Holywell Park Limited

Holywell Park

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 17 and 18 May 2016 and was unannounced. Holywell Park is a large country house dating back to the 17th century, adapted to provide accommodation and nursing care for up to 60 older people near Sevenoaks, in 52 bedrooms and two flats. There were 48 people living in the home at the time of our inspection, ten of whom lived with dementia.

The service was last inspected in December 2014 where breaches were identified in respect of: recruitment procedures; care plans; quality assurance system and records; and the administration of medicines. We had requested the provider to write an action plan and take action within a specific time frame. At this inspection, we found that all action had been taken.

There was a registered manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

People, relatives and staff told us there was a sufficient number of staff deployed to consistently meet people's needs. Staffing levels had been calculated taking into account people's specific needs.

There were thorough recruitment procedures in place which included the checking of references and full employment history.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

Staff had received essential training and were scheduled for refresher courses. All members of care and nursing staff received regular one to one supervision sessions. Staff reported feeling well supported in their roles.

Staff sought and obtained people's consent before they helped them. People's mental capacity was assessed when necessary about particular decisions; meetings with appropriate parties were held and recorded to make decisions in people's best interest, as per the requirements of the Mental Capacity Act

2005. The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences and restrictions.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect. People's individual assessments and care plans were reviewed monthly or when their needs changed.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People were involved in the planning of activities that responded to their individual needs. People and their relatives' feedback was actively sought at residents meetings, coffee mornings and through satisfaction surveys. Clear information about the service, the facilities and how to complain was provided to people and visitors.

Staff told us they felt valued by the registered manager and they had full confidence in her leadership. The registered manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service.

There was a system of monitoring checks and audits to identify the improvements that needed to be made. The registered manager acted on the results of these checks to improve the quality of the service and care.

Some areas of the home were not easily identifiable for people living with dementia or visual impairment. We have made a recommendation about this.

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. There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe.

Medicines were administered, stored and disposed of safely.

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

There was an appropriate system in place for the monitoring and management of accidents and incidents.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Safe recruitment procedures were followed in practice.

Is the service effective?

Good

The service was effective.

People could be confident that staff were knowledgeable and skilled to meet their needs, as staff received essential and specific training to support them in their role.

Staff had a good knowledge of each person's plan of care and of how to meet their specific support needs.

People's rights were protected because staff carried out appropriate assessments of their mental capacity and held best interest meetings when necessary. as per legal requirements.

The registered manager understood when an application for DoLS should be made and how to submit one.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's dignity was respected by staff who displayed a respectful attitude.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People, or their legal representatives, were involved with the planning and reviews of their care.

The delivery of care was in line with people's care plans and risk assessments.

People's care was personalised to reflect their wishes and what was important to them.

A daily activities programme that was inclusive, flexible and suitable for people who lived with dementia was implemented.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Good

The service was well-led.

There was an open and positive culture which focussed on people.

People, staff and relatives praised the registered manager's approach, style of leadership and support.

The registered manager promoted a positive culture that was person-centred. Emphasis was placed on continuous

improvement of the service. The registered manager welcomed people and staff's suggestions for improvement and acted on these.	

Holywell Park

Detailed findings

Background to this inspection

This inspection was carried out on 04 and 05 April 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. The expert by experience had experience in caring for older people.

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 carried out 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.

We looked at the service's action plan, and 15 sets of records which included those related to people's care and medicines. We made observations throughout the home and checked how medicines were acquired, administered and disposed of. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

The provider had completed a Provider Information Return (PIR) prior to our inspection. 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. We considered the PIR and looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events.

We spoke with 19 people who lived in the service and seven of their relatives to gather their feedback. We spoke with the owner (provider), the registered manager, the deputy manager, the head of care, three nurses, two senior care workers, three care workers, the activities co-ordinator, the head chef, and the head of housekeeping. We spoke with a nurse from the local hospice team and contacted a local case manager who oversaw people's care in the home. We obtained their feedback about their experience of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in Holywell Park. A person told us, "This is a safe place, there are many people about so if anything happens someone always comes to help." A relative told us, "I have total confidence in the staff; I know they watch over my Dad and are keeping him as safe as he can be."

There was sufficient staff on duty to meet people's needs. A relative told us, "I come and visit at any time and there is always plenty of staff around." People's individual needs were assessed and this information was used to calculate how many staff were needed on shift at any time. Before people came into the service, the registered manager completed an assessment to ensure the home could provide staffing that was sufficient to meet their needs. The registered manager recruited enough staff to ensure any staff absence was fully covered. Agency staff were seldom used and when they were, the same staff were used to ensure they were familiar with the service, the service's policies and people's needs. Additional staff had been provided to ensure the safety of a person who was disoriented in the home. When people approached the end of their life, the registered manager, the head of care and a care worker had taken turns to remain with them so they were not alone. This ensured staff were available to respond promptly to people's needs and ensure their wellbeing and safety.

We checked that action had been taken to address shortfalls identified at our last inspection in December 2014, in regard to staff recruitment documentation. All action had been taken and the staff recruitment system had been improved. The registered manager and deputy manager had ensured that any gaps in staff employment history had been explained and appropriately documented. Appropriate checks had been carried out to ensure that staff recruited to work in the service were suitable and of fit character. Checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work there. Staff members had provided proof of their identity and the right to work and reside in the United Kingdom prior to starting to work at the home. References had been checked before staff were appointed and where possible references had been taken up with the previous employer. Checks were made that nurses employed by the service had current professional registration and systems were in place to allow on-going monitoring. Disciplinary procedures were followed and action had been taken appropriately by the manager when a member of staff had behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Staff understood the procedures for reporting any concerns. All of the staff we spoke with were clear about their responsibility to report suspected abuse. There was a detailed safeguarding policy in place that reflected local authority guidance and the whistleblowing procedure. This included clear information about how to report any concerns. Staff told us they would not hesitate to report any suspected abuse or malpractice, and expressed confidence that any concerns would be addressed.

The premises were safe for people because the home, the fittings and equipment were regularly checked and serviced. There was an effective system in place to identify and log any repairs needed and action was taken to complete these in a reasonable timescale. Safety checks had been carried out throughout the

home and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They addressed the environment, the lift, first aid boxes, de-scaling, water temperature, Legionella testing, appliances and fire protection equipment. The lift had been repaired on 22 April 2016 following a breakdown during use and was fully functional. There were subsequent maintenance visits by an external contractor scheduled. Equipment that was used by staff to help people move around was checked and serviced annually. Portable electrical appliances were checked regularly to ensure they were safe to use. Each person's environment had been assessed for possible hazards. People's bedrooms and communal areas were free of clutter. A security system ensured that people remained safe inside the service and people were assisted or accompanied by staff when they needed or wished to leave the building.

There were plans in place that detailed how people would be kept safe in case of an emergency. The provider had undertaken a fire risk assessment in November 2015 and people had personal emergency evacuation plans in place. These were available to staff and emergency services and showed the level of support that people required evacuating the premises. Staff had received fire training and fire drills were regularly carried out and documented in order to ensure that staff had the skills and training to respond to an emergency. An appropriate business contingency plan addressed possible emergencies such as fire, evacuation, extreme weather and outbreak of infection. There was appropriate signage about the exits. There were regular checks of the fire warning system, fire doors, emergency exit doors, break glass points and emergency lighting.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. Appropriate logs were completed by staff and all relevant information was forwarded to the registered manager who analysed it on the day. The registered manager carried out monthly audits of falls and compared them to previous audits to identify any possible trends or patterns. Action was taken to minimise further risks of falls, such as the provision of mats to alert staff when people may get out of bed and needing assistance, and bed rails with people or their legal representatives' consent.

Risk assessments were centred on the needs of the individual. Staff were aware of the risks that related to each person. There were specific risk assessments in place for a person who chose to smoke tobacco, another who liked to visit the local pub, people who were at risk of falls, or who were at risk of pressure damage to their skin. Each risk assessment included clear measures instructing staff about how to keep people as safe as possible, taking in account people's individual circumstances and preferences. One person disliked being observed by staff when they moved around so staff were instructed to be 'as unobtrusive as possible' to respect this person's sense of dignity while keeping them safe. Staff helped people move around safely and people had the equipment and aids they needed within easy reach.

We checked that action had been taken to address shortfalls identified at our last inspection in December 2014, in regard to documentation relevant to the administration of medicines. All action had been taken to achieve compliance with relevant regulations. New systems had been implemented to ensure good practice and appropriate documentation relevant to medicines were maintained. Staff received regular training in medicines management or updates. All staff administering medicines underwent competency checks by the registered manager to ensure good practice was maintained.

All aspects of people's medicines were managed safely. Medicines trollies were locked when left unattended. Staff did not sign MAR charts (Medicines administration records) until medicines had been taken by the person. A nurse told us, "A lot of improvement has been done especially in the MARs." The charts were appropriately recorded by staff. Each person taking 'as needed' medicines, such as pain killers,

had an individual protocol held with their MAR chart. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects. Protocols and authorisation for the future use of syringe drivers (portable pumps which allow medicine to be administered by slow release over a period of 24 hours) had been devised and obtained. Staff were knowledgeable about these and the medicines they were giving.

All medicines were stored safely. Medicines requiring refrigeration were stored in a dedicated fridge. The temperature of the fridge and the room in which it was located was monitored daily to ensure the safety of medicines they contained. One person received medicines covertly, that is without their knowledge or permission. A mental capacity assessment had been undertaken and a best interest decision had been made with the relevant parties involved. This was consistent with the provider's policy and the law. The provider undertook monthly audits to ensure the safe and effective management of medicines which included a drug error audit. When errors had been identified, measures had been put in place to prevent re-occurrence. There were also regular external audits conducted by the provider's medicines supplier.

The home was clean, tidy and well presented. In each area of the home there were hand washing facilities readily available providing personal protective equipment such as gloves and aprons for staff to use. The head of housekeeping monitored cleaning schedules to ensure good standards of cleanliness and infection control were maintained. A person told us, "They are always cleaning and taking rubbish out and the place always smells nice." People were kept safe from the risk of infection as laundry staff segregated and processed laundry at correct temperatures. Best practice was followed and there were separate areas for clean and soiled laundry that ensured people were not at risk of cross contamination.

Staff had followed the guidelines in the home's infection control policy and had contained a recent spread of a particular infection in the home. A local authority case manager who oversaw a person's care in the home told us, "They dealt with this quite remarkably and had it contained within a week, it is never easy in a care home but they did it." The registered manager and head of housekeeping undertook audits of the home every two months to ensure areas were kept free from the risk of infection. Where potential issues were identified, action had been taken. For example as a result of these audits, a shelf to store bedpans had been fitted; blood spillage cleaning kits had been ordered; the flooring in some of the toilet facilities had been replaced; a system to sterilise all cutlery was implemented on a weekly basis.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "The staff understand my life, they understand me", "The staff listen to me", "They good at offering help" and, "They make me feel able to do what I want." A relative told us, "The staff are sensitive to the need for prompt action."

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 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.

Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options to keep these people safe.

Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. When people had been assessed as not having the mental capacity to make certain decisions, a meeting had taken place with their legal representatives to
decide the way forward in people's best interest. For example, this procedure had been followed for a person who had declined taking their medicines, and for another about resuscitation. This ensured people's rights to make their own decisions were respected and promoted when applicable.

Staff sought consent from people before they helped them move around or before they helped them with personal care. We observed staff asking people, "Is it all right if we help you now" and, "Would you like some help? I can help you if you would like" and waiting for replies before proceeding. A person told us, "They listen to me; they have a gentle tone of voice and are never rude."

Staff received training that was essential for their roles. A system was in place to monitor staff training and determine when they needed a refresher course. The monitoring system indicated staff were up to date with their essential training, which included first aid, fire safety, moving and handling, health and safety, person-centred care, mental capacity and safeguarding. Staff were reminded when they needed to renew their training and we noted training sessions were scheduled to take place in June 2016. These included additional training aimed at meeting people's specific needs such as dementia care, Parkinson's disease, stroke and end of life care. There were staff named 'key workers' who received advance training and who were designated leads in specific areas such as diabetes or diet and nutrition. All staff were encouraged to

choose and take a lead in a particular field, do research and gain further knowledge that could benefit people and the whole of the staff team. This ensured that staff had access to guidance and advice in particular fields, to care for people's specific needs effectively.

Care staff were supported to study and gain qualifications for a diploma at different levels in health and social care. All care staff held a diploma in health and social care at Level 2 and nine care staff at Level 3. Senior care staff were working towards supervisory management diplomas, and 12 kitchen and domestic staff held diplomas in hospitality and customer services.

New care staff underwent a thorough induction when they started work. This included shadowing senior care workers before they could demonstrate their competence and work on their own. The competency of all staff administering medicines had been assessed and documented. The 'Care Certificate' had been introduced for all new staff. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. A member of staff told us, "We get excellent support throughout our training and studies."

Staff knew how to communicate with each person. Staff bent down so people who were seated could see them at eye level. Staff checked people's hearing aids regularly. All staff used positive body language and were smiling when conversing with people. One person told us, "The staff spend the time to listen to what I have to say, they are very gentle and patient." We observed how staff communicated with people when they used equipment to help them move from one place to another. The staff talked clearly to the person in a reassuring tone through each stage of the procedure, ensuring the person knew what they were going to do next. People's care files included clear instructions to staff about best to communicate with people. They included how people preferred to be named, whether they had hearing or visual impairment, or whether they experienced any anxieties that needed specific communication methods. Instructions to staff for one person included 'to reducing noisy environment and offer a lot of reassurance'. We observed this being applied in practice.

There was an effective system of communication between staff. Staff handed over information about people's care to the staff on the next shift. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. We looked at a nurses handover that was comprehensive and detailed each person's current health and daily support needs. This ensured that updates about people's care were communicated effectively throughout the day. One person had requested an additional shower; this was communicated in the handover and provided the same day. There was a communication book used by staff to record people's visits from healthcare professionals and a diary updated with people's external appointments.

The registered manager and deputy manager provided regular one to one staff supervision to care and nursing staff. At these sessions, staff were encouraged to discuss any problems or difficulties they may have and gain support from the management team. One member of staff said, "I feel really well supported by a manager who cares about the staff." All staff were scheduled to have an annual appraisal.

We saw several people had their breakfast late in the morning as they preferred. We observed lunch being served in the dining area and in people's bedrooms. The lunch was freshly cooked, hot, well balanced and in sufficient amount. People were supported by staff with eating and drinking when they needed encouragement and aids were provided when necessary, such as beakers, plate guards or adapted cutlery. People told us they were very satisfied with the standards of meals. They told us, "It is lovely, very nice food", "The meals are good and there is a lot of choice." Two kitchens were manned by 18 members of staff who

were deployed in shifts of three; this ensured a continuous presence so that people were offered fresh food at any time they wished in addition to the main meals. Trolleys were circulated four times a day to bring cold and hot beverages, home-made cakes, fruit, biscuits and healthy snacks. Some people chose to have a sherry before bedtime. A person told us, "We get what we want and when we want." People were encouraged to drink fluids throughout the day to promote their health.

Attention was paid to how food was presented to people, to stimulate their interest and appetite. A relative told us how the chefs reshaped blended ingredients for their loved one, so they could recognise what they were. They said, "This is a nice touch, they go out of their way to present the food attractively." People were offered a choice of three to four main courses at lunchtime, and told us they enjoyed their meal. One person told us, "It is that good and we get that many choices every day." People were consulted about the food they preferred and seasonal menus were planned in accordance to their wishes. Each afternoon, people were asked by staff what they fancied for their evening meals which included simpler food such as jacket potatoes with a variety of fillings, omelettes, fresh soup, fish and a hot dessert. The head chef carried out a quarterly satisfaction survey and also sat regularly with people in the lounge to converse with them and get further feedback. When people came to live in the home, their likes, dislikes and preferences were recorded in a diet form and the kitchen staff were aware of these. People's allergies and special dietary requirements were displayed in the kitchen so staff were fully aware of what to serve them.

Staff used a screening tool to identify people who may be at risk of malnutrition. When people were at risk, staff documented and monitored people's food and fluid intake and reported their findings to the nurses. People were weighed monthly and fluctuations of weight were noted and acted on. For example, if people lost a specified amount of weight within a timeframe, they were weighed weekly or fortnightly, provided with a fortified diet, and were referred to the G.P., dietician or a speech and language therapist when necessary. This system ensured that people's nutritional needs were effectively met.

People received medical assistance from healthcare professionals when they needed it. Staff communicated daily with the local GP surgery and emailed to them a list of people who needed to be seen and the reason why. The surgery included five GPs. The registered manager told us, "We have a wonderful communication with them, and a GP comes more or less every day." People were able to retain their own GP if they wished, although when their GPs were out of area, this was discussed with them to ensure this was their informed choice.

People were offered routine vaccination against influenza and district nurses came to help with the administration of vaccines. A chiropodist visited every six weeks to provide treatment for people who wished it. People were escorted to their optician or dentist appointments when needed and a visiting optician service was available. People had been referred to audiology clinics via the GP; the home was supported by a specialist Parkinson's nurse and by the local hospice palliative nurses specialists. The deputy manager who was also the clinical lead was trained in ear syringing.

Holywell Park was not purpose-built however it had been adapted to suit people's needs and to provide them with a comfortable and welcoming environment. The home was well maintained and attention had been paid to personalise people's bedrooms as they wished. There were extensive grounds with well-kept lawns, flower beds and sitting areas for people to enjoy and relax in. A relative told us, "It is a beautiful building and although it is very old it is not run down, it is well maintained." A person told us, "I have my possessions in my room; it's my place and it makes me feel comfortable; lovely house here, wonderful views." However, we noted communal areas were not clearly differentiated; people's doors were not personalised to help them locate their bedrooms, and there were no distinctive walls coverings or hangings such as pictures in corridors. This did not make areas easily identifiable for people living with dementia or

visual impairment.

We recommend that any improvements to the environment are made in accordance with published research and guidance for those living with conditions such as dementia and sensory impairment.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "The staff are helpful, they really care about me", "The staff are always polite, from the people giving the meals and pushing the trolleys to those managing." Relatives told us, "I feel the staff are honest and to the point", "General care is excellent; everyone is so friendly, they seem concerned with your wellbeing and are always very polite" and, "We are always warmly greeted and can come any time; nothing is too much trouble for them."

We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. Staff treated people with kindness and respect. We observed laughter as well as gentle reassurance with appropriate body language, such as staff stroking a person's hand when they talked with them. The provider told us how staff had taken photographs of a person's bungalow to recreate exactly the same décor in their new environment down to small details, in order to give this person a pleasant surprise. As the provider and staff displayed a pro-active and caring attitude, people could be assured that their needs could be anticipated at times.

Specific communications methods were used by staff when necessary. A person was unable to communicate their needs verbally and their communication care plan instructed staff how to interpret their facial expression and body language. Staff used a consistently kind and patient approach with a person who displayed certain behaviour that challenged at times. A member of staff told us, "We make sure we talk with this resident as we would like to be spoken with, this is actually in the care plan but we would do this anyway and with everyone here." A senior care worker told us how they spent time with a person whose moods were low and who chose to stay for long periods of time in their bedroom, to chat and encourage them to recall positive experiences of their lives. A care worker told us, "I enjoy giving something back and seeing smiles on people's faces." Another care worker said, "We treat our residents here as if they are our own family; it is their home and not ours and we make their lives as comfortable as possible."

People were assisted discreetly with their personal care needs in a way that respected their dignity. Staff closed doors when helping people and people told us they were respectful, taking care to cover them when necessary. Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality.

People's spiritual needs were met with the provision of religious services in the home. A catholic priest and an Anglican priest visited the home every two weeks. The registered manager told us, "Should we have people with other faiths we would take any steps necessary to access religious leaders, ministers or priests on their behalf, if they so wished."

Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. People followed their preferred routine, for example some people chose to have a late breakfast, stay in bed

or stay up late. Staff presented options to people so they could make informed decisions, such as what they would like to wear, to eat and to do, so that people could be in control of their day. A couple were waiting to be transported to attend a church meeting. As staff encouraged people to do as much as possible for themselves, people's independence was promoted.

People were enabled to maintain their independence with a positive approach to managing risk. For example three people visited a local pub and were escorted by staff there and back when necessary. Some people went out by themselves and associated risks had been assessed and discussed with them.

Clear information about the service and its facilities was provided to people and their relatives. There was a brochure that provided information about the home. People were provided with a service users guide that contained comprehensive information about every aspect of living in the home, including people's rights and how to complain. The complaint procedure was also displayed in the main entrance area. People and their families were provided with a monthly newsletter that showed photographs of last events and activities, reminders of upcoming events, and updates regarding staff recruitment. The provider maintained an informative website about the home that was easy to navigate with a range of photographs that depicted the home and its facilities accurately. The home also featured on a social media site that people could access. With these systems of communication in place, relatives could contact the provider, the management team or the staff to remain connected with the service.

The weekly programme of activities was displayed on an information board, in a pictorial format to help people understand what was on offer. The registered manager was in process of having staff photographed to display their image and identity on a board, to help people and visitors be acquainted with staff and their roles. The head chef had started to photograph dishes and was in process of setting up a pictorial menu. The service users' guide was available in a pictorial form and in a large format to help people with visual impairment.

People were involved in their day to day care when they were able to and when they wished to be.
Staff built up close supportive relationships with the people they provided care for, and their family and friends. People were encouraged to recall their history which was shared with staff. This enabled staff to gain further insight and understanding of the resident's background and interests and ensures the care and support the resident received met their cultural and spiritual needs and lifestyle preferences were respected. People and when applicable their legal representatives were involved in decisions about their care and in agreeing their care and support plans. A relative told us, "We are involved and we have a say."

People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. These wishes, including decisions about resuscitation, were appropriately documented in people's files. Staff were supported and trained by two local hospices palliative teams with whom they worked in collaboration. Staff had anticipated some pf the people's needs and had obtained their authorisation for the future use of syringe drivers (portable pumps which allow medicine to be administered by slow release over a period of 24 hours). This was to ensure people could be assured to remain pain-free and comfortable. A specialist clinical nurse from the hospice team told us, "The staff are very caring and knowledgeable; they manage end of life care very well."

Advance care plans were discussed and written in partnership with people when appropriate. These plans give people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to

be their legal representative. Therefore people could be confident that best practice would be maintained for their end of life care.

Good

Is the service responsive?

Our findings

People gave us positive feedback about how the service and the staff responded to their needs. They told us "There is always something going on and always something to look forward to so we are definitely not bored" and, "They take really good care of me; they know me very well and they also know what I need." Comments that relatives had sent to the home included, "I have always been impressed with the level and quality of care at the home", "I appreciate the amount of time staff have been spending with X [relative]." A local authority case manager who oversaw a person's care in the home told us, "They provide person-centred care because they listen to their residents and they adapt to their needs."

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments were comprehensive and included people's personal accounts of their life history, their likes, dislikes and preferences over their care and lifestyle. An assessment of how people had been encouraged to express their wishes and contribute to their care planning was undertaken, to check that people had been involved with their assessments.

Individualised care plans about each aspect of people's care were further developed within 48 hours after their admission into the service, as staff became more acquainted with people's particular needs and their choices. People's care plans included more detailed information such as how best to communicate with the person, their mental state, their nutrition needs and preferences, their favoured routine and activities, their sleep patterns and skin integrity. People's preferences were taken into account, for example they had an 'eating and drinking care plan' that stated when a person enjoyed their preferred food such as cooked breakfast, how they required their food to be cut, and how they disliked waiting for their food. The staff we spoke with were aware of these particular requirements. People told us they could have a bath or a shower as often as they wished.

'Extra care charts' were put in place when people needed to be closely monitored until their health improved. These charts included records of people's food and fluid intake, of any signs of agitation or pain, of when they were repositioned in bed, of their continence, and of hourly checks. The charts were monitored by nurses, the deputy manager or the head of care daily.

All care plans were routinely reviewed and updated by staff on a monthly basis, or sooner when needed. Care and nursing staff were made aware of any changes and updates. People or their legal representatives were routinely invited to be involved with the review of their care. There were documented meetings with people's families, such as when a person had needed to receive their medicines covertly in their best interest and when bed rails had been put in place to keep them safe in bed.

Individualised assessments of risks were carried out such as possible risks of falls, malnutrition and skin damage. Staff placed emphasis on the promotion of good health and several people were of an advanced age. A relative told us, "Our mother came in quite poorly and is now a picture of health due to the good care, good food and regular drinks she has here." A person who had been staying in bed in their home due to ill health had come into the home with a palliative care plan. The registered manager told us how they had

provided a special chair, and how staff had given 'plenty of encouragement' to the person, who was now sitting up and feeding themselves. Another person who had previously been self-neglecting in their home had put on weight and had improved their health and mental state.

People were encouraged to personalise their bedrooms according to their taste. A person had chosen vivid colours for her room to be decorated with.

A range of daily activities that were suitable for people who lived in the home was available. An activities coordinator consulted people and planned activities in accordance to people's preferences. They presented options to people and adapted the activities of the day to suit people's moods and requirements. For example, when a person's mood may appear to be low, staff sat with them to do a 'memory tree' together. A person who had lost the full use of an arm was learning how to use their other arm to paint a picture. Routine activities took place daily that included art and crafts, cooking, flower arranging, colouring books, quizzes, reminiscence games, listening to music and singing, skittles, and gentle exercise. The activities coordinator told us, "We don't necessarily stick to the plan; we see what the residents want to do." People who liked gardening took part in a sunflower growing competition. The registered manager had researched websites that specialised in dementia to find new activities to include in the activities programme. As a result, sensory equipment had been purchased and was used by staff for people who had sensory impairment or cognitive difficulties.

The provider commissioned external performers 'five to six times a month' such as accordionists, performing dogs, birds of prey, magicians and singers. People who remained in bed were invited to take part in activities and were brought into the lounges or the gardens if they so wished. The activities coordinator visited people who preferred to stay in their room and provided one to one activities, such as reading, singing, looking at photographs and reminiscing.

Staff responded to people's individual emotional needs and ensured isolation was reduced. People's relatives were welcome at any time and were able to stay and share a meal with them. There was an aviary outside with a multitude of birds, budgerigars in a wide cage in one of the lounges, and a large aquarium stocked with tropical fish in the entrance. This provided a visual point of interest and promoted a homely atmosphere for people. The registered manager and care staff brought their pets on occasions and shared their company with people. One person told us, "I love the dogs; they remind me of the one I used to have." A care worker chose to come in the home during their time off when people enjoyed their 'coffee morning', to spend more time with them and introduce them to their children. A person enjoyed smoking in the conservatory which opened onto the gardens, reading newspapers. A care worker came to check whether they needed anything and stayed and chatted with them.

Outings were provided to maintain links with the community. A person had been escorted to visit the garden they used to own. Staff had taken photographs of it and had put two albums together, for the person and their family. People were able to visit local theatres, garden centres, churches and local pubs. People who wanted to attend a village hall's 'cooked breakfast club' where they could meet other people from the village were transported there and back. Two people who lived in the home attended a local Alzheimer's club and one had started their own support group.

Themed events were organised such as Wimbledon week where people dressed up and were offered strawberries and Pimms; a seaside day when people had enjoyed a paddling pool with sand and water and the use of a candy floss machine; National Train day when a visit to see antique trains had been arranged; and international days with foreign music and exotic samples of food. Staff held a yearly garden party with stalls, bouncy castles, bar, and entertainers, to which all the local community was invited. The registered

manager had booked an ice cream van to come every other weekend in summer, and a fish and chips van. A relative told us how they looked forward to the Queen's birthday party organised by the home. As the provider ensured people's interests were stimulated, people could be confident that their social and psychological needs were met as much as possible.

People had an opportunity to give their feedback about the quality of the service. The registered manager visited up to five people individually once a week , sat with them to discuss what they liked, any concerns they may have, what they would like to see improve, and to gather their overall feedback. These conversations were documented and when improvements were suggested, this had been carried out. For example a person wanted to be asked every morning if they still wished to have the same cooked breakfast in case they changed their mind; another person had wanted to remain in night clothes during the day. This was respected by staff in practice.

Bi-yearly satisfaction surveys were sent to people's relatives to seek their feedback about all aspects of the service provision. 100% of the replies received indicated that relatives felt the home was 'a good place for their relative to be living'. Improvements had been identified and implemented, such as an increase of activities, more comprehensive staff handovers, clearer notice boards, a four-week menu and the setting up of a newsletter. There were monthly coffee mornings to which people's families were invited, and they were able to voice any suggestions about how to improve the service.

There was a comments and suggestions box for staff and visiting healthcare professionals to use, although this was seldom used. A member of staff had made a suggestion to enhance the grounds of the home and this had been duly considered by the provider.

People were aware of how to make a complaint. The complaint procedure was displayed in evidence in the reception area. Complaints were addressed as per the service's complaint policy. Since our last inspection, four complaints had been received and remedial action had been taken to a satisfactory outcome. A person told us, "If I need to grumble a bit about anything I just talk with my favourite member of staff and I know she'll put it right

Good

Is the service well-led?

Our findings

People, relatives and staff told us the service was well led by the provider and the management team. All were complimentary about the registered manager's approach and style of leadership. People told us, "The manager is very nice, she comes and talk to us and she is very friendly", "I sometimes go in the office and sit, I am always welcome." Relatives told us, "You can sense that the staff are happy here and it is surely because they are well managed by a good team who care about them" and, "I have a good rapport with the manager, she is direct and she gets things done."

Staff were very positive about the support they received from the provider, the registered manager, the deputy manager and the head of care. They reported that they could approach the registered manager with concerns and that they were confident that they would be listened to and supported. They told us, "She runs an open door policy, we can go and see her at any time, she always makes time to listen to us."

The registered manager had been in post for two years and was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. The registered manager had ensured that the shortfalls we had identified at our last inspection in December 2014 in respect of: recruitment procedures; updated care plans; quality assurance system and records; and the administration of medicines had been remedied. At this inspection, we have found that all action had been taken effectively and that compliance had been achieved.

The registered manager researched websites and publications to ensure they remained abreast of latest updates relevant to legislation, people's care and management of care homes. They described their philosophy of care as, "Ensuring that everyone feels safe, wanted and valued." The provider told us they aimed to make Holywell Park "A home from home" for people.

The registered manager, deputy manager and head of care were very visible in the service and interacted positively with staff people and visitors. Each person we spoke with was aware of who the manager was and the manager knew each person by name as well as being well acquainted with their individual needs and preferences.

The registered manager held regular scheduled staff meetings and encouraged the staff to be involved with the running of the service. They met with the provider, the nurses, the day care workers and the night care workers, the head of housekeeping the head chef, the kitchen staff and the activities co-ordinator. At each meeting, the registered manager shared the results of quality assurance audits relevant to each department and of any improvements that had been implemented as a result. A nurse told us, "We all worked very hard to do exactly what the manager wanted and it works much better now." At a recent care workers meeting, how to improve the documentation of people's food and fluid intake charts, and how to improve the general tidiness of the home had been discussed. When staff had requested new fan heaters and more 'walkie-talkies' to improve communication, the registered manager had ensured these were provided. The registered manager met daily with the management team, and once every two weeks with the provider and the person responsible for the maintenance of the building. The provider told us, "As I live nearby I am very

often on the premises and in regular contact with the manager."

The registered manager involved people and their relatives in the running of the service. Feedback gathered at individual residents' meetings, at coffee mornings and through satisfaction surveys was analysed and acted on. The registered manager had written to each relative to thank them for their feedback and when they had raised a suggestion or a concern, the letter included details of what had been done as a result. For example, when a relative who did not live close by wanted an improvement in communication with the home, a regular phone call to give them updates of their relative's wellbeing had been set up.

There was an effective quality assurance monitoring system in place. The registered manager and deputy manager carried out monthly 'resident overviews' which was a series of check about people's nutrition needs, their weight, charts relevant to their food and fluid intake, assessments of their skin integrity, the state and settings of any specialist equipment they may be using. All records and monitoring charts were looked at to ensure they had been appropriately completed, and action plans were written when shortfalls had been identified. Audits of staff training, medicines, infection control, of accidents and incidents, and of satisfaction surveys were regularly carried out. When shortfalls were identified, action was planned and followed up until completion. For example, an audit on falls had highlighted a need for an increase in staffing levels at a certain time. As a result, staff had been increased to create a twilight shift that overlapped with the night shift, to ensure people's safety. A member of staff told us, "The manager acts on a lot things; she added a refresher course for manual handling, she moved a resident to another room more suitable for using a hoist when needs had increased."

The service's policies were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. The provider and the registered manager reviewed the policies regularly and updated them appropriately. Records were well organised, accurately completed, kept securely and confidentially. Archived records were disposed of safely and appropriately according to legal requirements.