meet their needs. In the minutes of the relatives' meeting held in November 2014 we read that the acquisition of a minibus for trips out had been discussed.

On the morning of our inspection, people were visited by representatives of a local church and an informal service was held in the lounge. The manager told us the involvement of this particular church was meeting people's faith needs at the time. It was reported in the home's statement of purpose that Holmwood House would 'Go to great lengths to ensure that facilities, diet and routines" were available to meet people's needs "whatever their religion or cultural background'.

The statement of purpose described a range of ways in which people could raise concerns or give feedback about the service. These included regular residents' meetings, although a programme of meetings had not been arranged. It was reported that the staff and manager were available to try and resolve any concerns, and a formal, written complaints procedure had been produced. The procedure was displayed in the home, although it lacked information about the role of the Local Government Ombudsman, who can be contacted when a complainant is unhappy with how their complaint has been dealt with by the provider. The manager told us that no complaints or concerns had been raised with them since they had been working in the home.

Inadequate

Is the service well-led?

Our findings

Our findings from previous inspections have shown a history of non-compliance with the regulations. This has covered a range of areas and when improvements had been made these had not always been sustained. This inspection again identified areas for improvement and highlighted shortfalls in how the service was led.

The provider was not meeting a condition of their registration at the time of this inspection. This was because the home was not being managed by an individual who was registered with the Commission for this service. The home had been without a registered manager since January 2013, apart from having a manager who was registered in June 2014 and who left in August 2014. The new manager was appointed in October 2014.

The lack of a registered manager meant that the provider, as the only registered person, had the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Their role in overviewing the management of the home was included in a statement of purpose for Holmwood House. The provider's approach to quality assurance was set out in a policy as being 'continuous self assessment and regular monitoring', with a programme in place for 'auditing all the key standards and procedures'.

We saw a 'Quality Management System' file which included records relating to various checks and audits of equipment and facilities in the home. There was also a training plan and we were shown a record of an analysis of accidents and incidents that was kept separately. However the audits did not cover all the key standards and procedures relating to the service. There was therefore a risk that shortcomings in the safety and quality of the service were not being identified and followed up appropriately.

Plans had been produced in response to shortcomings identified at inspections and by other agencies. This was consistent with the provider's policy on quality assurance which stated that external feedback enabled the home to 'measure its achievements against the required standards and make changes where needed to make improvements'. However, where changes had been made following inspections, these were not effective in ensuring that people's rights were always protected and they received a safe service. For example, we again found shortfalls in the procedures for assessing mental capacity and in the planning and monitoring of people's care.

The provider was not ensuring that all arrangements were being made as set out in the home's statement of purpose. We read that "In accordance with fire safety guidance, the doors of all unoccupied rooms are kept closed at all times"; this was not the case during the inspection.

It was also stated that "All staff have regular training about what to do in a variety of emergencies." However, the training records showed that only one member of care staff had completed first aid training, which was an emergency first aid course in July 2013.

The provider was not operating an effective system for assessing and monitoring the quality of the service. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Policies and procedures had been produced which set out the measures to be taken in relation to different aspects of the service. However, these were not all being adhered to or updated to reflect changes in practice guidelines. For example, staff support was not being provided as intended and guidance in relation to mental capacity had not been updated to take account of a significant court ruling, which came into force before the last inspection. A policy and procedure for 'pressure sore prevention' did not refer to the current clinical guidelines about best practice. These examples showed there was a risk that practice in the home would not meet the expected standard, or that the quality of the service would not improve. We saw policies and procedures on file with a front sheet on which it was recorded that they had last been reviewed in May 2014. However the review process lacked clarity as the policies were not dated and the review sheet did not indicate which policies had been reviewed on which date and whether any changes had been made.

The provider kept in contact with Holmwood House and made a number of visits throughout the week. Reports of the visits and any findings were not produced, although the manager said they regularly met with the provider and records were kept of the matters discussed. The manager had also met with the staff so they were aware of developments affecting the home. This involved individual meetings with staff and a team meeting had been held in

Inadequate

Is the service well-led?

December 2014, although it was seen from the minutes that only three staff had attended. The manager told us that a consultant had also undertaken a survey with staff but they didn't know what the results of this were.

Staff spoke positively about the manager's approach. The manager was described as being "helpful and easy to get on with." One staff member told us the manager had an "open door policy" and they felt able to see them at any time.

Our discussions with the manager showed they had got to know people well and were assessing how well the service was meeting their needs. The lounges and a dining room had recently been redecorated and some new furniture obtained. This had enhanced these areas for people and the manager told us about other refurbishment work that was taking place. We were told there was no overall development plan for the home although the manager said a priority for them was to continue to develop the home's training programme for staff.