

Techcrown Limited

Hollywynd Rest Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

Hollywynd is a residential care home which provides accommodation for up to 40 older people. At the time of our inspection there were 27 people living at the home. Some of the people at the home were living with dementia. This inspection was unannounced and took place on the 22 and 23 December 2015.

There was no registered manager in place at the time of the inspection. 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. However a new manager was in post and was in the process of registering with the Commission.

The home was previously inspected on the 27 January 2015 and we identified breaches of regulation in relation to staffing levels, people not being treated with dignity and respect at all times, care planning and delivery, meeting people's nutritional and hydration needs and ensuring that the premises were suitable for purpose. We

Summary of findings

found that improvements had been made and action taken by the provider to address the concerns from our previous inspection. However we identified new concerns and breaches of Regulations at this inspection.

At this inspection we found that the provider had taken action to address to improve staffing levels and there were sufficient numbers of staff on duty to keep people safe and meet their needs. We reviewed the rota and the numbers of staff on duty matched the numbers recorded on the rota. Relatives felt that there were enough staff on duty and we were told “I have to say last year it was a noticeable problem but I have to say that it seems a lot better”. We observed that people were not left waiting for assistance and people were responded to in a timely way.

With regard to treating people with dignity and respect we found that the provider had taken action to improve. Relatives spoke positively of the manner and response of the staff. One relative told us “the one’s I’ve seen are kind and caring, some are brilliant; (named member of staff) has never not got a smile on her face”. We spent time observing the care practices in the communal areas and saw that people’s privacy and dignity were maintained.

With regard to the planning and delivery of people’s we found the provider had taken action to address concerns raised at the last inspection. However care was not always provided in a way that met their needs and ensured their welfare because not all care plans had been accurately completed or updated. People and relatives told us that people had a choice in the support that they received and preferences around the gender of care staff was respected. Relatives told us that people had choices in decisions about their daily routine such as what time they got up in the morning and when they went to bed.

The previous inspection identified concerns that people were not supported to follow their interests and take part in social activities. The provider had taken steps to address this issue and activities were now in place. However we identified issues with the frequency of the planned activities. People told us they did not feel there were enough activities on offer. One person told us “I get so bored here. I get sick and tired of sitting and staring into space”. Health care professionals told us they had concerns about the lack of meaningful activities available for people.

The manager was in the process of updating people’s care plans to ensure that they were reflective of people’s needs and included their preferences. We saw that seven people’s care plans had been updated however other people’s care plans contained limited information or guidance for staff on how to meet their needs. This meant that people’s needs and preferences may not have been reflected in the care and support which they received.

The previous inspection raised concerns that people’s nutrition and hydration needs were not being met. We saw that the provider had taken action to address this issue and people spoke highly of the quality of the food. People told us they had enough to eat, enjoyed the food and were offered choices. People told us “the food is good, I’ve got nothing to complain about the food”. People’s dietary needs and nutritional requirements had been assessed and recorded. Weight charts were seen and had been completed appropriately on a monthly basis.

The previous inspection identified concerns around the raised entry into the showering/bathing facilities within people’s room. While the provider had not taken action to address this issue the impact on people was minimal as there were alternative bathing and showering options for people.

At this inspection we identified new concerns relating to the systems in place to identify risks and protect people from harm. We found that risk assessments were used inconsistently. From the care records reviewed risk assessments were in place for some people but not for others. The manager told us that they were in the process of updating the risk assessments for everyone and this “was a work in progress”.

Staff had undertaken appropriate training to ensure that they had to skills and competencies to meet people’s needs. One member of staff spoke with us about the increase in the training they had received since the new manager started they told us “(manager) has really gone to town on our training”.

People were supported to maintain good health and had access to health professionals. Staff worked in collaboration with professionals such as doctors, specialist dementia teams and the falls prevention team to ensure advice was taken when needed and people’s needs were met.

Summary of findings

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Systems were in place but not consistently used to identify risks. Guidance for staff on how to reduce risk was, at times, limited.

There were sufficient numbers of staff to keep people safe and meet their needs.

Staff had received safeguarding and whistleblowing training and knew how to recognise and report abuse.

Requires improvement



Is the service effective?

The service was effective.

People received enough to eat and drink and people spoke positively of the quality of the food

People were supported to maintain good health and had regular contact with health care professionals

People's rights were protected as the principles of the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards (DoLS) were followed

Good



Is the service caring?

The service was caring.

Staff were kind and caring in their response to people.

People were treated in a dignified and respectful way

People and those that mattered to them were involved in decisions about their care

Good



Is the service responsive?

The service was not always responsive

Care plans were being updated at the time of our inspection; however this was a work in progress and not all people had a care plan which reflected their needs.

Activities were available however these were not scheduled in a way that ensures people's social needs were always met.

There was a complaints policy in place and people felt comfortable raising any concerns

Requires improvement



Summary of findings

Is the service well-led?

The service was not always well led.

There was no registered manager in post at the time of our inspection, although the new manager was in the process of registering with the Commission.

People, staff and relatives acknowledge improvements in the service and felt that overall the quality of care provided was improving

Requires improvement



Hollywynd Rest 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.

The inspection took place on the 22 and 23 December 2015 and was unannounced. Two inspectors undertook the inspection.

Before the inspection, we checked the information that we held about the home and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is

information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during inspection.

Some people living at the service were unable to tell us about their experiences; therefore we observed care and support in communal areas and spoke with people and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us. We spent time looking at records including six care records, four staff records, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints, quality assurance audits and other records relating to the management of the service.

During the inspection we spoke with four people who lived at the home, seven relatives, two senior carers, three care assistants, one chef, the manager and the provider. We also spoke with three health care professional who agreed to us including their comments in our report

Is the service safe?

Our findings

The systems in place to identify risks and protect people from harm were used inconsistently. Risk assessments were in place for some people but not for others. The manager told us that they were in the process of updating the risk assessments for everyone and this “was a work in progress” and they were aware that not all people had up to date risk assessments in place. The care records which had been updated showed that where someone was identified as being at risk, actions were identified and referrals were made to health professionals as required. There were risk assessments regarding nutrition, falls and for the moving and handling of people. These assessments were reviewed on a monthly basis by the manager. However at times there was limited guidance available for staff on how to reduce the risk for people. For example we saw one person’s falls risk assessment which had been assessed and scored but there was no further guidance for staff on how to reduce this risk. We also saw that where a Malnutrition Universal Screening Tool (MUST) assessment had been completed and indicated that the person was at a high risk of malnutrition contact had been made with the doctor; however there was no guidance for staff on how to reduce the risk of further weight loss. MUST promotes best practice and identifies if a person was malnourished or at risk of becoming malnourished. We reviewed care records which had not been updated and saw that they contained limited information on the risk identified. We reviewed one person’s care plan and saw that this indicated that this person was at risk of falls. There was no further information available which detailed why this person was at risk of falls or what steps staff should take to mitigate this risk. Staff may not have been aware of the risk for this person or how best to reduce their risk of falls. This was discussed with the manager on the day of our inspection and they told us that they were aware that the information on risk was limited and reviewing and updating this information would be a priority.

Systems were not in place to assess, monitor and mitigate the risk relating to people’s health, safety and welfare. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

We saw examples of where people’s risks had been assessed and measures were put in place to mitigate the

identified risk. We reviewed a care plan and saw there had been an increase in one person’s Waterlow Score. Waterlow assessments measure and evaluate the risk of people developing pressure sores. The person’s care had been reviewed, health care professionals were contacted and the person now had a pressure relieving mattress.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored and given to people as prescribed. However on the day of our inspection we saw that medicines were not being disposed of safely. The medicines disposal box was full and had not been collected by the pharmacy since October 2015. The home’s medicines policy states ‘medicines for disposal should be stored securely in a tamper proof container within the cupboard until they are collected or taken to the pharmacy’. The container used for the disposal of medicines was not tamper proof and was easy to access. We spoke with the manager and they arranged for the medicines to be collected that day and agreed to consider the alternative of a tamper free container to ensure that they followed the home’s policy and that medicines were disposed of safely. We observed medicines being administered and saw that the staff who administered medicines did this safely. Staff confirmed that they were confident and understood the importance of this role. Medication Administration Records (MAR) were in place and had been correctly completed. Each person had an individual record of how they liked to take their medicines. Medicines were locked away as appropriate and where they were required to be refrigerated, fridge temperatures had been logged and fell within guidelines that ensured effectiveness of the medicines. However on the first day of our inspection the daily temperature of the storage room was not being monitored and recorded. We spoke with the manager about this and on the second day of our inspection they showed us that the temperature was being monitored and recorded. We completed a random spot check of people’s medicines stock and they matched the records kept. Only trained staff administered medicines. The manager completed an observation of staff to ensure they were competent in the administration of medicines.

At our inspection on the 27 January 2015 we identified that the provider had not provided sufficient numbers of staff to meet the needs of people using the service. We identified this as a breach of regulation. At this inspection we found that the provider had taken action to improve and this

Is the service safe?

requirement was now met. At this visit we found there were sufficient numbers of staff on duty to keep people safe and meet their needs. We reviewed the rota and the numbers of staff on duty matched the numbers recorded on the rota. Staff told us they felt there were enough staff on duty. Relatives also felt that there were enough staff on duty and we were told “I have to say last year it was a noticeable problem but I have to say that it seems a lot better”. We observed that people were not left waiting for assistance and people were responded to in a timely way. We reviewed the previous four weeks of rotas and saw that there were 5 care staff on duty in the morning, this was made up of two senior carers and 3 care assistants. In the afternoon there were four care staff on duty, this was made up of one senior carer and three carer assistants. At night time there were two members of staff on duty however there had been a reduction in the number of people living at the home and also fewer people needed assistance from two members of staff. These staffing levels helped to ensure that sufficient number of staff were deployed to meet people’s needs. The manager spoke with us about people’s fluctuating needs and how this impacted on staffing levels. The manager told us that if the number of people living at the home increased they would reassess staffing levels and increase this to ensure people’s needs were met. They also spoke with us about possible changes to the care and support which people received and that this would also lead to an increase in staffing levels. Agency staff were used occasionally. The manager told us they preferred to offer existing members of staff additional shifts to ensure the consistency of the care offered to people.

People were supported by suitable staff. Safe staff recruitment practices were in place and records showed appropriate checks had been undertaken before staff

began work. Disclosure and Barring Service checks (DBS) were undertaken. DBS checks identify if potential staff are not suitable to work with people in a care setting. Two references were obtained from current and previous employers.

People told us that they felt safe and free from harm. We spoke with one person about how able they felt to raise a concern if they felt unsafe. They told us that they knew who the manager was and would speak with them. Relatives told us they felt their family members were safe. People were protected by staff who knew how to recognise the signs of possible abuse. One staff member told us how they would respond to concerns: “I would approach the manager and report my concerns and document everything”. The manager was able to tell us about the safeguarding and whistleblowing policies and felt confident staff would discuss any concerns with her. Staff were able to identify a range of types of abuse such as emotional or physical and felt that reported signs of suspected abuse would be taken seriously. The manager understood the home’s safeguarding and whistleblowing policies and told us they would contact West Sussex Safeguarding team with any concerns. There was a whistleblowing policy in place and staff knew how to respond if they had a concern. Staff were able to explain the process and advised that they would feel comfortable speaking with the manager.

The manager had completed a fire zone map for the premises and there were personal evacuation plans for each person so staff knew how to support people should the building need to be evacuated. Environmental risk assessments had also been carried out.

Is the service effective?

Our findings

At our inspection carried out on the 27 January 2015 we found that people's nutrition and hydration needs were not being met. We identified this as a breach of regulation. At this visit we saw that the provider had taken action to address these concerns and were now meeting this standard. The concerns related to the poor quality of the food provided and the lack of drinks available for people. People and their relatives spoke positively about the quality of the food provided. People told us they had enough to eat, enjoyed the food and were offered choices. People told us "the food is good, I've got nothing to complain about the food" and "it was very nice today it was roast pork". We saw that people's hydration needs were met. We observed people's water jugs in bedrooms being filled up and a choice of water and squash drinks were available in the lounge. One person told us "I've always got jugs of water". People were offered a choice of hot drinks throughout the day. We saw that people's care records contained information on their preferred time for breakfast, where they liked to eat, what type of hot drinks they liked and what time they like to have breakfast. People were asked the night before which choice they would like from the menu and staff told us that if they changed their mind the following day the chef would accommodate this. The chef told us "staff go round in the afternoon and ask people for their choices, if they don't like something we offer another choice. People can change their mind the next day so we make sure there's extra". People told us that if they did not want either of the planned meals the chef would make them an alternative. Relatives felt that people had enough to eat and drink and their personal preferences were taken into consideration.

We observed the lunchtime experience and saw that people were supported to have enough to eat, drink and maintain a balanced diet. Throughout the lunchtime experience music was playing the background while people enjoyed their lunch. People's meals appeared hot and appetising. People were offered a choice of drinks. When people required protective aprons staff asked permission before assisting them with this. Staff encouraged people to eat and offered to refill drinks. Staff encouraged people to be as independent as possible with tasks. We saw a staff member cut one person's food into small pieces and offer support and encouragement for them to eat independently rather than offer physical

assistance with eating. Where people needed assistance with eating we saw that this was done at an appropriate pace. Staff sat beside the person and spoke with them to make sure this was a pleasant experience and asked the person when they would like more food. We saw a staff member sit beside the person they were supporting and asked "right my darling are we going to tuck into dinner now?". The person smiled and the staff member began to support them with their meal. Throughout the lunchtime people and staff spoke about Christmas and how they liked to spend their day.

A new chef had recently been appointed and staff and relatives spoke about the improvement in the quality of the food since they started. The manager told us that "since the new chef the quality of the food has improved". Special diets were catered for such as soft food and the chef kept a written record of people's requirements such as people who needed a gluten or lactose free meals in the kitchen. The chef spoke with us about someone who was lactose intolerant and told us that they replaced dairy products to ensure that they had similar meals to others. An example of this was using soya milk to make custard. The chef told us that they gathered feedback on the food from people and relatives through relatives and residents meetings. The chef spoke with us about the improvements which they had planned to the meal time experience and told us "we are planning theme days, maybe one or two a month alongside the activities lady. They'll be linked to like being on a world cruise and we will plan around the world events like a 4th of July menu".

Dietary needs and nutritional requirements had been assessed and recorded. Weight charts were seen and had been completed appropriately on a monthly basis to monitor and respond to any changes in people's weight. The Malnutrition Universal Screening Tool (MUST) was used to promote best practice and identified if a person was malnourished or at risk of becoming malnourished. People who were at risk were weighed on a monthly basis and referrals or advice was sought where people were identified as being at risk. The weight charts showed that people were slowly putting on weight since the new chef had started.

At our inspection on the 27 January 2015 we identified concerns about the premises. The concern was around the raised entry into the showering/bathing facilities within people's room. While the provider had not taken action to

Is the service effective?

address this specific issue, we found at this inspection that this had not impacted upon people's care and treatment as there were alternative bathing and showering options for people. There was a communal bathroom on the ground floor with an adapted bath which people chose to use. On the first floor there was a shower room and also an additional bathroom. Staff told us that most people chose to use the shower room as they preferred a shower. At the previous inspection we found that the first floor bathroom was being used as a storage room which restricted people's choice of facilities. At this inspection we saw that this room was no longer being used to store equipment and was regularly cleaned which meant that people now had access to this bathroom. However we spoke with the manager and the provider about the environment as tiles were cracked and the floor was heavily discoloured in the first floor bathroom. The manager told us that their priority had been ensuring people received safe. The provider agreed that this did not create a pleasant environment for people and agreed that this was an area for improvement to ensure a more pleasant environment for people.

Staff had undertaken appropriate training to ensure that they had the skills and competencies to meet people's needs. Staff spoke with us about the range of training they received which included safeguarding, food hygiene and moving and handling. One member of staff spoke with us about the increase in the training they had received since the new manager started they told us "(manager) has really gone to town on our training". The manager told us that since they started they had focused on ensuring that staff had access to not only mandatory training but any additional training which they or the staff felt would improve their practice. The manager told us that before she started "training, it was abysmal everything had run out we have a training matrix now. All staff are up to date on mandatory training, they've all now have dementia training through the dementia matron". The manager had also made arrangements for a specialist dementia team to visit and provide ongoing support and training to staff. They were currently awaiting confirmation of a date for this training. This improvement in training ensured that staff had the knowledge and skills needed to carry out their role. New staff undertook a comprehensive induction programme which included essential training and shadowing of experienced care staff. Staff had completed

the provider's induction checklist which involved staff familiarising themselves with the layout of the building, fire safety procedures, policies and procedures and reading through care plans.

Since starting the manager had introduced group supervision as they had identified that staff had not been receiving regular one to one supervision. Staff were given minutes from the group supervisions and they showed that meeting people's and any other issues relating to their role had been discussed. Staff told us that they found the group supervision helpful but also felt that individual supervision would be beneficial. We spoke with the manager and they told us one to one supervision dates were now planned in for staff and starting at the beginning of 2016. The manager planned to have supervision every two months and staff would also have a yearly appraisal to ensure that staff were supported and that areas for development were identified and addressed.

People and relatives felt confident that the appropriate medical professionals would be contacted when needed. People were supported to maintain good health and had access to health professionals. Staff worked in collaboration with professionals such as doctors, specialist dementia teams and the falls prevention team to ensure advice was taken when needed and people's needs were met. Staff told us that they keep people's relatives up to date on any changes to their health or the care they received. Health care professionals told us that the manager contacted them when there were changes to people's health and they needed advice or guidance.

Consent to care and treatment was sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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

Is the service effective?

authorisations to deprive a person of their liberty were being met. When needed we saw that DoLS applications had been submitted and the local authority had authorised two of these applications. We saw that people's capacity had been assessed and this assessment accompanied the submitted application.

People were able to make day to day choices and decisions, but where decisions needed to be taken relating to finance or health, for example, then a best interest

decision would be made for people who lacked capacity. A best interest decision involves relevant professionals, relatives and others involved in the person's care making a decision on the person's behalf based on their known preferences and needs. Where possible, the person would also be invited to be involved in this decision. Staff were able to describe the Mental Capacity Act and discussed the importance of presuming that people have capacity rather than making a judgement due to their health problems.

Is the service caring?

Our findings

At the previous inspection we identified concerns that people were not being treated with dignity and respect. We identified this as a breach of regulation. At this inspection we found that the provider had taken action to address these concerns and people were now treated with dignity and respect.

Relatives spoke positively of the manner and response of the staff. One relative told us “the ones I’ve seen are kind and caring, some are brilliant; (named member of staff) has never not got a smile on her face”. We spoke with the manager about how they ensured staff supported people in a dignified and respectful way and were told “residents come first and protecting their dignity and privacy”. The manager also told us that all staff had completed compassion in care training to ensure that staff treated people in a kind and caring way to ensure better outcomes for people. Staff spoke with us about this training and felt it had been useful in helping them understand the experience of people living at the home. This ensured that staff knew how to support people in a dignified and respectful way.

We spent time observing the care practices in the communal areas and saw that people’s privacy and dignity were maintained. Staff knocked on people’s doors before entering and made sure that they were happy for them to enter the room. We spoke with staff about how they ensured that people received care in a way that promotes their dignity and were told “I would knock on the door and close the curtains. I respect them like family” and “I always knock the door, shut the curtains, they are always covered with a towel, and if someone knocks the door I will ask them to wait”. A member of staff spoke with us about how they would respond to a situation if someone became upset: “if people wanted to talk I would ask them if they wanted to go back to their room”. We also spoke with two relatives who felt that at times certain members of staff could be short or abrupt with people. We raised these concerns with the manager and the provider at the time of our inspection and they agreed to discuss these individual concerns with staff.

People and relatives spoke positively about the manner and response of staff. One relative told us “I’ve never seen anyone be impatient”. Another relative told us “I’ve always found the staff to be kind; I’ve never had an incident where

I’ve been worried”. Staff knew which equipment people needed to support their independence and ensured this was provided when they needed it. We saw a member of staff support someone to walk from the dining room through to the lounge area. They made sure that the person had the equipment they needed to walk and encouraged them to walk slowly and take their time. We spoke with a relative who felt that their family member was always well presented when they visited. They told us “they always look nicely dressed”. Throughout our inspection we observed that people’s hair was brushed, that they were wearing glasses, hearing aids were in place and watches were set at the correct time. This promoted people’s dignity.

People’s rooms were personalised with personal items such as ornaments and family photographs. One person spoke with us about the pictures on their bedroom wall and told us “there are pictures painted by me on the wall”. People were involved in the decisions about what care they received and in their decisions about their daily routines. Staff encouraged people to make choices in their daily life such as about what clothes they would like to wear. They told us that when supporting someone to get dressed they would offer a selection of outfits and ask the person which they would prefer to wear that day. We saw that people were offered a choice of where they would like to spend their time and most people chose to spend their time in the lounge.

During our inspection we saw that staff knelt down when talking to people so that they were at the same eye level and repeated questions when needed. Staff spoke with people and gained their consent before providing support or assistance. We spoke with staff about how they communicated with people who were unable to communicate their wishes verbally. They told us they would watch their facial expression and gestures to understand their views. If someone refused their assistance they would respect their decision but would return later and offer support again.

We saw that during lunchtime people were involved in the choice of music playing in the background. One member of staff asked “shall I change the music? It’s a bit depressing”. People replied “Yes”; people were laughing and discussed which Christmas songs they would like to listen to.

Family and friends were able to visit without restriction. Relatives were made to feel welcome and felt comfortable

Is the service caring?

discussing any changes or updates to the care their relative received. Throughout our inspection we saw relatives visit and spend time with their family member in the lounge and dining area. Staff members knew who relatives were there to visit and family members appeared comfortable speaking with the staff on duty. One member of staff told us “family can visit when they want to, they’re welcome anytime.” The manager told us that during a relatives’

meeting family members had advised that they would like a better understanding of dementia to enable them to communicate better with their relative. The manager has arranged for a dementia specialist to attend the next relatives’ meeting to give family members better understanding of dementia and how this may affect their relative.

Is the service responsive?

Our findings

At the previous inspection we identified concerns that the planning and delivery of people's care was not done in a way that met their needs and ensured their welfare. In addition we found that people were not supported to follow their interests and take part in social activities. We identified this as a breach of regulation. At this inspection we found that the provider had taken action to address this. There had been improvements to people's choice and involvement as well as improvements to the activities offered to people. However we identified that further work was required to ensure people received person-centred care and activities to meet their needs. .

People and relatives told us that people had a choice in the support that they received and preferences around the gender of care staff was respected. Relatives told us that people had choices in decisions about their daily routine such as what time they got up in the morning and when they went to bed. A relative told us "she pretty much pleases herself if she wants to stay up till 11pm she can". Staff told us that they ensured that people are involved in choices about their care from when they move in. They told us "when people first come in we do a daily choices sheet". Throughout the inspection we saw that staff offered people choices regarding how their time was spent. We saw people were offered a choice of whether they wanted to go into the lounge or spend time in their room. Staff took time to make sure people understood what had been said or asked by making eye contact and repeating questions if needed.

There was a schedule in place which guided staff to what day's people preferred to have a bath or shower and staff told us that this was used as a "rough guide" and people were able to have a choice when they had a bath or shower. A staff member spoke with us about someone who had recently moved into the home and that they liked to have a shower every day. Staff respected this choice and ensured that they received a shower each day. Staff spoke with us about how they ensured people were involved in decision about their care and made choices in their daily routines. A member of staff told us "we always ask people what time they go to bed, we will give them options do you feel sleepy, would you like to watch TV for a while?" Another member of staff spoke with us about how they ensured that people's preferences were incorporated into their

care plans. The staff member told us "we build every care plan around what they like and what they would want, how they like to be dressed, daily routines, some people like to get up at 6am others at 8am".

Improvements had been made to the activities offered to people. However we found issues with the frequency of the planned activities. People told us they did not feel there were enough activities on offer. One person told us "I get so bored here. I get sick and tired of sitting and staring into space". Another person told us they enjoyed the activities but felt they would prefer more, they told us "we could do with more, when someone comes in everyone is happy". Relatives also felt there was a lack of activities and told us "I think it would be nice to have more activities, people look forward to seeing (activities coordinator)". Another relative told us "they have a lady that goes in but there probably could be more than that". Health care professionals told us they had concerns about the lack of meaningful activities available for people. We were told "despite the lounge there seems minimal communal activity. During my visits I have yet to see any structured activities or pending activities advertised". People told us that when the activities coordinator was not on duty the options for social interaction or activity were limited. A relative told us "there's more being laid on she needs stimulation, I think". Another relative told us "they don't take them out enough; I think it's boring, people are just sitting in the lounge". Although some work had been started to ensure that there were meaningful activities for people further requirements were needed to ensure that people's social and psychological needs were met and the risk of social isolation was reduced.

The manager told us that care plans were "a work in progress". They were currently in the process of updating care plans to ensure that they were reflective of people's needs and included their preferences. The manager told us they were being honest with relatives and advising that care plans had not been kept up to date. The manager told us "I'm going to relatives to discuss care plans and having to re ask questions they have already been asked". Staff spoke with us about care plans and told us that "care plans were getting there, things are improving". Another member of staff spoke with us about the improvements to the care plans and said "at first they were all over the place. Now they're much more organised, it makes it easier to read". We reviewed six care plans and saw one care plan that had not been updated. This care plan contained only risk

Is the service responsive?

assessments and contained no information on what care they should be offered. There was no guidance for staff on how to meet this person's needs or on their preferences on how they would like their care to be delivered. We spoke with staff and they told us that they had found out how to support this person by speaking with him and through discussions with other staff members and supervision. However without a clear care plan in place, this posed a risk that the person may not receive care that ensures their needs were met consistently and safely.

The manager told us they were aware that this care plan needed to be reviewed urgently. At the time of our inspection there were 27 people living at the home and seven care plans had been reviewed and updated since the manager started in September 2015. We spoke with a relative who told us the manager had advised them that they did not have a care plan for their family member who was living at the home. They told us "there was never one before, they're looking at that now, there's forms they have asked me to complete". A meeting had been arranged with the family member and the manager to start to put together a care plan. This meant that people's needs and preferences may not have been reflected in the care and support which they received.

The above demonstrates that there was a variation in the way people's care needs were assessed and care plans designed to meet people's needs. People's needs in relation to activities and stimulation were not consistently met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The manager told us that there was now an activities co-ordinator in place for six hours a week, they had started July 2015. The activities coordinator had planned music sessions, flower arranging, reflexology and quizzes. We spoke with the activities coordinator and they discussed the planned weekly activities. Activities were planned in line with people's interests and preferences. The activities coordinator spent time with each resident discussing their previous interests to ensure that the activities planned were person centred. They told us about a resident who was previously a dress maker and continued to enjoy dress making and sewing. A sewing machine had been bought and the activities coordinator supported this person to take

part in this activities. Each person had an activities evaluation form which detailed their individual interests and what their level of interest was in the activity. The activities coordinator also told us that they have planned outings three times a year. The first outing was to the local garden centre and took place in December 2015.

The activities coordinator spoke with us about the importance of ensuring the activities were personalised. They told us "each resident I sat down with and done an evaluation form, each resident has an interest checklist". The activities coordinator told us "the owners are good, if I suggest something they embrace". The activities coordinator told us they also ensure that people who prefer to spend time in their room are offered 1-1 activities in their room. They told us about someone who previously did not like to take part in group activities, They started by offered 1-1 activities in their room and over time they started to come into the lounge and take part in the group activities. The activities coordinator told us their next goal is to encourage them to go on one of the outings. Activities were planned in line with events throughout the year including a Christmas Pantomime and Carol Singing. There were also regular visits from the local minister as a newer resident requested. We spoke with the provider about activities within the home and they told us, "this should be somewhere that stimulates people". However, as identified above, people and relatives we spoke with did not always feel that the frequency and types of activities offered were meeting their needs. The provider accepted that this may be an area which would need to be improved further to ensure this was achieved.

Staff told us that they kept people's relatives up to date on any changes to their health or the care they received. A member of staff told us "relatives get updated, anything that happens we phone". People's care records contained a section which detailed the contact which had been made with the health care professionals such as the GP and noted advice and guidance which had been received. Daily records were kept in each person's bedroom. These recorded what the person had to eat, what support had been offered and accepted. The diaries also recorded information about people's moods and behaviours, any concerns and what action had been taken by staff. This ensured the person's needs could be monitored for any changes.

Is the service responsive?

Relatives spoke with us about care plans and told us “(manager) is very good, things have improved, she’s much more involved I’d say she’s on the ball, she made sure all the paperwork was all up to date”. Relatives told us they felt involved in care planning and were kept informed of changes. A relative told us “they’re very good; they always email me if anything changes as they know I work away”. We reviewed care plans which had been updated and saw that people’s needs had been assessed before they moved into the home and their care plans were based on this information. The pre-admission assessment was used to develop the care plan and this was developed and amended as staff found out more about the person. Care plans included information on people’s key relationships, personality and preferences. They also contained information with regard to people’s social and physical needs. People’s care plans contained a section detailing communication with healthcare professionals such as the GP. We saw that care plans had been developed and included information on people’s mobility, nutrition and communication needs. They also contained information on people’s social and physical needs.

Staff told us that got to know people’s likes and dislikes by speaking to people and relatives. A member of staff told us “we involved family we will chat to the family to get someone’s likes and dislikes, we try to involve them as much as possible”. We reviewed people’s care plans and saw that information on people’s life history and preferences such as how they liked to receive their personal care and what time they liked to get out of bed was limited. The manager told us that they were in the process of gathering this information from people and their relatives and some care records contained information on people preferences such where they liked to eat their meals, what food they liked and disliked and what activities they enjoyed. We also saw that the activities co-ordinator had begun to discuss people’s preferences in her conversations with them. We saw that one person with complex mental health issues had been referred to a local advocacy service to ensure that they were supported to express their views. When the advocate had been visited this was recorded in the persons notes within their care record. This ensured that staff had guidance on how to support people and ensured that care was consistent.

People’s views were sought through residents’ and relatives’ meetings, which the manager had recently

introduced. Relatives told us that they found this useful as they allowed them to feel involved in the home. Residents’ meetings took place every two months. The October 2015 residents’ meeting minutes showed that residents were asked where they would like to go and agreement was reached that the first planned outing would be to the local garden centre. The December 2015 residents’ meeting minutes showed that the trip to the garden centre was discussed and people indicated they enjoyed this. Ideas such as a trip to the local seaside town where discussed for the next trip. To get to know each person the activities coordinator sat down and went through an evaluation of what they enjoyed. Residents received an evaluation survey once a year. The provider spent time talking people through the survey to gain their views. The survey asked for people views on the care the care they received from the home on their bedroom and the food and activities available. The last survey was completed in June 2015 and was completed by seven residents. The responses to each question were mainly positive however two people commented that there were not enough activities and “they would like more”. People and their relatives were invited were possible to take part in putting together and reviewing care plans. A member of staff told us “we ask relatives to review care plans generally every six months”. This demonstrated the provider had mechanisms for seeking people’s views and experiences and acting upon their feedback.

People and their relatives knew how to make a complaint and would feel comfortable speaking with either staff or the manager about any concerns. A relative told us “I would say she would listen and deal with it, I wouldn’t have said that before”. Staff were able to demonstrate an understanding of how to deal with a complaint and told us that they would listen to the person’s complaint and then pass these concerns onto the manager. We reviewed the written records kept by the manger and saw that no complaints had been received since July 2015. Where complaints had been made we saw the details of the complaint had been recorded, the response was prompt and person or relative was kept informed of the outcome of the complaint. Staff demonstrated an understanding of how they would deal with a complaint and told us they would pass all details onto the manager.

Is the service well-led?

Our findings

The service was not always well led. The current manager was employed in September 2015 and at the time of our visit was not registered with the Care Quality Commission. However they were in the process of becoming registered.

Quality assurance systems were in place to regularly review the quality of the service that was provided. There was an audit schedule for aspects of care such as care plans and infection control. This allowed the manager to identify any concerns or possible risk to the service provided to people. We saw that the care plan audit had identified that care plans needed to be updated and recorded how many had been reviewed and updated by the date of our inspection. The manager told us that ensuring care plans reflected people's current level of need was their priority. However there was no date or timescale given for this to be completed. This meant that the manager could not be sure when all people would have an effective care plan which met their needs.

We also saw other examples where issues had been identified and the manager had recorded the action needed and timescales for completion had been achieved. The manager's infection control audit in November 2015 identified that new clinical waste bins were needed. This issue had been resolved by the time of our inspection. The manager had also identified that there was no infection control lead and a member of staff had been agreed to take on this role. Specific incidents were recorded collectively such as falls, changing body weight and pressure areas, so any trends could be identified and appropriate action taken.

Staff spoke with us about the changes in the home and the affect his had on the team. One staff member told us "the team were quite demoralised, it's so different now, it's amazing" and "it's improved a lot, it did need sorting out, it's more organised, she's made a difference". Other members of staff told us "team spirit is a lot better" and "morale is a lot better, people weren't communicating and staff were fed up". Staff felt supported by the manager and other staff members and they told us "everything is better and happier". We asked the member of staff what they thought may have caused this change and they told us they felt it was due to the manager's manner towards people,

relatives and staff. They told us "she respects you, she respect everyone". Staff told us they felt they would be listened to and supported by the manager if they raised any issues.

Relatives also acknowledged the improvements and thought the home was now well run, they told us "things are starting to pick up, it's more organised now". People told us they knew the manager, that she was approachable and they would feel comfortable speaking with her about any concerns that they had. A relative told us "she's very good, things have improved, and she's much more involved. I'd say she's on the ball". Another relative told us "she's very easy to talk to. She's very approachable and down to earth". We also reviewed thank you cards which the home had received and one card read: 'A very big thank you to all the staff that looked after my mum during her final years'. Another card read: 'this card is just to say a big thank you to each and every one of you at Hollywynd. You have all treated me so well, with so much kindness once again thank you'.

We spoke with the manager about how the views of people and relatives were sought to involve them in changes to the service. She told us that they have residents' and relatives' meetings where changes within the home are discussed and people are asked for feedback. They also used surveys to obtain people's views and make improvements. Relatives felt the manager tried to make them feel involved in the home. The first relatives' meeting was not well attended and the manager changed the meetings to a weekend afternoon to allow more relatives to come along. They told us "there was never any before; the first one was when (manager) started. The first had quite a poor attendance. The next had half a dozen or so, it was really good".

Throughout the inspection we saw that the manager spoke with people and staff in a warm and supportive manner. The manager was also focusing on building relationships with people's families and involving them in the support provided. A relative spoke with us about the manager's manner and told us "it's a noticeable difference. I've had more contact with her in the last few months than the previous one". The manager spoke with us about the importance of observing the staff team in their interactions with people and told us "I lead by example". The manager and staff told us there were senior carers on duty at all times and they could access an on-call system if

Is the service well-led?

managerial support was needed. The manager's mobile number was clearly posted on the office wall to be used in emergency. Monthly staff meetings took place and topics discussed included safeguarding, accidents and incidents and person centred planning.

The manager had an understanding of the challenges which the service faced and told us their first priority was to ensure the service was safe. They told us "my priority has been to getting the quality of life and care up to a standard. I feel comfortable that we are moving forward". She now felt that the home was safe but was aware of the issues identified at the time of our inspection such as risk

assessments which may not reflect people's current level of risk. The manager discussed the challenges that the home faced and told us "biggest challenge is the care plans, getting them up to a standard".

The provider spoke with us about their vision and values for the home and told us "this is their home and whatever we can do to improve their quality of life we should do. I feel we can help them and improve their quality of life". The manager told us that they have regular contact with the provider and they felt able to discuss any concerns they had with the running of the service. Staff also told us that the provider regularly visits the home and they would feel comfortable approaching them to discuss any concerns. A member of staff told us "the owners are good; if I suggest something they embrace it".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The registered person had not ensured that people's risk were assessed and mitigated. Regulation 12(2) (a)(b)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The registered person did not ensure that the care and treatment of service users was appropriate, met their needs and reflected their preferences Regulation 9 (1)(a)(b)(c)