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Hollybank Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an announced focused inspection, which took place on 25 February 2016. This inspection took place to follow up the five breaches in the regulations we found at our last inspection visit on 15 and 16 September 2015.

The breaches in regulations related to there being no manager registered with Care Quality Commission (CQC) since April 2014 and we had not received all the statutory notifications we should have from the home. The providers of Hollybank Nursing Home are legally obliged to report any incidents, which may affect the well-being of people to us as a statutory notification.

We also found breaches in safe working practices in relation to the administration of medicines, the use of equipment and risk assessments.

Hollybank Nursing Home is registered to provide nursing and residential care for up to 49 older people. The home was still being refurbished and at the time of our visit. No one who lived at the home was receiving nursing care and no nurses were employed at the home.

Before our inspection, we saw from our records that there was a manager now registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the registered manager for the services 'sister' home Oak Lodge. The registered manager was not in attendance at this inspection visit.

Our records showed and clarification at this inspection confirmed that we had received all the statutory notifications we should have from the service.

We checked the shower areas in use at the Orchard Mews unit at the location. We saw that there were no shower chairs in place that could cause entrapment. In people's bedrooms where bedrails were being used we saw that bedrail covers were in place to help prevent entrapment. Although detailed bed rail risk assessments were in place they had not yet been updated to reflect current practice and legislation. It was also noted that all the beds in the home were profile beds and had bedrails fitted as standard. We recommended the service considers current guidance and legislation in relation to the risk assessments of the use of bedrails to include profile beds.

We saw that a new medicines trolley had been purchased so that medicines could be stored securely during administration in communal areas of the home. There was no one taking 'as required' (PRN) medicines to help manage their behaviours at the time of this visit. The group manager and the home manager were aware of their responsibilities to ensure that clear guidance was in place for staff to follow when this type of medicine was to be administered in the future.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

We found that improvements had been made relating to the equipment being used to support people and around the home. However we have recommended that bed rail risk assessments were updated to reflect current guidance and legislation.

Medicines were seen to be securely held. The managers understood the reason that detailed records were needed when 'as required' medicines for managing people's behaviours were used. This was to evidence that they had been administered appropriately.

Is the service well-led?

Good

The service was well led.

There was a manager in place who was registered with CQC. We had received all the notifications we should have, which is a statutory obligation of the provider.

Hollybank Nursing Home

Detailed findings

Background to this inspection

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

Before our inspection we reviewed the information we held about the service including notifications the provider had sent to us. We contacted the local authority safeguarding and commissioning teams and no concerns were raised by them about the care and support people received from Hollybank Nursing Home. The inspection took place on 25 February 2016 and was undertaken by one adult social care inspector. The inspection was announced because we were checking that the breaches in regulation identified at out last inspection in September 2015 had been met. We needed to be sure that the managers we needed to speak with were available.

During the inspection, we spoke with the group development manager and the home manager. The registered manager was not available to attend this inspection. We looked round some parts of the building, shower chairs and bedrails, and medicines management.

Good

Is the service safe?

Our findings

At our last inspection, we saw an old shower chair that could present as an entrapment risk to male service users was being used. We talked with the managers about the potential risk the shower chair could cause. The shower chair was removed from the premises immediately. At this inspection, we checked the shower rooms in use on Orchard Mews. We saw that shower chairs in use had appropriate sized drainage holes to help prevent entrapment.

At our last inspection we saw in the bedrooms that we looked at that beds provided for people to use were profile beds that had bed rails fitted to them even though they were not always required. We also saw that where the bed rails were in use that covers were not always in place to help ensure that people were not hurt by them, for example, damage to a person's feet if they had a seizure. We saw that the risk assessment format for bedrails was dated April 2004 and was in need of review to check that it covered current legislation and guidance.

At this inspection, we saw that where bedrails were in use that bedrail covers were in place to help prevent entrapment. However when we reviewed the risk assessment documentation, although detailed, it had not yet been updated to reflect current legislation and guidance. We were told that the group manager would address this immediately. We recommend the service considers current guidance and legislation in relation to the risk assessments of the use of bedrails to include profile beds.

At our last inspection, we saw that there was a monitored dosage system (MDS) in place for the administration of medicines. We saw that there was not enough room in the medication trolley to store the MDS rack system of medication and were these kept on top of the trolley throughout the medication round. This meant that medication was not always securely held. At this inspection, we saw that a new medicines trolley had been purchased by the provider so that medicines could be stored securely on the medicines round.

At our last inspection we looked at medicines that were prescribed for two people to help support and manage their behaviours. We saw that were 'as required' (PRN) medicines had been given the reason why had not been recorded on the back of the medication administration record (MAR) or could not be found in the person's care plan. There was no care plan to direct staff in the use of this type of medication, for example, what action to take to try to de-escalate and distract the person before resorting to the use of medication to help calm people down.

At the time of this inspection, no one was taking 'as required' (PRN) medicines to help manage their behaviour. Discussions with the group manager and the home manager demonstrated that they were aware of their responsibilities to ensure that clear guidance was in place for staff to follow when administering this type of medicine in the future.

Good

Is the service well-led?

Our findings

At our last inspection, the service did not have a manager in place who was registered with the Care Quality Commission (CQC) as required under the conditions of the service provider's registration. There had been no registered manager at the home since April 2014. This was because a person who intended to register with us left the post. The new manager had submitted four applications to CQC but they had been rejected by us because they had not been completed properly.

A manager for the service has registered with us since our last visit and the condition of registration is now met. The registered manager was also the registered manager for the services 'sister' home Oak Lodge.

At our last inspection, we found that we had not received two notifications in relation to the death of a service user and a safeguarding incident. The provider has a statutory obligation to notified us of these issues so that we can check that any action required has been taken by the provider

At this inspection we found no evidence to show that the provider had failed to notify the CQC as required by legislation, of any deaths, safeguarding or accidents or incident which occurred at the home. The breach in regulation was met.