Hollycroft Care Limited

Hollycroft Nursing Home

Inspection report

8-10 Red Hill
Stourbridge
West Midlands
DY8 1ND

Tel: 01384394341

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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**

Summary of findings

Overall summary

This inspection took place on 16 and 17 October 2018 and was unannounced. We last inspected the service in June 2017 and rated the service overall as 'requires improvement'.

Hollycroft Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hollycroft Nursing Home accommodates 37 people in one adapted building. People using the service have a range of needs which include dementia, physical disability or old age. Whilst some people lived there permanently, the service also provides care to people on a short-term rehabilitation basis, often following discharge from hospital. On the day of the inspection, 14 of the 31 people living at the service were living there on a short term basis.

There was a registered manager. 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.

Quality assurance checks in place were not always effective and there continued to be no analysis of accidents, incidents that could improve people's experience of the service. Staff competencies were not routinely checked. Audits had failed to identify a number of areas that came to light on the inspection, including care records and risks assessments inconsistently kept up to date and information missing in recruitment files.

People felt safe. Staff were aware of their responsibilities to report any concerns and of the risks to people on a daily basis.

Staffing levels were determined by the dependency levels of the people living in the home, but the deployment of staff at mealtimes, remained a concern.

People were supported to take their medicines as prescribed by staff who had received training in this area.

People were happy with the care they received and considered the staff who supported them to be well trained. Staff felt supported and listened to by management and described the registered manager as 'approachable'.

People said staff were kind and caring. Staff treated people with dignity and respect and supported people to regain their independence, where appropriate.

People said they were involved in the planning of their care, but there was little documented evidence of this. Activities took place but did not always take into consideration people's choices and preferences.

There was a system in place to record complaints and people were confident if they raised any concerns they would be acted on.

There had been, and continued to be a programme of refurbishment across the home which had a positive impact on the environment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People felt safe and were supported by staff who were aware of the risks to them. Poor deployment of staff impacted on people's lunchtime experience. Analysis of accidents and incidents had not taken place to enable lessons to be learnt. People were supported to receive their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had been received training to provide them with the skills to meet their needs. Staff obtained people's consent prior to offering support. People were supported to eat and drink and maintain good health.

Is the service caring?

Good

The service was caring.

People described staff as kind and caring. People were supported to regain their independence. Staff were mindful of respecting people's privacy and dignity when providing support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People said they were involved in the planning of their care but care records did not always reflect this. Activities were limited and did not always reflect people's choices. People were confident that if they raised a complaint it would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People were complimentary about the staff and the registered manager. Progress had not been made in respect of improvements required at the last inspection. Governance

systems in place were not always effective.

Hollycroft 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.

This inspection took place on 16 and 17 October 2018 and was unannounced. The inspection team consisted of one inspector, a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. 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 to us.

We spoke with the Registered manager, deputy manager, two nurses and four care staff, the cook, the activities co-ordinator, a visiting assistant physiotherapist and an occupational therapist. We also spoke with seven people living at the service, three relatives. We reviewed a range of documents and records including the care records of six people using the service, two medication administration records, two staff files, training records, accidents and incidents, complaints systems, safeguarding records, minutes of meetings, activity records, communication records, surveys and audits.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 10 June 2016, we rated this key question as 'Requires Improvement.' At this inspection the rating remains unchanged.

At our last inspection, concerns were raised regarding staffing levels and the deployment of staff across the home. Following that inspection the provider informed us they would be introducing an allocation sheet which would be put in place to highlight to staff their roles and responsibilities. This in turn would ensure better staff deployment throughout the day, including to 'improving the dining experience to ensure people were supported and served meals in a timely manner'. The registered manager told us there was no allocation sheet as such, but that "Staff worked together to ensure people's needs were met". However, we found concerns remained the same at lunchtime and saw some people were left sitting in the dining room for up to 40 minutes before their food was served, as meals were not served until everyone was seated. Further, we noted the two people who had entered the dining room first, were served after everyone else. We spoke with the registered manager and expressed our disappointment that the lack of organisation at lunchtimes continued. We discussed ways in which this could be improved, for example, by supporting small numbers of people to the dining room, ensuring they were seated and had their meals and then supporting other people to enter the dining room. On the second day of the inspection we saw that this practice had been introduced and staff spoke positively about this.

People told us there were not always enough staff available to meet their needs. For example, one person told us, "At night they [staff] take ages. They say 'just a minute' and I have an accident. I feel degraded. They say it's ok". A relative told us, "There are enough staff, but my relative did tell me they had an accident as they rang the buzzer at night to go to the toilet, the staff said they had to wait and they had an accident, but the staff told them not to worry". During the day, people felt differently about the staffing levels and we received the following comments,
"Yes, I think there are enough staff, they come as quickly as they can", "Always someone around when in the lounge" and "I call or ring the buzzer if I need carers and yes there are enough staff all the time". However, another person commented, "When the home is full, no, but at the moment is ok as it is not full". We were told there was a dependency tool in place to assess staffing levels and that there were currently six vacant beds in the home but the staffing levels had remained the same. Both the registered manager and staff spoken with told us that things became more 'hectic' as more people were admitted to the home. The registered manager told us despite the fact that they did not have a formal allocation system in place, they were confident that staffing levels were adequate to meet people's needs. We observed the atmosphere to be calm and saw that when people requested support, for example to be taken to the bathroom, staff were available.

Where accidents and incidents took place, they were logged and individual analysis was in place for any lessons learnt. However, there was no evidence of the information being analysed and acted on for any trends. For example, we saw for one person, three separate falls had been logged for the month of September. We noted that individual actions were recorded following each fall, but there was no analysis to

see if there were any patterns or trends which would assist staff in reducing the risk to the person.

We found there was a lack of consistency in paperwork around recording and risk assessments and that people did not always have their risks assessed and mitigated. For example, we saw one person's risk assessment indicated due to a number of falls their risk level had increased; but there was no updated information regarding what additional support the person may need to reduce the risk and keep them safe. For another person we were told that appropriate action had been taken when a person had attempted to climb over a bed rail and that their bed had been lowered and a crash mat put in place to reduce the risk of falls, but the person's care record had failed to reflect this change. We raised this with the registered manager who confirmed they would ensure care records were updated immediately. Staff spoken with were able to tell us of the risks they were aware of to the people they supported, one member of staff said, [in order to reduce a person developing pressure sores], "We make sure [person] is assisted to move very two hours to prevent pressure sores developing".

Staff told us that prior to commencing in post, recruitment checks were carried out and references sought. We looked at the personnel files for two members of staff and found one did not hold a copy of the member of staffs' application form. In another staff file we noted a significant gap in one person's work history and no evidence that this had been explored which could potentially compromise the safety of service users. We raised both of these points with the registered manager for them to follow up immediately.

This meant recruitment processes in place were not robust and could place people at risk at being supported by staff who were unsuitable having looked at

People told us they felt safe living at the home. One person told us, "Oh yes, I feel safe. All together, always someone around," and another said, "Yes I feel safe living here. I prefer home but they look after me well". A relative said, "They [person] are safe. They [staff] are honest. Told us about [person's] fall, showed me the sheet where it was recorded". Staff were aware of their responsibilities to raise any safeguarding concerns and the processes to follow, should information of concern come to light.

At our last inspection we found that PRN protocols were not in place for pain relief. At this inspection, we noted that the protocols were in place. People told us they had no concerns regarding their medication and that they received it on time.

We looked at the medication records of two people and checked to see that systems were in place to ensure the safe storage and administration of medication took place. We saw that medication was stored safely and fridge and room temperate checks were routinely made. We looked at Medication Administration Records [MAR] and saw that what was in stock tallied with medication that had been administered. People were supported by staff who had been trained to administer medication but there were no formal documented competency checks taking place to ensure staff were administered medication as prescribed. A member of staff told us, "We watch them [staff] when we can, they know what to do".

The home presented as clean and odour free. Staff followed infection control guidelines and used aprons and gloves when supporting people with their personal care and at mealtimes. However, we noted that people were offered biscuits from a communal biscuit tin and were not given a plate or serviette to place them on. We raised this with the registered manager who agreed that in the interests of infection control, that this was not best practice and confirmed they would address this.

Good

Is the service effective?

Our findings

At the last inspection on 10 June 2016, we rated this key question as 'Good'. At this inspection the rating remains unchanged.

Prior to moving into the home, people's needs had been assessed. These assessments gathered information regarding people's personal care needs, their medical history and their social needs. People had been asked about their dietary preferences, their family, whether they needed any particular equipment to support them.

One person told us, "Alright [staff], they help you, they're good. If you want any help, they help you". Other people told us, "It's alright. I am happy here. I would rather be at home", "They [staff] are very nice and they look after me properly". A relative said, "I think all the staff are well trained, they know what my relative likes. The physio said that the work that they do with my relative is carried on by the care staff, so they must be well trained".

Staff told us they felt supported and well trained. We saw the induction of new staff included the opportunity to shadow experienced colleagues on shift. Staff advised they received regular supervision, but were not aware that their practice was observed to ensure they were competent to perform their caring duties. We discussed this with the deputy and registered managers who told us they observed staffs practice but there was no written evidence to support this.

There was a training matrix in place which provided the registered manager with up to date information regard staffs training needs. A member of staff told us, "I feel well trained, if I was struggling there's someone you can ask". They went on to describe how additional training was sought in specialist areas such as continence care, which they found beneficial.

The provider told us in their Provider Information Return [PIR] that they would like to source training for staff to enable them to be comfortable speaking to people about their end of life wishes. The registered manager advised they intended to contact the local hospice with a view to obtaining this training.

One person told us, "The food is brilliant. Meal times are relaxed. People can take their time" and another person said, "It's quite good the food and you get lots of choices". We observed for those who required support at lunchtime, this was provided and one person told us, "The food is alright. I can't chew, they mash it up for me". We saw the cook was aware of people's dietary needs and personal preferences. We noted people had access to hot and cold drinks throughout the day.

We asked if people had access to fresh fruit during the day. The cook told us fresh fruit was available and people 'only had to ask for it' and pointed to a bowl which appeared to contain oranges and very over-ripe bananas but was kept in the kitchen, not on display for people to see. We discussed with the cook and the registered manager, the idea of providing people with a choice of small pieces of fruit to accompany their drinks as an alternative to the usual biscuits that were provided with the tea trolley. The registered manager

advised they would look into this.

We saw that people were supported to maintain good health. One person told us, "If I'm not well they will get the doctor in". Staff were aware of people's healthcare needs and worked alongside visiting occupational therapists and physiotherapists in order to provide effective care. For example, a relative told us, "I asked if my relative could work on walking down the stairs. I asked if I could come in when the physio was here to talk to them about this. I came in and they explained to me that this was not a good idea as this had been tried and deemed risky". We spoke with a physiotherapy assistant and occupational therapist during the inspection and both confirmed the care staff worked well with them in order to meet people's needs. One healthcare professional told us, "Communication [between them and staff] is good and we have weekly meetings to discuss people's needs. Staff are great" and the occupational therapist told us, "We have constant dialogue with nurses and share information. We also gain insight from carers as well as to how people are doing. Communication is very good".

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 were cared for by staff who obtained their consent prior to supporting them and we observed this. One person said, "Yes, they [staff] ask for my permission before helping me. They're golden" and another person said, "They [staff] ask like when they put my feet up, they always ask". A relative told us, "They [staff] always ask consent" and another said, "They [person] make their own decisions but I can ask about their progress".

Staff had received training in MCA and DoLS and understood what it meant for people living at the home. One member of staff said, "[Person's name] has dementia, but they can still make decisions, they just sometimes get mixed up". The registered manager confirmed there was no one living at the home who required an application to deprive them of their liberty.

At our last inspection we noted that due to the amount of equipment that was being used in the home to support people, there was an issue about storage. We found at this inspection that a solution had been found to this problem and additional storage had been provided, whilst still ensuring people had access to the equipment they needed daily.

Good

Is the service caring?

Our findings

At the last inspection on 10 June 2016, we rated this key question as 'Good.' At this inspection the rating remains unchanged.

We received many positive comments from people regarding the kind and caring nature of staff. They included; "They [staff] are very respectful, can't fault them", "They ask how I am especially when they first see me for the day" and, "How they [staff] are with you, down to earth, you can have a laugh and joke with them". Other people told us how they felt reassured by being supported by staff who they could talk to if they were worried or upset. One person said, "Just them [staff] being there sometimes is enough" and another added, "I feel I can talk to them and they listen". Relatives were equally positive and told us staff were, "Very caring" and "They [staff] know my relative. They are as good as gold". We observed staff to present as kind and caring and noted a number of interactions between people living at the home and staff, that evidenced this. For example, we saw one person become upset when they received some news. A member of staff spoke kindly to the person and offered appropriate words of reassurance and support.

People and their relatives told us they were treated with dignity and respect and staff were able to describe to us how they maintained people's dignity whilst supporting them with their personal care, for example by ensuring curtains were closed and people were covered with a towel.

The nature of the service provided meant that the majority of the people living at the home were actively encouraged and supported to regain their independence and skills to allow them to return to the community and their own homes. One person told us, "Staff try to encourage me to do things on my own" and another said, "They [staff] do encourage me to do things, I couldn't at first but I do now". We observed staff encouraging people, and giving them the time to mobilise at their own pace. For example, we saw one person walking along the corridor. They told a member of staff, "I don't think I'll do much further" and the member of staff replied, "That's alright, you're doing well, let's get you a wheelchair". A relative confirmed their loved one was supported to regain their independence and added, "It's done quite well here, far better than when [person] was in hospital".

People told us they were involved in making decisions about their care and support. One person told us, "Yes I can make choices of what I want to do, I like to go to my room" and another person commented, "I usually like to get up at 8.00 am and they get me up at 8.00 am". Another person said, "They [staff] are quite respectful. They asked what I like to be called, I like the shortened version of my name and they do that". People told us staff respected their privacy and always knocked their bedroom door and waited for an answer before entering.

The provider told us in their Provider Information Return [PIR] that they would like to introduce a less formal information booklet to replace the current service user guide. We discussed this with the registered manager who told us this was a work in progress and they hoped to develop an additional guide for people who were being supported to regain their independence.

Staff were aware of how to access local advocacy services for people, should they require this type of support. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 10 June 2016, we rated this key question as 'Requires Improvement.' At this inspection the rating remains unchanged.

At our last inspection, the lack of activities for people to participate in was raised as an issue. At this inspection, some concerns remained in this area. People provided us with the following comments; "I think they [staff] know what I like to do. I like my embroideries", "I play bingo but I don't like colouring. How old am I?!", "There are activities. I like bingo and we are making window decorations for Halloween" but another person said, "I don't know what time it is, but I'm fed up of sitting here".

There was a lack of evidence that people had been invited to engage in activities they enjoyed taking part in. We saw that people were involved in creating Halloween decorations but some told the registered manager it was not an event they liked to celebrate. The registered manager told us after this conversation they were going to 'rethink' the plans around these celebrations and ask people what they would like to do instead. We saw the activities co-ordinator had left people with small pieces of paper cut out of a colouring book, to colour in. The paper was placed on small, low tables next to people which would have been difficult to use to lean on to colour the pictures in. The activities co-ordinator asked people why they hadn't done any colouring in and one person responded, "Well I don't really want to do that". We observed the activities co-ordinator did sit and engage in conversation with the person, asking them what they would like to do. In another lounge we later observed people were involved in a quiz, which many of them enjoyed taking part in. However, throughout the inspection, we saw many 'empty laps' and people sat with little or nothing to do to occupy them or help pass the time of day. The activities co-ordinator shared some information regarding activities that had taken place, such as art and crafts, or visits from the 'animal man' and celebrating the recent royal wedding. There was an activities newsletter that highlighted events that would be taking place but this was kept in the activities folder and was not on display for people to read.

At our last inspection, people told us they had not been involved in the planning of their care. Following the inspection, the provider sent us an action plan advising that 'every care plan is formulated with the involvement of the service user and/or their family'. There was inconsistent evidence in people's care files to demonstrate that people had been involved in the planning of their care and some plans lacked detail with regard to people's emotional and social needs. The registered manager had told us in their Provider Information Return [PIR] that they had plans for care staff to become involved in developing person centred care plans. They told us they were currently looking into this. One person said, "Yes, they have conversations to get to know us" and a relative said, "Yes they [staff] did a care plan, full assessment. I was a bit overwhelmed, so came back later and answered the rest of the questions. I have been going to them with regards to my relative's care and they have always been responsive". Staff told us as new people came into the home, they felt were provided with the information they needed to meet people's needs.

One person told us, "I'm ok. No complaints" and another said, "I have worked in homes in the past and was really worried about coming here but it is really good. I would go to the manager and have never made a complaint". Other people told us if they had any concerns they would raise them with staff or the registered

manager and were confident they would be dealt with. We saw there was a system in place to log and record any complaints received. We saw where one complaint had been received, it had been responded to and acted on appropriately. The registered manager told us, "We don't tend to get written complaints, we deal with any issues on the spot". We noted the service had received a number of thank you cards from relatives thanking staff for the care and support of their loved one. One person had written, "Thank you so much for all your kindness".

We were informed that no one at the service was currently receiving end of life care, but were told systems were in place to support this.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 10 June 2016, we rated this key question as 'Requires Improvement.' At this inspection the rating remains unchanged.

Following the last inspection, the provider forwarded to us an action plan to address a number of areas that required improvement across the home. During this inspection, despite assurances that action would be taken, we found a number of areas of improvement continued to be outstanding. We saw that allocation sheets highlighting roles and responsibilities on each shift had not been put in place. This had a direct impact on people at lunchtime, as the allocation of staff during this period was disorganised and many people were not served their meal in a timely manner. Care plans seen did not consistently demonstrate that people and/or their relatives were involved in the planning of their care which meant the registered manager could not be confident that people were receiving personalised care that was responsive to their needs. Accidents and incidents had not been analysed which meant opportunities to analyse information and learn lessons in order to reduce the risk to people, were lost.

There was a lack of effective systems and process in place that would provide the registered manager with oversight of the service and assurances that people were receiving safe and effective care. We saw the quality assurance systems in place were not effective and the provider had failed to identify key areas for improvement. For example, they had failed to identify the actions still outstanding from the action plan that had been sent through following the last inspection. Further, there were no records of staff competencies being checked to ensure staff were supporting people in line with their care plans and information was missing in some staff recruitment files.

We noted where audits had identified areas for improvement there was little or no evidence of action taken in response to the findings. We saw care plan audits had failed to identify inconsistencies and gaps in recordings in files. For example, we noted records stated that one person had put on four kilograms in weight in one month. This was recorded on their file, but at their review there was no acknowledgement of this weight gain, or questioning of it. We saw as a result of a falls management audit that action had been taken to reduce the risks to a person, but their care plan and risk assessment had not been updated to reflect this. We saw that the audit for pressure cushions had been completed and all had been signed off as 'fit for purpose'. However, when we looked at this with the registered manager, they told us they disagreed with the findings and informed us they had ordered six additional cushions due to wear and tear.
The registered manager told us it was the responsibility of the deputy to complete audits, but acknowledged they had no system in place to oversee the work the deputy was completing.

We saw a number of policies and procedures had not been updated and some of the information held in the service user guide was out of date, including the name of the deputy manager.

Staff described the registered manager as, "Supportive and approachable". They told us they were aware of the home's whistleblowing policy and told us that if they had concerns, they were confident they would be listened to. One member of staff said, "[Registered manager's name] is always available and you can have a

private chat. They are approachable". Staff spoke positively about working at the home and told us they would be happy to recommend it to others. One member of staff said, "Staff are friendly, we get along well, I like how the home is run and residents are treated. It's just a good place to work. I wouldn't want to work anywhere where I thought people were not being well treated". Other staff described their positive working relationship with colleagues and the deputy told us, "[Staff] are great, they are fully aware of what needs to be done and work together".

A member of staff said, "Since the last inspection it is much better. Staff address people when they go into the lounge, which is better and there have been improvements to the environment". Staff told us the provider visited the service often, adding, "We can contact them if we need anything and if there are any concerns they do follow it through". We saw improvements had been made to the environment such as new flooring and redecoration and were told plans were in place for work to continue.

The registered manager told us, "I'm confident staff are supporting people correctly from the feedback from service users". We saw surveys had been sent out to people earlier in the year to obtain their feedback on the service. We saw where individual responses had been received, actions were noted. For example, one question asked, 'do care staff help residents follow up activities and their own interests?" A person had responded 'not at all' and it was noted a conversation had taken place with them regarding their wish to attend an activity outside of the home. The registered manager told us, "Unfortunately, we had to explain they could not do this until they had been rehabilitated and were able to go home". We saw a survey had recently been sent to family members to obtain their views of the service.

The provider had recently notified us about events that they were required to by law and had on display the previous Care Quality Commission rating of the service.