Milelands Limited

Holme House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Holme House Care Home took place on 27 November and 4 December 2017. We previously inspected the service on 8 and 13 February 2017; at that time we found the registered provider was not meeting the regulations relating to dignity and respect, safe care and treatment, nutrition and hydration, staffing and good governance. We rated them as inadequate and placed the home in special measures. We asked the provider to complete an action plan to show what they would do and by when to improve the service. The purpose of this inspection was to see if significant improvements had been made and to review the quality of the service currently being provided for people.

Holme House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Holme House is a nursing home currently providing care for up to a maximum of 68 older people. The home has three distinct units Memory Lane, Oakwell Avenue and Redhouse Lane, providing care and support for people with nursing and residential needs including people who are living with dementia. On the days of our inspection 61 people were living at the home.

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

Staff had received training in safeguarding people from the risk of harm or abuse and understood their responsibilities in reporting any concerns to a senior member of staff.

Information recorded in moving and handling records was detailed however, it was not always clear which hoist sling belonged to which person.

External contractors were used to service and maintain equipment. Internal checks were completed on the fire system. People had a Personal Emergency Evacuation Plan in place but these were not always an accurate reflection of their current needs and we were not able to establish from the records available that staff had completed a simulated fire drill.

Staff were recruited safely and we saw people's needs were met in a timely manner.

The temperature at which some medicines were stored was not always appropriate but action was taken by the registered manager to address these concerns. The recording of creams was not robust; there was a lack of information available for staff to ensure they were applied correctly. We have made a recommendation regarding the management of creams.

The registered manager had implemented a system to review accidents and incidents. This provided an opportunity to address shortfalls and reduce future risk.

Policies referred to legislation but they did not always reference current good practice guidance.

New employees received induction but there was currently no facility at the home to support staff who had no previous care experience to access the Care Certificate. Staff received training and a programme was in place to provide further training for staff in regard to supporting people who were living with dementia. Not all staff had received regular supervision, the registered manager had begun to complete staffs' annual appraisal.

Most people we spoke with told us the food was good. People were able to choose where they wanted to eat and were supported appropriately by staff. Where staff recorded people's diet and fluid intake, improvements needed to be made to ensure the records were accurate and detailed.

People received support to access other healthcare professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We saw evidence mental capacity assessments had been completed and where appropriate, DoLS applications had been applied for.

People told us staff were caring and kind, staff treated them with dignity and respect. We saw kind caring interaction between staff and the people they supported. There was a range of activities provided at the home.

Care plans were stored securely but daily records were stored in unlocked cupboards. People's care records were detailed and person centred, but care staff did not have access to them and two of the staff we spoke with told us they had not had opportunity to read them.

At the last inspection we recommended the service seek guidance from a reputable source, in regard to end of life care planning and record keeping, but this recommendation had not been implemented.
There was a system in place to ensure concerns and complaints were listened and responded to.

Feedback from people who lived at the home and staff was mainly positive. The registered manager had been in post since February 2017, they were supported by a deputy manager and two office based care co-ordinators. The registered provider visited the service on a weekly basis. A range of checks and audits were completed by the management team and an external consultant to monitor the performance of the service.

Meetings had been held with staff, people who lived at the home and their relatives to gain feedback about the quality of the service provided to people. The registered manager had recently sent a survey to people, the majority of respondents had given positive feedback.

This service had been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. However, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 regarding person centred care and good governance.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

Records regarding fire safety lacked detail.

The management of topical creams needed to be improved.

Staff understood what may constitute abuse and were aware of their responsibility in reporting any concerns.

Staff recruitment was safe.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

The registered manager was not able to evidence how good practice guidance was used within the home.

Staff completed induction and received training. Not all staff had received regular supervision or an annual appraisal.

People were generally happy with the meals they received and health care need were met.

Consent to care was sought in line with legislation.

Is the service caring?

Requires Improvement

Then service was not always caring.

Peoples records were not always stored confidentially.

We observed nice interactions between staff and people.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

There was a lack of information recorded as to how people wished to be supported at the end of their life.

Care records were person centred and activities were provided for people to participate in.

There was a system to manage complaints.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

Improvements had been made since the last inspection but there were still a number of areas as identified within the inspection report where further work was needed.

There was a registered manager in post.

Regular meetings were held with staff and people who lived at the home.

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 27 November 2017 and was unannounced. The inspection team consisted of three 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 in caring for an older person. Two inspectors also visited the home again on 4 December 2017, this visit was also unannounced.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with four people who were living in the home and five visiting relatives. We also spoke with the registered manager, deputy manager, a nurse, senior carer and eight care assistants, two members of the kitchen staff and the activity organiser. We reviewed four staff recruitment files, thirteen people's care

and/or medication records and a variety of documents which related to the management and governance of the home.

Requires Improvement

Our findings

Most of the people we spoke with told us they felt safe living at Holme House. People's comments included; "I feel safe but a bit isolated, they have offered to move me. I was feeling very depressed before, I had a talk with the night carer who was very nice to me", "I feel safe because it's like a family here, the staff are very good" and "I feel safe with the buzzer because I know there is someone on the end of it." Relatives also felt their family member was safe, one relative told us, "My relative has been in three homes before this one and this is the best so far. [Name of relative] is safe here and gets on well with the staff." One person we spoke with told us they did not feel safe living at Holme House; we discussed this with the registered manager at the time of the inspection.

Staff understood what may constitute abuse and were aware of their responsibility in reporting any concerns to a senior member of staff or the registered manager. The deputy manager said any safeguarding matters were logged, investigated and reported to the local authority safeguarding team. The registered manager told us all staff had competed safeguarding training; new staff had to complete this module of training prior to them commencing working in the home. This helped to ensure staff had the knowledge and skills to recognise when people may be at risk of harm or abuse.

There was a system in place for reviewing and investigating safety, safeguarding incidents and events when things went wrong. The registered manager kept a log of safeguarding concerns; this included a record of the date of the incident, relevant names of people involved, a brief description and the outcome. A monthly analysis of accidents was completed and we saw the analysis included a section where the registered manager recorded actions to be taken to reduce the risk of future incidents. However; while reviewing the care file for one person we saw an incident form dated 19 November 2017 which recorded the person had slid to the floor while transferring onto a weighing chair. When we spoke with the registered manager they told us the matter had not yet been fully investigated. Following the inspection we received further correspondence from them to confirm they had since concluded their investigation.

Our inspection in February 2017 found the registered provider was not meeting the regulations in regard to safe care and treatment. At this inspection, we reviewed the care files of four people who required the use of a hoist to enable them to transfer. Three of the records contained adequate details for example, the type of hoist and sling to be used and how the sling should be applied and fitted. But the fourth care plan did not instruct staff which loops to use on the sling. However, the records were person specific; for example, one person's record stated 'place a palm on their lower back for support'. During the inspection we observed safe moving and handling transfers.

Staff told us people had their own individual hoist slings but it was not always clear which sling belonged to which person. Although the slings each had a serial number, they were not marked with a person's name and the serial number was not recorded in the persons care file. We saw three slings draped over hoists in the corridor but when we asked a member of staff about one of the slings they were unsure which person it belonged to. When we asked another member of staff, they said they would have to ask the senior staff member on duty which sling they were to use for people. Ensuring the sling is appropriate for the individual helps to reduce the risk of harm.

Some people had air wave pressure reducing mattresses on their beds. These mattresses helped to lower the risk of the person developing a pressure ulcer. It is important to ensure these mattresses were set correctly so they work effectively. We checked two people's air wave mattresses and found one was incorrectly set, we brought this to the attention of the nurse on duty who immediately adjusted the setting. We saw where care plans recorded people needed to be sat on pressure reducing cushions, we observed they were in place and people were sitting on them.

Our inspection in February 2017 identified people were not adequately protected from the risk of fire as fire extinguishers were not readily available on Memory Lane and not all staff had completed a fire drill. At this inspection we found notices were clearly displayed on both fire exit doors on Memory Lane to inform staff where the fire exits were located. When we asked two of the staff who were on duty on Memory Lane they were able to tell us where the fire extinguishers were located. This is important as it ensures staff are able to locate firefighting equipment promptly in the case of emergency..

From the records we looked at we noted fire drill training had taken place in July and August 2017, the registered manager told us a further fire drill had taken place in October 2017. We asked the registered manager if these had been simulated fire drills to practice the procedures for progressive horizontal evacuation; they said they were but we were unable to evidence this from the records presented to us at inspection. Participating in regular fire drills helps to ensure staff are confident in their role in the event the fire alarm is activated.

Each of the care files we reviewed contained a Personal Emergency Evacuation Plan (PEEP). This is a document which details the safety plan for a named individual in the event the premises have to be evacuated. Each PEEP recorded the name of the person and the number of staff needed to assist them but they did not record evacuation routes. We also questioned if the references to equipment was appropriate. For example, one person required the use of a hoist to transfer them on a daily basis but their PEEP did not refer to the use of any equipment to support staff to evacuate them. Another PEEP recorded the person would need a hoist to enable staff to transfer them however; we raised the question with the registered manager as the appropriateness of this piece of equipment to enable their speedy evacuation in an emergency situation. When we reviewed the registered providers fire risk assessment it recorded 'Additional care must be taken with regards to bedrooms [bedroom numbers] when dealing with the lift lobby areas and any one residing in these bedrooms must be moved immediately behind two fire doors if a fire occurs' but this information was not recorded on the PEEP of a person who was living in one of these bedrooms. Following the inspection we brought this to the attention of the registered manager. They told us the person had recently moved into this bedroom and this was the reason for the information not being recorded. It is important that all relevant information is included on a PEEP as soon as any changes occur; this reduces the risk of harm in the event of a fire.

The registered manager told us the fire alarms were tested weekly. We looked at the fire bell testing records and noted the alarm was tested most weeks, although between 5 September and 29 September 2017 the fire alarm test had not been completed. We noted the emergency lighting was checked at least monthly and

fire extinguishers had been audited on a monthly basis. We also saw portable fire equipment and fixed hose reels had been serviced in October 2017

We saw a range of maintenance certificates were in place and up to date, which included, service and calibration of a set of weighing scales, lift and the electrical installation certificate. We saw the gas safety certificate was dated 1 December 2016. The registered manager told us they had changed to a biomass system in July 2017 and would request a copy of the safety certificate from the registered provider. LOLER (lifting operations and lifting equipment regulations) certificates on bath chair and hoist, runway tracks, portable personal hoists and lifting attachments were up to date. However, there was no central register of all the slings in the home; this meant it was not possible to clearly evidence each sling had been LOLER tested. We discussed this with registered manager and a care co-ordinator and they assured us they would consider implementing a register to ensure all the slings in use were compliant with the LOLER regulations.

At the last inspection we found cleaning chemicals stored in unlocked cupboards in the communal areas at this inspection we did not see any evidence of this, although on both days of the inspection we saw two store rooms on Oakwell Avenue which were unlocked despite having stickers in place which instructed staff to keep the doors locked.

We looked at four staff files and we reviewed the recruitment process to ensure appropriate procedures and checks had been made to establish the suitability of each candidate. We found recruitment practices were safe. We saw relevant checks had been completed, which included a disclosure and barring service check (DBS). The DBS is a national agency that holds information about criminal records. We noted references had been obtained. We also saw staff files contained a completed application form, interview assessment and a contract of employment.

Our inspection in February 2017 found the registered person was not meeting the regulations in regard to staffing as there were insufficient numbers of suitably deployed staff to meet people's needs. During this inspection we saw people's needs were met in a timely manner although feedback from people and staff was mixed.

We asked people if they were satisfied with the staffing levels at the home. Three of the people we spoke with told us there were not always enough staff on duty. One person told us they had to wait until staff were available to help them get up rather than getting up at a time of their choosing. A relative told us they had telephoned the home on three occasions the day before our inspection to ask how their relative was and once on the day of the inspection but was told no-one was available on the unit to talk to them, they said the staff member who had answered the telephone said someone would call them back but they did not.

Some of the staff we spoke with felt the staffing levels were sufficient, others felt an extra member of staff would be beneficial. One member of staff told us, "It would be better with five staff on a morning; sometimes I think night staff get them up too early." Two other staff said an extra staff member in a morning would enable the staff team to be more efficient.

At our inspection in February 2017 we found some aspects of medicines management, including the management of creams, needed to be improved. At this inspection we found the management of creams needed to be improved.

The rooms where the medicines trolley was stored were kept locked and a check was maintained on the temperature of the room, although we noted on Oakwell Avenue the room temperature was recorded as above 25° centigrade on 14 out of 27 occasions in November 2017. We also noted the fridge temperatures

were recorded as 1°centigrade on six out of 27 during November 2017. The document where staff recorded the temperatures noted 'Medication storage areas should be <25° and fridge between 2-8°C'. This is important as when medicines are not stored correctly this can affect their efficiency. We discussed these issues with the registered manager and on the second day of the inspection we saw air conditioning units had been fitted and a new fridge was in place.

We observed medicine rounds on each unit, this was done safely. The staff administering the medicine locked all medicines back in the trolley while they were administering people's medicines and we saw staff check the medicine administration records (MAR's) prior to dispensing the medicines and signed the MAR following administration. Although we did see that despite staff wearing a tabard which requested they were not to be disturbed during their medicine round, we saw they were interrupted to see if they could take a telephone call. Staff asked people if they wanted their medicines and explained what the medicine was for prior to their administration.

We noted one person's lip was sore, we saw an entry in their records which referred to them biting their lip 'a few days ago'; we also noted their diet and fluid intake had reduced since this had happened. Although we saw evidence a doctor had been consulted and some cream was prescribed, despite the person already being prescribed pain relief, there was no evidence to suggest it had been offered or administered to them. This person lacked capacity and was not able to effectively communicate their needs to staff. This indicated staff had not considered the benefits of providing pain relief to this person to improve their well-being.

We found the recording of topical creams and lotions was not adequately recorded. For example, we saw, Conotrane in room in a bedroom, the person's MAR recorded the cream should be applied 'as needed'. We saw entries in the daily records, completed by staff which confirmed they had applied the cream but we could not see any information which instructed staff when, where or why to apply it. Another person had three creams in their bedroom; they had a single 'cream application record' in their room which listed two of the creams. The body map had an 'X' marked on each buttock but there was no instruction as to which cream was to be applied there or when. We brought this to the attention of the registered manager, they told us the instructions would be in the care plan, but when we looked, they were not. We recommend the service consider current guidance on the management of time specific medicines and topical creams and lotions.

Staff whose role included the administering of medicines told us they had completed training in medicines management and an assessment of their competency was completed on a regular basis. We spoke with a member of staff who had recently started working at the home, they told us they had received mentoring and an observational assessment of their competency to administer medicines had been completed before they were able to administer medicines unsupervised. We saw evidence of staffs training and competency assessments in one of the staff files we looked at. This meant people received their medicines from staff who had the appropriate knowledge and skills.

At our inspection in February 2017 we identified some concerns with the cleanliness of the home at this inspection we found the majority of the home was clean and odour-free. However, on both days of the inspection we identified an unpleasant odour in the corridor by the lift on Memory Lane. On the first day of the inspection a relative complained to us their family member's bedside table, arm chair and carpet were soiled. They said they had asked a member of staff to clean the chair and the table but this had not been done. We returned to the person's room at 4.30pm and found the table; chair and carpet were still unclean. We brought this to the attention of the registered manager who arranged for the items to be cleaned. We checked on the second day of the inspection and found the room to be clean.

Prior to the inspection the registered manager had submitted a statutory notification regarding an error with a person's medicines. We asked the registered manager if any lessons had been learned as a result of this; they said this incident had highlighted a weakness in the audit tool and plans were in place to amend the format of the audit to reduce the risk of this incident occurring again. They also said the staff involved in the incident had received further training and had opportunity to reflect on their individual practices to see where lessons could be learned. This was corroborated when we spoke with another member of staff. These examples showed improvements were made when things went wrong.

Requires Improvement

Our findings

We asked both the registered manager and the deputy manager how they ensured peoples care and support was delivered in line with current legislation, standards and evidenced based practice. The registered manager was aware of how to access evidence based guidance but they were not able to provide any examples of how they were using evidence-based guidance to achieve effective outcomes for people. The deputy manager told us about their professional qualifications, which included a Bachelor of Science (Bsc) in dementia care. They told us how they were applying elements of their learning to improving staffs' practices and the environment at the home; they made reference to NICE guidelines and the work done by Stirling and Bradford University in regard to improving dementia care for people.

We reviewed a sample of the registered provider's policies and saw they referenced relevant legislation, such as the health and safety at work act and the equality act. Some policies also refered to current good practice guidance, for example, the medication policy referred to Nice guidelines (for care homes) 2014 however, the weight monitoring policy made no reference to the use of the malnutrition universal screening tool (MUST) despite us seeing evidence of its use within the home to assess peoples nutritional risk.

Most people we spoke with told us staff were sufficiently skilled and experienced to support them in the way they would like, relatives confirmed this.

We looked at staff files and were able to see information relating to the completion of induction. The document noted the induction was to be completed by staff members over a five day period; however, we noted in the staff files we looked at staff had signed and dated the induction form to say all the elements had been completed in one day. The registered manager told us all the elements could be completed in one day and the induction record required updating and the registered provider's head office were currently in the process of reviewing this. The deputy manager told us staff completed e-learning sessions during induction and also completed a three monthly probation period. We asked the registered manager if new staff without prior experience in adult health and social care completed the care certificate. They told us this was not currently being provided to staff but they were looking at implementing this in the future. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

We saw a range of training certificates in the staff files we looked at, which included people movers, moving and handling, principles of safeguarding, health and safety, Dementia awareness, basic life support, Mental Capacity Act and Deprivation of Liberty Safeguards. We noted from one file a staff member had completed

nine e-learning sessions on the same date therefore, we raised the question with the registered manager as to the effectiveness of the training for this individual. The registered manager told us they would complete a knowledge check of their learning at the staff member's next supervision meeting.

At our inspection in February 2017 the deputy manager told us they 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. At this inspection we saw evidence some of this training had been completed and further training was planned. A member of staff who had attended the training spoke positively about this and was able to tell us how this had improved their knowledge and skills.

Staff told us they received supervision. One staff member said supervision was every six months and took about 30 minutes, "They are always give you the time you need." Another staff member told us the supervisions had been "useful."

We looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We saw some staff supervision meetings were topic specific, for example, one staff member had received supervision on shower checklist, life histories and food and fluid charts. However, we noted one staff member had a supervision contract which stated their supervision was going to be carried out bi-monthly but their most recent supervision meeting had been in June 2017. A second staff member had received two specific topic supervisions but only one other development supervision at the time of our inspection. The registered provider's supervision policy noted 'All care and nursing staff should have at least one formal supervision session of at least one hour planned every three months. (Minimum 4x a year)'. The supervision matrix for 2017 showed most, but not all staff had received several supervision meetings; however, the matrix also showed five staff had not received any supervision, during 2017.

The registered manager told us they had begun to complete staffs annual appraisal. A matrix was in place and we saw to date, of the 48 staff listed, 16 had staff had received an appraisal. A regular appraisal of staff's performance from an appropriately skilled and experienced person helps to identify training, learning and development needs and to enable the registered provider to plan training and support the person to develop.

Our inspection in February 2017 found the registered person was not meeting the regulations in regard to meeting people's nutrition and hydration needs. At this inspection although we found a number of improvements had been made, further work was still needed.

Most people we spoke with told us the food was good and the relatives who commented on the food agreed. People commented; "The food is quite nice, but I am faddy. I don't like spicy food or vegetables. You get two cooked meals a day and you can have a sandwich if you don't like what is on the menu. They cut my food up for me because I cannot use a knife", "The food is very good, I enjoy it. Most people do, they wouldn't stay here otherwise" and "The food is absolutely splendid, like home cooking. It's always hot enough." People also told us they had choice of meals and the hot choice offered at teatime was as a result of suggestions made at the resident and relative meetings. Relatives told us, "I give the food 8 out of 10. It is usually good" and "The food must be nice because my [name of person] relative eats it and is always eating, my relative likes the puddings." Another relative we spoke with said, "There is a good roast dinner on a Sunday and people have access to tea, coffee and biscuits."

On the first day of our inspection on Oakwell Avenue we observed four people were in the lounge/dining room at 8.20am and a further person was brought in at 8.30am, of the five people, two were given a cold drink but it was 9.15am before anyone was offered or provided with any breakfast or hot drinks.

On Memory Lane we saw some people eating breakfast in the dining room and the lounge/diner; we also heard staff discreetly discussing the breakfast preferences of people who wished to have breakfast in their bedrooms. One staff member said, "I have asked [name of person]; they want their breakfast in bed." This showed staff respected people's preferences. We saw one person eating their cooked breakfast, they were visibly enjoying their food but some of it was spilling off their cutlery, a member of staff asked them if they wanted any help but the person clearly said "No." This showed staff respected people's right to decline support. During the morning we saw people were offered hot and cold drinks and biscuits, we saw staff prompt people to choose their own biscuits.

At lunchtime on Memory Lane we saw people were asked what they wanted to eat and drink. Staff enabled people to retain their independence but we also saw and heard staff giving verbal prompts to people where they were distracted and no longer eating their meal. Where people were not able to make a choice from the options staff told them about, staff made a choice for the individual, however, we noted staff did not take opportunity to try alternative methods of communication to enable choice. For example, showing the person both options in the form of a plated meal, which meant they would be able to visually understand the choice as well as smell the food. Although we did see an example of staff doing this at lunchtime on Redhouse Lane, the person selected their meal and then the staff member offered them gravy and said, "You can pour on as much gravy as you want."

At lunchtime on Redhouse Lane music was playing, people chose where they wanted to sit to eat. Assistance was given if needed, people were not rushed and staff cut up food for people who needed it to aid independence. Although staff did not offer to cut up the food for one person until other people sat with them were having pudding, when the person saw the puddings, they lost interest in their main course. We also observed a member of staff providing one to one assistance for a person who needed support to eat their meal. At the beginning of the meal, the staff member asked the person if they wanted to eat their food in a particular order. We observed them interacting with the person very naturally throughout the whole of the mealtime which made this a positive experience.

Where staff needed to record peoples food and fluid intake, we found the quality of the information recorded needed to be improved. For example, the care plan for one person instructed staff to offer the person supper, however, their daily notes over a ten day period in November 2017 only made one reference to supper. We reviewed the food and supplement records for another person; there was no evidence they had been offered or provided with a mid-morning, mid-afternoon or supper snack on seven of the eight days we reviewed. We also looked at the fluid records for the same person for an eight day period. The records noted they had consumed less than one litre of fluid on six of the eight days, on one day there was no record of staff offering or providing them with a drink between 1pm on 25 November and 2pm on 26 November 2017. The template used by staff to record peoples dietary intake enabled staff to record how much of the meal the person had eaten, for example, all or half, but as staff failed to record the amount of food offered, such as 'two sausages' or 'one slice of toast with butter and jam', the information regarding how much they had eaten was meaningless.

We reviewed the care plan for one person who had lost weight since their admission to the home. We saw evidence of the involvement of the GP and dietician and their nutrition care plan had recently been updated. We also saw their weight was monitored at frequent intervals and their nutritional risk assessment updated. However, their food and supplement records over an eight day period provided little evidence they were offered or encouraged to eat high calorie snacks or fortified food. For example, for the mid-morning or mid-afternoon snacks there were a number of gaps where staff had not made an entry, where they had been provided with a snack, they only had biscuits. We saw one lunchtime they had eaten mashed potato but there was no evidence if this had been fortified to add extra calories or how much they had been offered.

Following the inspection we spoke with the registered manager about improving the quality of these records.

The kitchen staff were not able to provide us with any information regarding peoples individual needs, for example, they did not know who was diabetic or the name of the person who was vegetarian. The records in the kitchen were basic and lacked details. For example, the lunchtime meal on Sunday 3 December 2017 was recorded as 'beef', one person who lived at the home required a vegetarian diet but there were no records as to what the vegetarian option had been on that day. There was a paper record for each person kept in the kitchen relating to their nutritional needs, these identified eight people had 'blended' meals, but there was no other information as to whether this meant a 'soft' or pureed meal. One of the staff told us 'blended' meant pureed although a second member of staff was able to describe the difference between a soft and a pureed meal. The records had a section for staff to record people's cultural or religious preferences, but this was blank in each of the records we reviewed. Due to the diversity in religions, cultures and individual beliefs, it is always good practice to ask people or their representatives about dietary requirements. At the end of the inspection we discussed our findings with the registered manager; they told us they had already identified the lack of information in the kitchen as a concern. They said they had already placed an order for a wipe able board to be placed in the kitchen to enable staff to have information regarding peoples' individual needs.

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

Steps had been taken to ensure the staff team worked together to meet people's needs. One of the staff we spoke with said, "I think we've got good teamwork." There were notice boards in the staff areas of the home which provided a variety of information and staff attended a daily handover at the start of their shift where information was shared. Staff told us that some staff worked predominantly on one unit while others worked on different units, all the staff we spoke with said they were happy with how they were allocated. The deputy manager said they tried to ensure staff were allocated to meet the needs of the home but also so they were happy with the unit they were assigned to. This showed the management of the home were allocating staff to ensure the needs of both staff and the people who lived at Holme House were met.

All the people and most of the relatives we spoke with told us staff obtained medical advice if it is needed. People also told us they had access to other healthcare professionals such as an optician and chiropodist.

The nurse and senior care staff we spoke with were able to tell us how other relevant professional were involved in individual peoples care and support. They were able to tell us how they accessed support, for example, the dietician or speech and language therapy and circumstances under which and a referral may be appropriate. The deputy manager said they felt the home had good relationships with external healthcare professionals.

We saw evidence in the care files we reviewed where advice had been sought from external healthcare professionals. We reviewed the care file for someone who had been identified as being at risk of falls. Staff had made a referral for an occupational therapy review, their records evidenced they had been provided with equipment which enabled them to maintain their independence and reduced their risk of falling. This showed people received additional support when required for meeting their care and treatment needs.

Both Redhouse Lane and Oakwell Avenue had a single large communal lounge/dining room. Memory Lane had three small individual communal areas each incorporating easy chairs as well dining tables and chairs. 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. Communal bathrooms and toilets had signage which combined both words and pictures and there was signage on the corridors to guide people as to the location of bedrooms and communal areas. Memory Lane was on the top floor of the building and therefore, had no direct access to outside and the windows in the communal areas were too high for people to be able to see outside. Since our last inspection a number of garden themed murals had been placed on some walls which gave people a sense of the outdoors.

Our inspection in February 2017 found the registered person was not meeting the regulations in regard to good governance as people's 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.

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."

Each of the care files we reviewed contained a consent form regarding people having their photograph taken and to confidential information being shared with relevant professionals. Where possible people had signed this form themselves, another person who was not able to sign the form but could verbally consent, staff had written 'verbal consent by [name of person]'. We noted that where one person lacked capacity to make this decision, a family member had signed on their behalf although there was no evidence to suggest they had the legal authority to do so. Following the inspection the registered manager confirmed the family member did not have the legal authority to sign the consent form.

We also checked documentation relating to the use of covert medicine for one person living with dementia who would sometimes refuse the medicines they needed to stay healthy. Covert medication is the administration of any medicine in a disguised form. We found a capacity assessment had been competed regarding this matter and the care plan referred to the involvement of their family, GP and pharmacist in reaching the decision that it was in the individual's best interests to administer their medicines covertly. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005

When people are deprived of their liberty, the home must request DoLS authorisations from the local authority in order for this to be lawful. We checked the care file for a person who was not able to consent to living at Holme House; we saw a capacity assessment had been completed in regard to this decision and a DoLS was in place. We also reviewed the DoLS documentation for a person who had a condition attached to the authorisation. We saw evidence the condition had been met.

The staff we spoke with said they had received training on mental capacity and consent. Their answers demonstrated understanding how they applied the principles in practice.

Requires Improvement

Our findings

Our inspection in February 2017 found the registered person was not meeting the regulations in regard dignity and respect; at this inspection we found significant improvements had been made.

Most people we spoke with told us staff were kind and caring, people felt staff listened to them. One person said, "I like the staff, they are very nice, I like my care worker." Another person commented, "The regular staff are good, competent and caring." Relatives said. "Staff are caring, kind and responsive to people, I have nothing to complain about at all" and "Staff are great, I say it at every meeting, 1st class staff." Most of the relatives we spoke to told us their family members were well groomed although one relative was concerned their loved one had not had a shave that day as they were usually immaculate.

The deputy manager told us, "Everyone is individual, but everyone is treated equally. People are unique and that is what makes them special." We saw from the training matrix staff were required to complete equality and diversity training, this promotes staff awareness and helps to reduce the risk of discriminatory practices.

Three of the people we spoke with told us they were aware of their care plans and had been involved in a review, another person said, "I don't know about a care plan but I think there will be one somewhere." Each of the care files contained a document which recorded if they or their family wanted to be involved in their care plan or not. This showed people were provided with the opportunity to discuss and review the records relating to their care and support.

We observed interactions between staff and people who lived at Holme House which were kind and gentle. People seemed comfortable with staff and staff seemed to know people well. We observed a staff member asking one person how they were. When the person told them they felt cold, the staff member immediately went to get them a cover. We also saw one person had a runny nose, when a member of staff approached them on the corridor they noticed this and went to get a tissue, assisting them to wipe their nose.

On the first day of the inspection we saw a person who was unsettled for periods of time during the morning. We reviewed their care files which noted the person liked to carry two dolls but we did not see any evidence they were provided with them on either day of the inspection. We asked a member of staff about this, they said they had not seen the dolls for some time, they told us the person had an alternative soft toy in their bedroom; we did not see the person with this toy either. Following the inspection we contacted the deputy manager regarding this matter they assured us this would be addressed.

People told us their personal preferences were respected in regard to the gender of the staff member providing their care. One person told us they could have a female staff member if they chose to although another person said this was not always possible at night when agency staff were on. On Memory Lane two people had religious mementoes in the memory box outside their bedroom. When we asked one of the staff, they were aware of their religious beliefs and they told us people were able to choose if they attended a religious service when it was held at the home. We asked the registered manager how these two people were supported in regard to their beliefs, they told us one person was no longer 'practising' their faith and the other person had stopped as their cognitive ability had deteriorated. We were unable to evidence if this was personal choice or because the person was no longer able to practice their faith without the support of others to assist them. This example and the person who was not provided with pain relief, who we referred to earlier in the report, highlighted that where people lacked capacity or had reduced cognitive ability not all their needs were met by staff.

People told us staff respected their privacy, treated them with dignity and encouraged them to do as much as possible for themselves. One person said, "I have never felt uncomfortable with personal care, they change me and keep me covered up, they are very discreet, I even feel okay when the male carers do it. They are all very nice, friendly and get on with each other. They respond to my choices, keep the door open and unlocked it when I asked." Other comments included; "They cover me up when I have a shower", "Dignity and respect works both ways, it's important how you treat them. They respect my privacy; they close the doors and cover me up. No one just walks in' and "They keep me covered up and shut the door." A relative told us, "My relative does most things them self, they had a fall in the shower so they now stay with [name of person]. [Person] is shy and they respect their privacy, [person] puts their back to them and they wrap a towel around them from behind." This demonstrated staff respected people's privacy and treated people with dignity.

Peoples care files were kept in a locked office which reduced the risk of unauthorised access but also prevented care staff being able to access and read them. However, people's daily records were kept in a cupboard on each unit, while this ensured they were accessible for staff, it also meant that personal information was not always stored securely.

Requires Improvement

Our findings

People we spoke with told us they could do what they wanted each day, they were aware of the activities held within the home and participated as and when they chose. One person said, "I have plenty of choice to say what I do and don't want to do." Another person said, "I do what I want to do each day. Those pots in the garden I planted those. I am not involved in activities but that's my personal choice."

One person told us they were not interested in many of the activities but they said the activity co-ordinator would come to their room to chat to them. However, another person we spoke with told us they were limited as to what they could do because of their mobility. They said they felt lonely in their room and staff did not have much time to chat to them, they said they were not interested in activities but they had not been asked about getting involved. Another person said they found communication in the lounge difficult as they had a hearing problem so they mainly stayed in their bedroom watching TV.

During the morning we saw an activity taking place involving a multi-coloured parachute and beach ball which people took enjoyment in hitting to each other. We saw a number of people who were engaged with this activity clearly enjoyed it. There was also musical bingo and in the afternoon a party was held for a person, who was celebrating their birthday, there was entertainment with a musical duo and people from other units came to Red House to be part of the celebrations. We also saw evidence of engagement with the local community as children from a local school had visited Holme House the week before our inspection; we were told the children would be visiting again to perform a nativity play for Christmas. Singers, ponies and donkeys had visited the home. The last trip out was to watch a film at Cleckheaton town hall.

We spoke with one of the two activity coordinators who had been recently employed at the home. They told us they had been learning about people and building up a profile concerning their life history, hobbies and interests. They showed us the information they had gathered so far and saw some initial information had been gathered for 18 people. The activity co-ordinator said they also had plans to meet with families to develop a 'This is me' document for people. This is a simple form to record information about the person, details on the person's cultural and family background; events, people and places from their lives; preferences, routines and their personality. This information helps staff understand people and provides potential topics of conversation for people to engage with.

We saw evidence in the care file for a person who had recently been admitted to the home, that a pre-admission assessment had been completed. This is an initial assessment used to determine people's care and support needs as well as how the service proposes to meet those needs.

People's care records were detailed and person centred. For example, one care plan detailed the type of beaker the person liked to drink from and how they wanted to be seated in relation to the dining table. At lunchtime we saw they were seated as their care plan described and their drink was provided in the correct beaker. Another care plan recorded the person may at times exhibit behaviours which may challenge others. Their care plan noted behaviours staff should observe for which may indicate the person was becoming agitated; the tactics staff could deploy to reduce the escalation of these behaviours and the action they should take if the persons agitation continues to escalate.

Some care records needed further information adding to them. For example, we saw a care plan in place for a person who was at risk of seizures but there was no information recorded as to how to make them safe or under what circumstances staff may need to request medical assistance. Another care plan recorded the person may at times exhibit behaviours which may challenge others but there was little detail recorded as to what staff should do in response to these behaviours.

Care plans should provide staff with clear direction to enable person centred care for individuals; therefore, ensuring people receive safe, effective and consistent care that meets their needs. For this to be effective, staff need to be able to access peoples care plans and be provided with the opportunity to read them. Although staff who had been employed at the home for a period of time knew people's like and preferences; two staff who had been employed at the service for less than three months told us they had not had any opportunity to read peoples care files. We asked one of the staff how they learnt about individuals needs and preferences, they told us, "The other staff tell me." Enabling staff time and opportunity to read care files helps them get to know people and what is important to them. This can be particularly important when people had memory impairments and may not be able to communicate their preferences. We raised this with the registered manager at the time of the inspection.

Only one person we spoke with was aware of the complaints procedure but all the people we spoke with told us they would complain to the registered manager, deputy manager or another senior staff member. They each told us they felt comfortable about doing so if necessary.

We looked at the complaint records and saw there was a clear procedure that was followed should a concern be raised. We saw complaints were fully investigated and resolved where possible to their satisfaction. We noted one complaint did not have action or a response recorded although the deputy manager was able to explain what action had been taken and said it was an oversight that it had not been recorded on the complaint record. They were going to correct this immediately. This showed people's concerns were listened to, taken seriously and responded to promptly.

As people entered the final stages of their lives, the home was supported by GP's and for people with residential care needs, community nursing staff. We reviewed the care file for one person and saw there was no end of life care plan in place and no evidence the matter had been raised with either the person or their family. When we asked the deputy manager about this they told us a member of staff had asked the family about this but they had not wished to extend the conversation, we told them there was no evidence of this discussion within their care file.

A further two care files we reviewed contained an 'advanced decisions' care plan, however, they simply noted the person had a Do Not Attempt Resuscitation (DNAR) in place and for staff to contact a named family member in the event their health deteriorated. No other information was recorded, for example, where the person wished to be cared for in their final days.

At the last inspection we recommended the service seek guidance from a reputable source, in regard to end

of life care planning and record keeping. We asked the registered manager about end of life care planning, they simply told us, "We are discussing this with families", they did not initiate any further conversation to evidence this recommendation had been acted upon. The lack of detail recorded in the end of life care plans we reviewed further evidenced that no action had been taken by the registered manager to address this matter.

This demonstrate a continuing breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Our findings

Our inspection in February 2017 found the registered person was not meeting the regulations in regard to good governance. Feedback about the service was mixed and not all staff felt valued. Systems of governance had not been sufficiently robust to ensure the home was compliant with all aspects of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The feedback we received at this inspection was predominantly positive. Most people told us Holme House felt like home and that it was well managed. Three people we spoke with knew who the registered manager was and felt they could talk with them. People said, "It's nice living here, it's clean, staff are nice, food is nice, that night nurse supported me well. The person in charge is nice", "The place is well managed because everything goes okay" and "The place is well managed because things seem to go well. It's great living here, home from home. I would recommend it and tell people 'you'll be alright here. You get what you want when you want, whenever you need it. You will always be happy here."

Relatives told us they would recommend the home. One relative said, "People get what they need, they changed my relative's bed and got them a new one after we asked. You never feel unwelcome. I have recommended the place because people are well looked after, they can have their own phone and fridge etcetera in their rooms." Another relative said, "I am very happy and satisfied with everything."

All but one of the staff we spoke with was positive about the homes management. One staff member said, "She is the best manager since I've been here. She's really approachable." Another staff member said, "I think the atmosphere is a lot better. I enjoy it here."

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore, this condition of registration was met. Both the registered manager and the deputy manager were visible and accessible on both days of the inspection, the deputy manager told us they worked a mixture of clinical and supernumerary shifts. They were both clear in their vision for the home, to provide quality, person centred care.

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. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

We saw evidence a number of internal checks and audits were completed by the management team, including the registered manager, deputy manager and two office based care co-ordinators.
This included checks on the environment, equipment, catering and medicines. A daily walk around was also completed by the registered manager on each unit. We saw evidence where issues were identified, this was recorded and action was taken to address the matter. The registered manager and the deputy manager also told us they had completed a couple of unannounced night visits to the home. They explained this was to enable them to check care standards were being met and maintained by staff during the night.

The registered provider told us they visited the home on a weekly basis; provider visit reports were completed on a monthly basis, alternating between the registered provider and an external management consultant completing a quality audit report. The registered provider said their visits concentrated on observations of staff practice, dining experience audits and ensuring people were treated in a dignified manner, with the management consultant auditing documentation and records. We reviewed the registered provider visit reports dated August and October 2017, and the quality audit reports dated May and November 2017. They covered different aspects of the service and we saw where deficiencies had been identified, recommendations for improvement were noted. The report dated 23 May 2017 noted 'This service had a full audit in March 2017 and the manager has updated her action plan as a result of the recommendations made. It was clear that work had continued and is still in progress'. We saw the registered manager had an action plan in place; this had been updated and tracked the progress of the service, towards achieving regulatory compliance.

The registered manager involved people and staff and sought to gain their feedback.

People said they felt they had been involved in decisions about their care, activities and menus but not in regard to any other aspect of the running of the home, although one person told us they thought they could be if they wanted to. Two people we spoke with told us they had recently completed a questionnaire; another person said they had attended a resident and relatives meeting in August 2017. They told us this meeting discussed the Care Quality Commission (CQC) as well as speaking about privacy, dignity and food. A further person told us they had made suggestions regarding the menus at the August 2017 meeting.

The registered manager told us a relatives and staffs survey had been recently sent out. We noted several completed surveys had been returned to the registered manager, with the majority of the surveys showing positive feedback. Although some survey comments required further action, the registered manager told us they were in the process of reviewing and responding to the surveys and still had to produce some analysis for the survey information. They also told us they we in the process of creating a 'you said, we did' noticeboard to be displayed in the entrance to the home.

Staff told us regular staff meetings were held. The registered manager told us staff meetings were carried out on a three monthly basis. The staff meeting minutes we looked at showed a range of meetings had taken place during 2017 which included full staff meetings, night staff and nurses and senior staff meetings. The meeting minutes for September 2017 showed a range of topics which included paperwork and daily notes, sickness and absence, personal care and issues with the laundry. We saw the meeting attendance record for 2017 recorded some staff who had not attended any of the meetings; however, meeting minutes were made available.

During our inspection we saw evidence the home worked in partnership with relevant other agencies, for example the local authority safeguarding team. The registered manager also told us they had good relationships with other health care professionals.

During this inspection we found a significant number of improvements had been made since our last inspection relating to relating to dignity and respect, safe care and treatment, nutrition and hydration, staffing and good governance. Due to the relatively short time frame since the last inspection, we were unable to evidence these improvements were truly embedded and standards of care delivery were consistently maintained. Also as evidenced within this report there were still a number of areas where improvements were needed, for example, fire safety, management of creams, evidencing care and support has been delivered in line with evidence-based guidance to achieve effective outcomes, recording of nutrition and hydration and end of life care planning.

Future inspection will seek to evidence a sustained and consistent high level of quality has been achieved and that systems of governance are reflective, transparent and robust.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's records did not provide sufficient details to ensure they received care at the end of their life which was specific to their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Complete, accurate and contemporaneous notes were not kept in relation to peoples nutrition and hydration needs.