Milelands Limited

Holme House Care Home

Inspection report

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13 February 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Holme House Care Home took place on 8 and 13 February 2017. We previously inspected the service on 5 and 15 October 2015 at that time we found the registered provider was not meeting the regulations relating to safe care and treatment. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Holme House is a nursing home currently providing care for up to a maximum of 68 older people. The home has three distinct units providing care and support for people with nursing and residential needs including people who are living with dementia. On the days of our inspection 52 people were living at the home.

The service had a manager in place but they were not yet registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and staff understood their responsibility in reporting concerns about harm or abuse.

Not all aspects of people's care and support had been robustly assessed. We found inconsistent information regarding the moving and handling needs of one person, we also found a lack of information in their care plan regarding the equipment they used. One person had had a number of falls but the care plan did not detail how staff were to help the person to get up from the floor.

On both days of our inspection, no fire extinguishers were available on the corridors of Memory Lane. Cleaning materials were stored in an unlocked kitchenette cupboard.

There were insufficient numbers of suitably deployed staff to meet people's needs in a timely manner and people were left unsupervised.

Some aspects of staffs' recording in regard to medicines administration needed to be improved.

Not all areas of the home were clean.

Staff received regular training but some staff said they would benefit from more specific training around supporting people who exhibited behaviour which challenged others.

The majority of the staff had competed training in the Mental Capacity Act 2005 (MCA) but care records did not evidence the decisions made where people lacked capacity had been taken in line with the

requirements of the MCA 2005.

People told us they were not satisfied with the meals at Holme House and our observations of meal times raised concerns about the suitability of the food for some people and the skills and deployment of staff to meet people's needs. People did not receive adequate support to eat their meals.

People and relatives said the care they received was acceptable but people said the care could sometimes be a bit inconsistent. Staff told us they did not have time to read people's care plans and staff were not always aware of people's needs.

We noticed that where people had limited ability to express themselves, staff made choices for them and did not always involve them in making decisions. People were not always supported in a way which maintained their dignity. We saw people using their fingers to eat scrambled eggs with beans and sponge with custard.

Records relating to the care people received as they entered the closing stages of their lives lacked evidence that people or their families had been supported with this aspect of their care. We have made a recommendation in regard to end of life care planning and record keeping.

People's care plans were person centred but where people's care needs had changed, their care planning records were not always updated to reflect those changes. People's food diaries did not provide adequate detail of the food they were offered. Where care plans instructed staff to weigh people on a weekly basis, recent weights were not recorded.

Relatives told us the list of activities provided at the home was not an accurate reflection of the current programme. The manager told us they were recruiting for a second staff member to increase the provision of activities for people.

People told us they were not always satisfied with the response from the home's management team in regard to concerns. We saw complaints, including verbal concerns were logged, but on this occasion we did not inspect the investigation records regarding individual complaints.

People did not feel the home was well led and staff felt unappreciated. A range of audits had been completed but these had been ineffective in addressing the issues we identified at our inspection.. Audits and action plans for the home had failed to highlight or the issues we have raised within this report. .

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate

The service was not safe

Not all aspects of people's care and support had been robustly assessed and people's moving and handling records lacked detail.

People were not adequately protected from the risk of fire and cleaning chemicals were not always stored securely.

There were not always enough suitably deployed staff to meet people's needs

Is the service effective?

Requires Improvement

The service was not always effective.

There was a programme in place for staff to receive on-going training and supervision.

People's care plans did not evidence the service was complying with the requirements of the Mental Capacity Act (2005).

People were not provided with adequate support to eat and drink to ensure their dietary needs were met.

Is the service caring?

Inadequate

The service was not caring.

Staff were not always aware of peoples specific care needs.

Although staff interacted with people with a kind and caring approach, they did not always demonstrate respect for people's individual likes and preferences.

People's dignity was not consistently maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a failure to ensure accurate and robust records were kept regarding people's care and support.

People's care plans were person centred.

Complaints were logged and a record was kept of the action taken to address the issues.

Is the service well-led?

Inadequate

The service was not well led.

There was a manager in post but they were not yet registered with the Care Quality Commission.

There was a lack of robust and effective governance systems in place to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings had been held with staff and people who used the service.

Holme House Care 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 8 and 13 February 2017 and was unannounced. The inspection team on day one consisted of two adult social care inspectors, a specialist adviser 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. The expert by experience on this occasion had experience of both working in health and social care and caring for an older person. Two adult social care inspectors visited the home on 13 February 2017.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Not all the people who lived at the home were able to communicate verbally. We used a number of different methods to help us understand the experiences of people who lived in the home including, the Short Observational Framework for Inspection (SOFI), this is a way of observing care to help us understand the experience of people who could not talk with us. We also spent time in the lounge and dining room areas observing the care and support people received. We spoke with seven people who were living in the home, seven relatives and a visiting social worker. We also spoke with the director of care, the manager, two office based co-ordinators, a nurse and an agency nurse, five care assistants, two catering staff, a laundry assistant

and the activities organiser. We reviewed four staff recruitment files, nine people's care records and other related documentation and a variety of documents which related to the management of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection on 5 and 15 October 2015 found the registered person was not meeting the regulations as people's care as treatment was not provided in a safe way.

Relatives we spoke with told us they felt their family member was safe. One relative said "I feel [name] is safe here and I can go home ok after [name] is in bed." A person who lived at the home told us, "I feel safe here" another person commented, "I feel safe here. I have had to use the call button and staff came quickly."

Staff understood their responsibility in keeping people safe. When we asked staff about safeguarding people from harm they were able to tell us what they would do if they were concerned about a person's safety. We saw from the training matrix, safeguarding training was to be refreshed three yearly, the majority of the staff had completed this training and where they had not, this was clearly highlighted on the matrix.

At the last inspection on 5 and 15 October 2015, we found not all aspects of peoples care and support had been robustly assessed and peoples moving and handling records lacked detail. On this inspection we found although progress had been made, further improvements were still required to ensure people received safe and appropriate care.

We spoke with a social worker who was visiting the home to review a person who had been admitted to Holme House at the beginning of January 2017, but a risk assessment had not been put in place for a specific health condition or in relation to skin integrity or falls. This meant not all aspects of this person's care had been robustly assessed. We spoke with the manager following the inspection and they assured us these had been put in place as soon as they had been made aware of them.

We reviewed the care plan for another person and found the moving and handling information inconsistent and confusing. For example, an entry on an evaluation sheet dated 10 January 2017 recorded 'hoist for all transfers', however, the mobility care plan, dated 29 December 2015 although having a hand written amendment which recorded they needed to be hoisted, also had a typed entry 'if [name] has enough strength to walk, they must be supported by 2 staff'. We also saw a continence care plan dated 29 December 2015, which noted the person needed two staff to support them with their continence needs but made no reference to the need for a hoist. The client handling plan referred to both a standing and full body hoist being used but did not detail which hoist was to be used and in what circumstances. A falls screen risk had last been updated 4 October 2015. This inconsistent and out of date care plan information put this person at risk of unsafe or inappropriate care.

Care plans did not detail how equipment should be used for individual people. For example, for one person, an entry on an evaluation sheet dated 7 November 2016 noted they spent time in a recliner chair in the lounge but there was no information with their care plan as to how this equipment was to be used in order to reduce the risk of harm to the person. A care plan for a person who was mobile with a zimmer frame, provided no information regarding either the method or equipment needed to enable them to access the bath or shower. This meant staff may not know how to use equipment safely for each individual.

One of the care plans we reviewed recorded the person was at high risk of falls and noted 'there have been several recorded falls while [person] has been at Holme House' but there was no information recorded as to how staff were to support the person to get up from the floor once they had been assessed as being safe to do so. While we were present on Memory Lane we observed the person slide from their chair to the floor, staff were unable to prevent this and the person was unharmed. The staff then brought a stand aid hoist to assist them in getting the person from the floor. A stand aid hoist is designed to support people move from a seated position to a standing position. The staff realised they could not use this equipment and they telephoned another unit to ask for a hoist to be brought up to enable them to get the person off the floor. We noted the person was sat on the floor for 15 minutes while staff organised the necessary equipment and staff members to assist in getting the person from the floor. We also noted from the care plan, the person was to wear hip protectors; these reduce the risk of a hip fracture in the event of a fall. We asked the manager if the person was wearing them, they said they were, however we checked on both days of our inspection and found they were not, we told the manager about this at the time of the inspection.

These examples demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 5 and 15 October 2015, we found accidents and incidents were logged but a robust analysis was not in place. At this inspection we found the system for accident analysis had improved but was still not robust. Although a monthly analysis was completed enabling a breakdown month by month and by individual unit, the method did not enable the manager to see the overall picture in regard to the home or within a given length of time. The manager said they were aware improvements were required and assured us they would implement this promptly.

People were not adequately protected from the risk of fire. Staffs attendance at fire drills was recorded on the training matrix, however, this did not record how often this should be refreshed, it also identified 28 of the 67 staff listed had not yet attended a drill. Participating in regular fire drills helps to ensure staff are confident in their role in the event the fire alarm is activated.

On the first day of the inspection we did not see any fire extinguishers located on the corridors on Memory Lane. We informed one of the co-coordinators who arranged for the extinguishers to be placed back on the corridors. On the second day of our inspection, we checked and found there to be no fire extinguishers available on the corridors of Memory Lane. We raised this with a member of staff and they said a person who lived at the home often removed them. We brought this to the attention of the manager at the time of the inspection and discussed ways of ensuring fire extinguishers were available should they be required while reducing the opportunity for people who lived on Memory Lane to remove them.

Each of the units had a kitchenette area, we looked in some of the cupboards and found cleaning materials were stored in them. People who lived on Memory Lane were living with dementia, some of whom were able to walk about independently. We found cleaning solution in an unlocked cupboard under the sink. We showed this to a member of staff who promptly said "It's always there, but I suppose it should be locked up really." They then removed the chemical. On Redhouse Lane, where people have a range of needs, we found four cleaning products in an unlocked cupboard. We noted this issue had also been identified during an external health and safety audit report dated 31 January 2017. This meant people were not adequately protected as they had access to cleaning products, which if not used correctly, or ingested, could cause serious harm. We informed the manager about this after the inspection and they assured us action would be taken to address the matter.

These examples further demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

We saw evidence external contractors were used to service and maintain equipment, for example the gas and electrical safety and moving and handling equipment. This showed there was a system in place to ensure the premises and equipment were suitably maintained. At our last inspection we found a record of the water temperatures from all the sinks and baths at the home was not maintained. Following the inspection the director of care provided us with a record to evidence each hot water outlet had been tested once in a twelve month period to ensure the hot water temperature did not exceed 44°C. However, this meant that some hot water taps had not been tested to ensure they were safe, for nine months.

We checked staff had been recruited in a safe way.

We reviewed the recruitment files of four staff and saw application forms had been completed and a record of the interview questions and answers had been retained. There were two written references in each of the recruitment files we looked at and Disclosure and Barring Service DBS checks had been completed. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Relatives told us there were insufficient numbers of suitably deployed staff to meet people's needs, "The staff are rushed off their feet and sometimes are a bit slow to respond" and "When I ask the staff to take my [person] to the toilet, they say 'in five minutes', then you have to remind them and they say 'well [person's] got pads on' and you still have to wait." A relative, whose family member lived on Memory Lane, said, "It is ok today, there are three of them (staff) but when there are only two (staff), some people need two staff so they can both be in a bedroom and then there are no staff about."

Staff who were employed as care workers said there were insufficient staff to meet people's needs. We spoke with one staff member at 4.30pm, who said they had been on duty since first thing in the morning and had not yet had a break. They also said they felt that Memory Lane was the 'forgotten floor' as staff were borrowed from this unit when other units were short. They told us there had been only two staff on the unit on some shifts, and when they had told the manager about this, the numbers had been increased back to three. Three staff told us there were nine people living on Memory Lane but they were all mobile with three people being at high risk of falls and four people who needed two staff to support them with personal care tasks. This included supporting people to get up, washed and dressed in the morning, accessing the toilet throughout the day and assisting them to bed in the evening. One of the staff said, "If we had more staff we could engage with people more."

The manager told us 10 people were living on Memory Lane which was staffed with a nurse and two care staff, Oakwell had 16 people and was staffed with a nurse and three care staff while Redhouse Lane had 27 people and was staffed with a senior carer and three care staff. The manager also told us there was a further care assistant who 'floated' between the units to provide extra support.

At lunchtime on Memory Lane, we observed one person slide from their chair to the floor. There was only one care worker and the activity organiser present to deal with this. While they were busy, we saw the hot trolley had been brought up and placed in the dining room. There were two people sat in the dining room but no staff were present. When we checked ten minutes later, we noted one person had got up and changed seats, there were still no staff present. We asked the care worker how many staff were present on the unit. They told us told there were only themselves and a nurse as the other care worker had been sent to support on another unit. Five minutes later we saw a co-ordinator in the kitchenette was starting to serve lunches. The co-ordinator and the activity co-ordinator were not allocated to work on Memory Lane and did

not routinely work on a weekend, therefore if this incident had occurred on Saturday or Sunday, they would not have available to provide this extra support for staff.

On Oakwell one of the staff told us 15 of the 16 people who lived on Oakwell, needed two staff to support them. They said at breakfast time this meant two staff were providing care while the other care worker served and supported people to eat breakfast and the nurse administered people's medicines. We saw, and a member of staff confirmed, that staff did not finish serving breakfast to people until 11am and they began to serve lunches at 12.35pm and six people needed support to eat their meals. The last person to receive their meal was served at 12.55pm.

During lunch on Redhouse Lane there was a period when there were no staff present in the communal lounge/dining room, we observed two people become agitated with each other. A relative intervened to de-escalate the situation and a member of the inspection team went to locate a member of staff to inform them and enable them to address the matter.

We informed the manager of our findings regarding the numbers and deployment of staff at Holme House.

The manager showed us a dependency tool, dated 30 January 2017; this was used to assess the number of staff hours required. The tool included a number of physical tasks people may need support with, the tool did not incorporate the specific needs of people who were living with dementia. For example, people who may be resistive to the interventions of staff and it did not refer to a person requiring the support of two staff, for example, moving and handling or pressure area care. This meant there was a risk the dependency tool was not an accurate reflection of people's holistic care and support needs.

Following the inspection we were contacted by a member of staff who was concerned about the night staffing levels. They said only one staff member was routinely allocated to work on Memory Lane at night. We asked them, in the event of an emergency how they would summon help. They said they either had to telephone staff on another unit or press the nurse call. In the event this was not possible, they were unable to alert staff on the other units that they needed assistance. We contacted the manager and asked them if they had a lone worker risk assessment in place. They told us they were not aware of one but they also told us that following a review of recent accidents at the home, they had requested the registered provider authorise an increase in the night staffing levels to enable two staff to be deployed on Memory Lane, and this had been approved.

Although this reassured us that the manager was taking steps to review staffing at the home, at the time of the inspection, our observations demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection we observed two staff administering medicines to people. We saw the two staff members followed safe procedures, for example, they ensured all medicines were locked in the trolley between administrations and they checked they had the right person, the correct medicine and dose and before they administered a medicine to a person. We saw the medicines trolleys were kept in a locked room although staff did not consistently record the temperature of either the room or the medicines fridge; we had no concerns regarding either temperature on the day of the inspection.

We checked a random selection of boxed medicines and found the stock tallied with the recorded number of administrations. We reviewed two medicines that were prescribed to be taken 'as needed' (PRN) and found protocols were in place. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. We also saw there was also a system in place

to ensure the destruction of unwanted medicines was safe.

We found some aspects of medicines management needed to be improved. For example, we reviewed a pain relief medicine which was administered via slow release patches applied to the person's skin every 72 hours. We saw there was a body map to identify where the patch had been placed but there was no record of staff checking the patch was still in place between administrations, thus ensuring the person was still receiving their pain relief, and there was no system to record the removal of the previous patch, to reduce the risk of over medication.

Recording this level of information enables staff to evaluate the effectiveness of the medicines they are administering to people. We spoke with one staff member who told us that not all nurses and senior care staff were consistent in their approach to managing people's pain. They said some of the staff would ask care workers to document and observe the person rather than go to the person themselves to assess if anticipatory medication was required.

Records regarding the management of creams were not robust. For example, we saw a chart in the room of one person which recorded a cream was to be applied twice daily but the record had not been signed since December 2016. During December 2016, documentation for the application of this cream had also been inconsistent, having been signed on only 13 days of the month. We looked at the medicine administration record (MAR) for another person and saw they were prescribed a moisturising cream, the MAR noted 'see cream chart' but there was no cream chart in their bedroom.

We asked one of the nurses if their competency to administer people's medicines had been assessed following their employment at the home. They told us it had and we saw evidence of this when we reviewed their personnel file. Assessing the competency of staff helps to ensure they have appropriate knowledge and skills.

People who lived at the home and relatives commented favourably on the cleanliness of the environment. A relative said, "[Persons] room is always clean. The cleaners are good." We saw protective equipment, for example, gloves and aprons were readily available for staff and there was liquid soap and paper towels in toilets and bathrooms.

We identified some concerns with the cleanliness of the home. For example, found the kitchenette sink on Memory Lane was heavily stained and soiled. We also heard a person complaining to staff that their cup was stained inside. This person also told us staff often washed up at the kitchenette, they added "The water isn't hot enough, they can't clean things properly." One of the staff told us that after the tea time meal staff had to wash up the crockery and cutlery at the kitchenettes on each unit, "The kitchen staff leave at 5pm, we wash up in the sink, I know it's not ideal but we have to." Although this was confirmed by a second member of staff, the director of care told us, and the duty rota confirmed, that the cook finished work at 6pm. However, this could result in care staff being detracted from their duties to complete ancillary tasks which may not always an effective use of their time.

We also saw evidence food debris was not promptly cleaned up in dining areas. At 12.25pm we saw a member of staff remove the remains of a person's breakfast from the lounge carpet. We also saw a member of staff serve a meal to a person in the dining area but they did not pick up the apron or food from the floor at the side of them and we noted a lounge table had dried, encrusted food debris around the edge. This showed people were not consistently cared for in a clean environment.

On the second day of the inspection we observed staff using the same red toileting sling for two people. We

asked a member of staff if people were provided with individual slings, they said "Yes, but I can't find them in their rooms." It is considered good practice to ensure people have their own individual slings to reduce the risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

As part of the inspection we looked to see how new staff were supported when they commenced employment at Holme House. A co-ordinator said all new staff completed an induction programme; this included the completion of training, an introduction to the home and shadowing a more experienced member of staff. When we asked staff if they had received an induction, with the exception of one staff member, all said they had. We looked at four staff personnel files and saw evidence three of the staff had received a programme of induction which had been completed over a five day period but when we reviewed the file for the staff member who told us they had not received an induction, there was no evidence to suggest they had received any formal induction since their employment at Holme House. We brought this to the attention of the manager on the day of the inspection.

Staff we spoke with told us they received regular management supervision and staff said there was a system in place for staff employed in a senior role to have responsibility for the supervision of other staff. However, the staff member who told us they had not received any induction also told us they had not received any formal supervision since their employment had commenced during 2016. We checked their personnel file as there was no evidence of supervision, although there was evidence of regular supervision in the three other files we looked at.

Staff told us they had regular training, the majority of which was E-learning, although they confirmed there was practical element to the moving and handling training. One of the staff we spoke with told us they felt staff would benefit from receiving training in how to manage people who exhibited behaviour which was challenging to others. We asked other staff about this, one staff member told us "I think you need physical training" Another member of staff also said this training was online, we asked if they had completed training in de-escalation, they said they had not.

We raised this point with the manager and deputy manager. The deputy manager told us they already had plans to implement further training for staff in regard to enabling them to improve the support provided to people who were living with dementia. This showed the deputy manager recognised the need for staff to receive extra training support.

Following the inspection the manager sent us a copy of the training matrix. We saw it recorded staff's name, role and start date as well as the individual courses staff had completed. The matrix also evidenced the frequency of refresher training except for fire drills. Ensuring staff receive thorough training and regular updates mean staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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.

We saw from a log kept at the home regarding DoLS applications. The manager told us a record was maintained of expiry dates to ensure, where appropriate, a further application was submitted. They also told us they were reviewing the current DoLS authorisations to ensure where a condition had been applied to the DoLS, a care plan was in place and staff were aware.

Staff told us they received training in MCA and we saw from the training matrix this was to be refreshed every three years and 50 of the 67 staff listed were up to date with this training. From our conversations with staff it was clear staff understood people's rights to make decisions where they were able and how to support people on a day to day basis with making choices about their daily lives. One staff said, "(The MCA) it is about how much understanding someone has, if they can make decisions. If they can't, then we act in their best interest."

When we looked at people's care plans we found the records did not evidence decisions made on behalf of people who lacked capacity had been taken in line with the requirements of the Mental Capacity Act 2005. For example, the care plans for two people who lived on Memory Lane, which was specifically for the needs of people who were living with dementia did not contain a mental capacity assessment for any aspect of their care. We showed one of the care plans to the manager; they were also unable to see any evidence of mental capacity assessments.

A third care plan for a person living on Memory Lane contained a medicines care plan dated 1 November 2016 which recorded they could not manage their own medicines and it was in the person's best interests for staff to manage their medicines. We saw a mental capacity assessment document in their file which had not been completed and there was no evidence of the best interest decision making process. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005.

We reviewed the care plan for one person and saw a mental capacity care plan dated 20 October 2015. This recorded the person was unable to make complex decisions but was able to make day to day decisions, for example what they would like to eat and drink. We also saw a mental capacity assessment had been completed but this did not record the decision to which it related as it noted 'unable to make decisions independently'.

These examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 5 and 15 October 2015, feedback from people regarding the meals they received at Holme House was mixed. At this inspection, we spoke with people about the meals and on the first day of our inspection we observed the lunch on all three units and we observed lunch on two of the units on the second day of the inspection.

On Redhouse Lane food was a source of complaint for all the people and relatives we spoke with. They said the food was poor quality; the meals were repetitive, not always well cooked, with little choice and insufficient staff capacity to serve the meal in a timely fashion. People spoke of breakfast and tea as the two

meals that were acceptable. One person said, "I've been here two years, why can't we have better food?"

We saw there was one menu on an A4 sheet of paper which was on the wall and in small print. We did not see any menus on the tables and there were no visual images of the food available to show people although staff did verbally inform people of the options available. During lunch we heard people asking staff if they could have condiments to put on their food and we saw one person who ate their lunch in their bedroom but staff failed to give them the necessary cutlery to eat their meal, a member of the inspection team had to ask for this on their behalf. There was a delay in the cutlery being brought to the person as there was insufficient cutlery available on the unit. We did not see any options for dessert, other than the pudding which was served, such as ice cream or yogurt available for people even after they had been requested.

We found people were not adequately supported on Memory Lane at lunchtime. People ate lunch in three different communal areas but people were sometimes left unsupervised and there were insufficient staff to provide people with adequate support. For example, at 1.05pm we saw two people sat in a lounge with their lunch, unsupervised, one of them was picking at their meal, when we checked them again at 1.20pm we noted they had eaten only a minimal amount. We asked a different member of staff about the support this person needed to eat their meals they said, "If [person] is tired they need a hand, [person] won't pick up their knife and fork." Later in the day we spoke with the relative of this person, who told us, "[Person] needs help with meals. [Person] can't use a fork, and so quickly loses interest." When we checked their care plan this recorded '[person] has a poor appetite. [Person] should be assisted with their meals]'.

We observed another person sat in the main lounge at the table, we noticed they were using their fork but very little of the food they placed on the fork made it into their mouth so they could eat it. We asked them if they wanted any help, to which they responded "Well I could always do with some help" but they then said the food was cold. We saw a member of staff had left a pudding in front of the person despite them not having completed their main course. We moved the plates around to enable them to eat their pudding but they ate a spoonful before saying the pudding was cold and it 'looked awful'. We told a member of staff about this.

In the dining room we saw a member of staff attempting to serve custard to people, although the custard was hot, it was too thick to be poured and had a lumpy consistency. We asked the member of staff, if the custard was served to them in its current form, would they eat it, they told us they would not. We heard one person shout for a cup of tea but a member of staff gave them a drink of juice. Another member of staff brought them a cup of tea but the nurse told the staff member to take the tea away and make another as the cup offered was not fresh.

On Redhouse Lane staff offered people a choice of cold drinks but hot drinks were not offered until twenty minutes later. We observed staff ask people if they had eaten enough before removing plates from people, but where people had not eaten much, we did not see or hear staff prompting them to eat, offering support to eat or offering an alternative meal. One person was sat in an easy chair, we noted staff did not offer them anything to eat. We asked a member of staff and they said they thought the person had eaten as they had an apron on the floor at the side of them following our prompt, staff then served the person with a meal.

When we reviewed people's fluid records we saw very little evidence to suggest people were offered or provided with hot drinks on a regular basis. For example, we looked at the fluid records dated 2 to 7 February 2017 for one person. Of the 33 entries, only four were a warm drink, the remainder were cold drinks of juice. We also looked at the fluid charts for another person dated 6 and 7 February 2017, of the 13 entries, only two were for a warm drink.

These examples demonstrate a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from people's care records they had access to external healthcare professionals, for example, GPs, speech and language therapists, opticians and podiatrists. We saw an entry in a care plan for a referral to the dietician on 6 January 2017 but when we reviewed the record of professional visits there was no evidence they had been reviewed by the dietician or that staff had chased up the referral. We asked the manager about this and after discussion with other staff members they said they did not know if the person had been reviewed but they assured us this would be acted upon.

Redhouse Lane and Oakwell Hall both had a large communal lounge/dining room. Each of the unit bathrooms and toilets had signage which combined both words and pictures. There was also signage on the corridors to guide people as to the location of bedrooms and communal areas. These were, on the whole, placed above the handrail to enable people to see them easily. On Memory Lane bedroom doors were painted in a variety of colours to make them stand out while doors that were not accessible to people, for example, store rooms, were painted in a colour which made them blend in. Hand rails and communal toilet seats were a different colour to the walls, this helps draw people's attention to key features.

Inadequate

Is the service caring?

Our findings

People and relatives we spoke with said the overall care received was acceptable but commented care could sometimes be a bit inconsistent. One person said, "There aren't enough staff; but they do a marvellous job." Another person said, "The care staff change too often; it makes it difficult to form a relationship." Relatives' comments included; "The staff seem very patient, the home is very local for me, so I can visit often, which is important to me. [Person's] room is nice. But we never get offered a cuppa when we come", "I like it here. The staff are brilliant, so caring; though the food could be better", "Regular care staff tend to move floors which makes for inconsistency in care and there have been times when medication has been erratic. It could also help if they had name badges."

We asked a co-ordinator if staff worked on a dedicated unit within the home, they said staff worked over all the units but they tried to ensure a balance between staying on a unit and moving between the units to ensure they were aware of everyone's needs. Feedback from staff was mixed. One staff member said they generally worked on a particular unit and they enjoyed that. We spoke with another member of staff who was working on one unit on the morning shift and a different unit in the afternoon. We found staff were not always aware of people's specific needs. One of the staff we spoke with told us they had never read a care plan whilst working at Holme House. They said care delivery was based on 'what you know'. When we asked another staff member if they had opportunity to read peoples care plans they said, "We try to read them but not enough as we would like, we need time to read the care plans." This is important as it enables staff to be aware of people's care needs, likes, dislikes and aspects of their care and support which are important to them. This can be of greater importance, particularly where people have memory or communication impairments and may not always be able to communicate their preferences.

We reviewed the care plan for a person on Memory Lane which recorded '[name of health care professional] advised [name of person] eats their meals in their room'. At lunchtime we saw them sitting in the dining room. When we asked a member of staff where this person usually sat to eat their meals, they responded 'the lounge or dining room'. We told them about the entry in their care plan but they were unaware of it. On the second day of our inspection, on Redhouse Lane, we saw a member of the catering staff serving breakfast to people. We asked them how they knew if people had specific dietary requirements, for example, soft diet or thickened fluids. They said this information was kept in the kitchen so they would have to ask a member of staff, they added "I suppose it would be easy to make a mistake I suppose".

During our observations at the home we noted people were generally smart and well dressed, people had clean nails and gentlemen were clean shaven, although a relative we spoke with said, "[Person] looks clean but [their] clothes don't always match."

Staff interacted with people in a pleasant way but there were examples of missed opportunities for engagement. We observed two staff supporting a person to stand from a seated position. Staff did not provide any verbal direction to the person to advise them of what they needed to do. However, we also observed two staff supporting a person to transfer with a hoist, the staff explained and chatted to the person throughout and the person appeared relaxed and comfortable.

Although staff were able to tell us how they maintained people's privacy and dignity, for example closing doors and using towels to cover people during personal care, we saw a number of examples of staff failing to maintain people's dignity or respect people's right to make individual choices. At meal times we noted where people were able to make a choice or state their preference, staff were more consistent in offering them options but people who were less able to verbalise their preference, staff frequently made no attempt to support them to choose.

At lunchtime on Redhouse Lane, staff offered people a verbal choice of the two main courses then the meal was plated up by staff at the bain marie, including adding gravy, without asking people first what they would like or how much. Staff served one person a meal with a Yorkshire pudding. They did not offer to cut the Yorkshire pudding up, we saw the person use their fork and fingers to eat the pudding. We suggested to a member of staff that they cut the food up for the person, which they did.

We also noticed a person who was eating lunch in their bedroom using their fingers. We checked their care plan and this confirmed the person prefer to eat with their fingers and was therefore provided with food which was suitable for this. However, we asked a member of staff what options this person had for dessert; they told us the only dessert was cherry flan with evaporated milk. We asked the staff how the person would eat this and they told us they intended to sit and help them as they would not be able to eat this themselves.

People were presented with meals without always being offered choice. For example there was no choice of dessert at lunchtime on two of the units and staff added custard or cream without asking people. This demonstrated staff did not always demonstrate respect for people's individual needs and preferences.

On Memory Lane we saw a member of staff prompt a person to eat including trying to place food in their mouth. We asked the member of staff if the food was now cold and would they be prepared to eat the meal, they said they would not be prepared to eat the meal themselves, they got up and took the meal away. We did not see what alternative meal was provided for the person. We saw a co-ordinator show people a visual choice of either orange or blackcurrant juice but we also saw staff give people a cup of tea without them being asked or shown any alternatives. At lunchtime we asked a member of staff if people could have a hot drink with their meal, they told us hot drinks were offered after lunch. When we asked them if people wanted a hot drink with their lunch they said they did not know. We heard one person shout for a cup of tea at lunchtime but a member of staff gave them a drink of juice, we then saw the person spill the juice over the table but this was not noticed by staff despite them walking past them while serving meals to people.

On the second day of our inspection while on Redhouse Lane, we saw a person sat in a wheelchair at the furthest point from the dining area, where a member of catering staff was serving breakfast. We noted the person was eating scrambled egg and beans with their fingers. We asked the person if they wanted help, they replied 'yes', we went to locate a member of staff and they came to sit with the individual and assisted them to eat the remains of their breakfast in a more dignified manner. The nutrition care plan for this person, dated 8 December 2016 noted 'poor appetite and lost weight', and 'needs lots of prompting, appetite is poor and [person] falls asleep at meals, staff to encourage [person]'. Although we saw their weight had been stable between November 2016 and January 2017, we shared our findings with the manager. We also saw a person on Memory Lane eating their sponge and custard with their fingers. A member of staff went to the table on two occasions but failed to rectify the situation. We also observed two staff who supported a person to transfer using a hoist, the person was wearing a skirt without any tights or stockings, their bare legs were exposed to their mid-thigh.

These examples demonstrate a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the inspection we looked at how people were supported as they neared the end stages of their lives. We saw training was provided to staff in the form of E-learning and we noted of the 67 staff listed on the matrix, 50 staff had completed the course.

We looked at the 'advanced care plan' for two people. Both care plans lacked detail and were used to simply record if a person had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) in place and their preferences for a burial or cremation. Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing. It enables people to discuss and record their future health and care wishes and also to appoint someone as an advocate or surrogate, thus making the likelihood of these wishes being known and respected at the end of life.

We also reviewed the care plans for two people who had recently died at the home. In one of the care plans we reviewed it was documented the family had raised concerns regarding a particular symptom their relative was experiencing. There was no record in the care plan that anticipatory medication had been administered or if that had been effective. In the second care plan it was clearly documented the person was peaceful and their family had spent time with them. But there was no documentation of discussions held between staff, the person and/or their family as the person neared the end stages of their life.

We recommend the service seeks guidance from a reputable source, in regard to end of life care planning and record keeping.

Requires Improvement

Is the service responsive?

Our findings

We asked people how they spent their time at Holme House. One person said, "You either stay up or go to bed, there's not enough to do and there aren't enough staff; but they do a marvellous job." A relative told us an aromatherapist visited the home at regular intervals and provided manicures and mini massages. There was information around the home about activities taking place but two relatives told us the information the activity boards did not relate to current practices. One of the staff we spoke with told us people did not get enough social interaction. On the first day of our inspection we saw an external company visited the home to provide music and movement. The person who led the session clearly knew people who lived at the home, speaking with them by name and encouraging their participation, and people present were smiling and joining in where able.

The manager told us the activities organiser was new to the home following an internal transfer from another of the registered provider's homes. They worked full time, flexibly, including some weekends. They said they were currently looking into further job specific training for them and they were also recruiting for a second activities organiser for the home.

Our inspections in September 2014 and October 2015 found the registered provider was not meeting the regulations regarding records. On this visit we still found evidence of poor record keeping.

Care plans were personalised, recording details which were specific to the person. For example, one care plan noted 'first language is English, but when stressed will use foreign language' and 'staff should observe [person] for triggers that may indicate they want the toilet, such as wandering around opening doors'. We also saw another care plan which detailed a specific tactic for staff to use in the event they became verbally aggressive. This level of detail is important as it helps staff to understand people and react appropriately to their needs.

Some people who lived at the home had food and fluid charts in place but the records lacked adequate detail to evidence people were offered and provided with adequate nutrition and hydration. Food diaries did not record the detail of the meal or snack people were offered or the amount offered, only the amount of consumed was recorded, for example, '½' or 'all'. The food diaries we reviewed also failed to evidence people were offered or provided with regular, nutritious mid-meal snacks. We reviewed the food diaries dated 2, 4, 6 and 7 February 2017 for a person who we had seen eat very little at lunchtime on Memory Lane. There was no evidence they were offered a mid-morning or mid afternoon snack on three of the days and on 6 February 2016 staff had written 'declined' for breakfast and there were no other entries until the tea time meal. The food diaries and daily records did not evidence if or how staff had encouraged them to eat or what food they offered to prompt the person to eat. In the food diaries for another person, dated 2, 4 and 6 February 2017 there was no evidence they were offered a mid-morning and mid afternoon snack on only two days. We checked the food diaries from 1 to 12 February 2017 for a third person and saw no mid-morning or mid afternoon snack had been recorded on 11 of the days and there were no entries at all for 1 February 2017. These concerns were shared with the manager on the day of the inspection.

We found records of people's weights were not consistently recorded in people's care plans. For example, when we looked at the care plan for one person there were no weights recorded since 17 January 2017 despite a nutritional risk assessment dated 11 January 2017 which identified they were a high risk and a care plan, dated 12 May 2016 instructing they were to be weighed weekly. The nutritional care plan for a second person dated 5 July 2016 recorded 'weigh weekly' but the last weight recorded was 24 January 2017, and a third person whose care plan also instructed staff to weigh them weekly, there was no recorded weight since 19 January 2017. This meant we could not clearly evidence people had been weighed in line with the instructions in their care plans and we were therefore unable to review if there were concerns regarding individual's nutritional well-being.

Due to recent safeguarding concerns staff recorded their observation of the location of a person who lived on Memory Lane, every 15 minutes. We looked at the records dated 1, 2, 3, 4, 5, 7 and 8 February 2017 and saw each entry was consistently recorded at the same time every 15 minutes. On 1 February 2017 staff had recorded '15', '30' and '45' but they had not signed to record they had completed an observation of the person. This indicated the times recorded were not an accurate time for the observation of the person.

One person who lived at the home had a Percutaneous endoscopic gastrostomy (PEG) feeding tube fitted. It was in their care plan that rotation of the PEG should be undertaken weekly but we were unable to evidence when this had been done. Failing to do this can lead to future complications with the feeding tube.

We spoke with one relative who told us they had asked staff to enable their family member to wake naturally in the morning and not be woken by staff. They said staff were carrying out this request as their family member was less tired during the day. We checked the person's care plan and saw this change had been added to the care plan although the entry had not been signed or dated. However, we found other people's care plans were not routinely updated to reflect changes in their needs. For example, while reviewing the care plan for one person we saw a record of a GP visit, dated 23 November 2016 which noted 'the doctor said that he can't do nothing about this, but will prescribe some anticipatory drugs because [person] is palliative care'. The staff member who had made the entry had not provided any information as to what 'this' was. Anticipatory medicines are prescribed for people who may be nearing the end of their life, they are prescribed in order to enable staff to administer them promptly to alleviate specify symptoms people may have. As the staff member had recorded the person was to receive palliative care and be prescribed anticipatory drugs, we reviewed their medication care plan. The medication care plan was dated 12 April 2015 and made no reference to their change in care or to the prescribing of anticipatory medicines.

These examples demonstrate a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home and their relatives told us there was limited responsiveness from the management of the home, relatives told us, "I've had a problem with the nursing staff and made formal complaints, but you don't get answers. One of the reasons that I come twice daily is because I'm not confident here." Another relative said, "Relatives rarely get informed of anything, you have to ask if you want to know anything. I've put suggestions in the suggestion box but nothing ever happens, so I've given up. I didn't know they'd had a relatives and residents meeting." A further comment was, said "[Person's] bedding hadn't been changed once for three weeks and I had to raise this. It is sorted now but should never have happened. I now take the personal laundry home to make sure it's done and that [person] gets their own things." A person who lived at the home, said "It's like talking to a brick wall here, nothing alters. They could do with a miniature atom bomb to blow it up and start again."

At our previous inspection on 5 and 15 October 2015 we found the registered provider did not keep a record

of verbal complaints which were raised. On this inspection we saw a log of complaints and compliments was retained, including verbal concerns. This noted the date of the complaint, details of the complainant, the complaint, action taken and the outcome.

Inadequate

Is the service well-led?

Our findings

We asked people if they felt the service was well led. One person said, "The food is poor. They can't get care staff. The staff do work hard. Your stuff gets lost in the laundry sometimes. It would be better to have small quality portions of food rather than the large poor quality ones, much of which gets wasted. We hardly see management, they stay in the office." One relative commented that there was little point in raising issues as they were not listened to and there was rarely any response or feedback. Three of the people we spoke with were worried about being identified from the feedback they gave us.

A member of staff told us their work was not recognised and they only seemed to receive negative comments or criticism when things had not been done properly. Another staff member said they did not feel they were always appreciated, "A good home has a good working relationship with managers and seniors but that is not always the case here. It's not always an open door policy, managers are not always approachable or recognise when staff are struggling, CQC shouldn't have to ask staff to come and help from another floor.'' However, another staff member told us they had raised a concern with the registered provider and they felt they had been listened to and action taken.

The registered provider is required to have a registered manager as a condition of their registration.. The previous registered manager had left the service during 2016 and the director of care told us a further two managers had been employed at the service in succession to each other, but they were no longer with the organisation. There was a manager in post on the day of our inspection but due to the short period of time since their employment commenced, they had not yet begun their application to register with the CQC.

A new deputy manager commenced employment while we were conducting our inspection. We asked the manager and the deputy what their plans were for the service. They said they intended to have weekly meetings with the provider, regular staff and resident and relative meetings and implement an action plan. The manager also showed us a walk around audit they told us they planned to implement over the next few days, they said this was to ensure daily checks were competed in order to begin to improve standards.

We saw a range of audits had been completed by the management team, including checking beds, cleaning and equipment. We saw a medicines audit had been completed in January 2017; although actions were identified on the report, we were unable to evidence from the audit if the actions had been completed. We also looked at a file where people's weights were recorded but we could not locate the weekly weights for January 2017 and we could not see that a person who had been admitted to the home in recent months, where concerns had been raised in regard to weight loss, had been added to the log. After the inspection, the manager sent us a health and safety audit report dated 31 January 2017 completed by an external health and safety consultant. The service received a score of 84.85 'very good', although a number of areas were identified as needing remedial action to be taken.

At the inspection we asked to see reports of visits or audits by the registered provider but we not shown any. We did not receive any reports of visits or audits by the registered provider after the inspection and the manager told us they were not aware of any. Following the inspection the director of care submitted three

quality assurance visits from 2016 and an action plan. We saw the action plan listed a number of issues and included details of who was responsible for the action and why. The action plan also recorded when actions had been addressed.

We looked to see how the views of people who lived at the home, relatives and staff were gained. We saw minutes from a staff meeting dated 23 November 2016 and saw topics discussed included management changes, staff recruitment and audits. We did not see any other minutes to evidence other staff meetings had taken place although a member of staff told us a staff meeting had been held in December 2016. A care co-ordinator also told us twice weekly team meetings were held at the home to ensure key issues were shared with in the various departments within the home. This was confirmed by another member of staff who we spoke with. Following the inspection the director of care emailed copies of meeting minutes which had been held during 2016. A staff survey had been undertaken in November 2016, and we saw the content of this had been discussed at the staff meeting in November 2016. Following the inspection we asked the manager if they were aware of an action plan in regard to the findings of the audit but they said they were not aware of one.

We asked to see evidence of resident meetings, we saw hand written minutes dated 7 March 2016 but there were no other minutes to evidence any meetings had taken place since then. Following the inspection the director of care emailed copies of two further meeting minutes which had been held during 2016. The last survey of people who lived at the home was 2015, the manager said they were not aware one had been completed since then. Following the inspection the care director emailed us evidence of a meal time questionnaire which had been completed in July 2016.

Meetings and surveys of staff and people who use the service enable people to express their views and be involved in making decisions about the service. It is also an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people living at the home.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. We saw evidence the registered provider submitted these notifications in a timely manner.

Although during discussions with the director of care they told us they were aware the service provision was not meeting the expected standards, it is the responsibility of the registered provider to ensure the service is compliant with all aspects of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified a number of concerns regarding people's safe care and treatment, nutrition and hydration, dignity and respect and governance. This included a failure to ensure peoples care and support was robustly assessed to reduce risks to their safety and welfare, an issue had been raised at the previous inspection.

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

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 Care and treatment was not provided in a safe way; risk was not robustly assessed and there was a failure to do all that was reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not met.

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 Systems or processes did not operate effectively to ensure compliance with all aspects of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not have a robust systems or processes to assess, monitor and improve the quality and safety of the services provide. The registered provider did not have a robust

systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.
An accurate, complete and contemporaneous record in respect of each person was not maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably deployed staff to meet people's needs.