Aegis Residential Care Homes Limited

Holly Bank Care Home

Inspection report

The Promenade
Arnside
Carnforth
Lancashire
LA5 0AA

Tel: 01524761277
Website: www.pearlcare.co.uk

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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?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 05 and 06 February 2018.

Holly Bank Care Home is a care home in Arnside. It is registered to care for up to 31 people assessed as needing residential care. The building comprises a pair of semi-detached Victorian villas that have been combined, adapted and extended for its current use as a care home. The home has three floors with a lift for access between floors. At the time of the inspection visit 23 people were receiving care and support at the home.

Holly Bank Care 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.

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

Holly Bank Care Home was last inspected December 2016 and was rated as requires improvement. During that inspection process we made recommendations in regards to staff training and requirements relating to the Mental Capacity Act.

We used this inspection visit carried out in February 2018 to check to see if the recommendations had been acted upon to ensure improvements had been made. We found some but not all improvements had been made. Work was on-going to ensure documentation maintained in relation to MCA reflected good practice. The registered provider had reviewed staff training and had invested in an on-line training package so that staff training could be provided and monitored. In addition staff had been provided with face to face training.

Although we noted some improvements we found staffing levels and deployment of staffing was not always effective to ensure the safe care of people who lived at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

We found recruitment procedures were not robust. Pre-employment checks had not been consistently carried out to ensure fit and proper people were employed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

We found that paperwork maintained by staff at the home was not always accurate, complete and up to date. Auditing systems implemented at the home were sometimes ineffective and had failed to pick up concerns we identified during the inspection process. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

Arrangements were in place for managing and administering medicines. However these were not always consistently carried out to ensure good practice guidelines were followed. We have made a recommendation about this.

People's healthcare needs were monitored and managed appropriately by the service. People told us guidance was sought from health professionals when appropriate. We saw evidence of partnership working with multi-disciplinary professionals to improve health outcomes for people who lived at the home.

People who lived at the home and relatives told us relationships with staff were sometimes limited due to staff not having time to respond to people's needs and due to communication barriers.

There was an emphasis on promoting independence for people who lived at the home.

Arrangements were in place to protect people from risk of abuse. Staff had knowledge of safeguarding procedures and were aware of their responsibilities for reporting any concerns.

We saw evidence risk was appropriately managed and addressed at the home. This included managing the risk of people falling and managing behaviours which can challenge a service.

Infection prevention and control processes were embedded into service delivery. People praised the standards of hygiene at the home.

End of life care had been discussed with people and their relatives. Provisions were in place to promote a dignified and pain free death.

Feedback was routinely sought. We saw feedback had been received through residents meetings and formal questionnaires.

Care plans were person centred and took the needs and considerations of the person into account. People who lived at the home said they were involved in the care planning process. People were asked to consent to having care and support provided. Care plans were reviewed and updated at regular intervals and information was sought from appropriate professionals as and when required.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff we spoke with were aware of the principles should someone require being deprived of their liberty. Good practice guidelines were consistently implemented to ensure all principles of the Mental Capacity Act (MCA) 2005, were lawfully respected.

People were happy with the variety, quality and choice of meals available to them. People's nutritional needs were addressed and monitored.

People were offered opportunities to carry out activities of their own choosing. Staff understood the importance of encouraging and motivating people to be active. Activities were person centred, innovative and creative.

People who lived at the home praised the living standards offered at the home. The home was described as a 'home from home.' Bedrooms had been personalised and individualised with people. Premises and equipment were appropriately maintained.

The registered manager was aware of their role and statutory responsibilities and demonstrated a commitment to continuous improvement at the home.

This is the third time the service has been rated as requires improvement.

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 sometimes safe.

People who lived at the home and relatives told us people were safe.

Staff were not suitably deployed to meet the needs of people who lived at the home.

Arrangements were in place for the safe management of medicines but these were not consistently followed.

Recruitment procedures were carried out to assess the suitability of staff. However checks were not always consistently carried out.

Infection prevention and control systems were implemented at the home.

Processes were in place to protect people from abuse. Staff were aware of their responsibilities in responding to abuse.

Risk was addressed and suitably managed within the home.

Is the service effective?

Good

The service was effective.

People's health needs were monitored and advice was sought from other health professionals, where appropriate.

People who lived at the home told us their nutritional and health needs were met.

Improvements had been made to ensure staff had access to ongoing training to meet the individual needs of people they supported.

Consideration had been taken to ensure the environment in which people were living met their needs.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and the relevance to their work.

Is the service caring?

Requires Improvement

The service was sometimes caring.

People and relatives told us that on the whole staff were kind and caring. However, relationships were sometimes restricted due to low staffing levels and communication barriers between staff and people.

We observed person centred care being delivered. People were treated with patience, dignity and respect.

The registered provider was working proactively to implement technology at the home to improve the care of people who lived at the home.

Is the service responsive?

Good

The service was responsive.

Records showed people were involved in making decisions about what was important to them. People's care needs were kept under review and staff responded quickly when people's needs changed.

The service had a complaints system to ensure all complaints were addressed and investigated in a timely manner.

There were a variety of activities offered to people who lived at the home.

End of life care was discussed with people and relatives. Processes were in place to promote a dignified and pain free death.

Is the service well-led?

Requires Improvement

The service was sometimes well led.

Relatives told us they considered the home to be appropriately managed.

Paperwork was not always accurate and up to date. Audits in place had failed to identify concerns we found during the inspection process.

Staff told us morale was sometimes low due to deployment of staffing and the increased workloads placed on staff.

The registered manager demonstrated a commitment to ensuring service delivery was based upon good practice guidelines.

The registered manager was aware of their statutory responsibilities.

Holly Bank Care Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 05 and 06 February 2018. The first day of the inspection was unannounced.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. We spoke with the Local Authority contracts teams, the Clinical Commissioning Groups responsible for commissioning care and Healthwatch. Healthwatch is a national independent champion for people who use healthcare services. We used the information provided to inform our inspection plan.

In addition, we reviewed information held upon our database in regards to the service. This included notifications submitted by the registered provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people. We also reviewed other feedback upon our database which had been provided to us. We used this information to inform our inspection plan.

We looked at information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us plan our inspection visit.

On the first day of the inspection visit, the inspection team consisted of one adult social care inspector 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 adult social care inspector returned alone on the second day to complete the inspection process.

Throughout the inspection visits we gathered information from a number of sources. We spoke with six

people who lived at the home, seven relatives and one visitor to seek their views on how the service was managed. In addition, we observed staff interactions with people in their care.

We also spoke with the registered manager, the area manager, four members of staff responsible for providing direct care, the activities coordinator and the cook. In addition, we spoke with a health care professional who was visiting the home during our inspection visit.

To gather information, we looked at a variety of records. This included care plan files related to six people who lived at the home and medicines administration records for people who lived at the home. We also looked at other information related to the management of the service. This included health and safety certification, auditing schedules, training records, team meeting minutes, policies and procedures, accidents and incidents records and maintenance schedules. We also viewed recruitment files and Disclosure and Barring Service (DBS) certificates relating to three staff members who had been employed since the last inspection visit.

In addition, we walked around the building to carry out a visual check. We did this to ensure required improvements had been made; and to ensure it was clean, hygienic and a safe place for people to live.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home and relatives told us people were safe. Feedback included, "I feel far too safe. I only use my walking frame for security." ` And, "Oh Yes, I do feel safe." Also, "If I did not believe my [relative] was safe I would not have brought them here."

As part of the inspection process we reviewed staffing levels at the home. We did this to ensure there were appropriate numbers of staff employed to meet the needs of people who lived at the home. On the first day of our inspection visit there was one senior on duty alongside two care staff. The registered manager informed us they were also supporting the team to provide care and support that morning.

We asked people who lived at the home if they thought there were enough staff on duty to meet their needs. Three of the four people we asked told us they considered the home to be understaffed. Feedback included, "They are very understaffed, by about 25% to 30%." And, "There is not enough staff here." Also, "It varies; sometimes there is only two members of staff on."

Four of the seven relatives we spoke with also spoke negatively about staffing levels. Feedback included, "I do not feel my (relative) is unsafe but I do think there is not enough staff." And, "At certain times you think, "Where is everyone?" Also, "Sometimes I find it difficult to find staff. They are rushed off their feet."

We asked staff their views on staffing levels. All staff we spoke with passed comment on the low staffing levels and the demands placed upon workloads. Three staff told us there had been a recent decrease in staffing levels. They said the home had been unable to recruit and the registered manager was no longer able to use agency staff at the home to bolster staffing levels. All staff told us they did not think staffing levels always met the needs of people who lived at the home. Feedback included, "We usually have one senior and three staff on duty, at the moment there's only a senior and two staff. If the senior is doing medicines that only leaves two staff and that's difficult. There is not enough hours in the day." Also, "At the moment it's been tight staff wise, we haven't time to deliver quality care."

We asked staff to give examples of when they had been unable to fulfil their tasks because of staffing levels. One staff member said, "There have been many times when we have been unable to answer call bells." Another staff member who was not responsible for delivering care said, "I am sometimes called upon to carry out tasks if the staff are busy." Another staff member said, "We have been allocated 30 minutes a day to complete training but it's not reasonable. It can't be done."

We spoke with the registered manager about staffing levels. They confirmed they did not have a full staff team at the home and were no longer able to use agency staff. They said they sometimes worked delivering care when staff required additional support. They said they were able to call upon staff providing activities or completing housekeeping tasks to assist if required. The registered manager said they sometimes used staff from another home if they were short staffed.

We asked the registered manager to clarify the support needs of people who lived at the home. They

clarified nineteen people who lived at the home required some type of support with four people requiring two staff for support. They confirmed only four people who lived at the home were independent.

We looked at the dependency tool used by the registered provider to calculate staffing levels. The form had not been completed correctly to indicate the needs of the individuals and how this correlated to support needs. The dependency calculator stated there should be three staff in the mornings, with one staff on activities, three staff in the afternoon and two staff during the night.

We reviewed four weeks rotas and noted that staffing levels did not always match those indicated within the staffing dependency calculator. Over a twenty day period we identified twelve occasions when staffing levels were lower than the stated levels on the staffing dependency calculator. There was no other evidence available on the rotas to show staffing voids had been filled.

As part of the inspection process we reviewed call bell times to check to see if call bells were answered in a timely manner. We found response times were variable ranging from one minute to seven minutes.

We asked people who lived at the home if they were happy with call bell response times. We received mixed feedback. Feedback included, "It can take anything from a couple of minutes up to an hour. It depends on the time of day and what they are doing." Also, "It depends on how busy they are – usually between 10 to 20 minutes." And, "Sometimes straight away, it depends on where they are in the building."

In addition we looked at staff deployment in communal areas. We found that at times, there was an absence of staff in communal areas. We identified occasions when there were no staff deployed to communal areas and people did not have ready access to call bells to summon help in an emergency.

The above matters demonstrate this was a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) 2014, as the registered provider had failed to ensure suitable numbers of staff were deployed at all times.

We looked at recruitment procedures to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed staff records for three staff employed at the home. We found suitable processes were not in place. All files we reviewed did not have full employment checks in place. For example, one member of staff had three unexplained gaps within their unemployment history. Another staff member had not given the full dates of employment and another person had not documented all reasons for the leaving their previous employment.

This was a breach of Regulation 19 of the Health and Social Care Act 2009 (Regulated Activities) 2014 as the registered provider had failed to ensure systems for recruiting staff were robust, risks were fully assessed and decisions documented to ensure the suitability of staff employed.

We looked at how medicines were managed at the home. People who lived at the home told us they received their medicines in a timely manner. We reviewed medicine and administration records (MAR) relating to each person who lived at the home. We did this to ensure people who lived at the home received the correct medicines at the correct times. MAR records demonstrated staff were signing as and when required to show medicines had been administered. There were no gaps in MAR sheets which indicated medicines had been administered accordingly.

We looked at how controlled drugs were managed within the home. Controlled drugs are subject by law to additional checks to ensure they are appropriately managed. We checked stocks of controlled drugs against

the MAR records and noted the medicines in stock matched the recorded balance. This indicated there was a suitable system in place for monitoring the usage of controlled drugs.

We spoke with staff responsible for administering medicines. They told us they received appropriate training to enable them to carry out the role. This included regular refresher training and competency checks.

We reviewed how medicines were stored. We found medicines were stored securely within a medicines trolley which was locked away when not in use. Whilst looking at how medicines were stored, we found good practice guidelines were not consistently followed. For example, we found one person's eye drops had not been discarded within the recommended time. In addition, staff did not always sign to show when medicines had been opened. It is important that dates of opening are placed on medicines so they can be discarded within the time frames set.

We recommend the registered manager reviews processes at the home to ensure practice consistently meets good practice guidelines.

We looked at how safeguarding procedures were managed by the service. We did this to ensure people were protected from any harm. The registered manager told us they were a nominated safeguarding champion for the home. Champions are individuals who take on additional training to promote effective working practices. Good practice information is then shared with other staff at the home so that good practices can be implemented. In order to ensure staff were supported and confident to raise safeguarding concerns the registered manager had developed a guide for staff to follow should they need to raise a safeguarding alert. The registered manager said, "I can't be here at all times. Staff need to know what to do." This showed us the registered manager took the reporting of safeguarding concerns seriously.

We spoke with staff. They told us they had received safeguarding training. They were able to describe different forms of abuse and were confident if they reported anything untoward the registered manager would take immediate action. One staff member said, "There is always someone I could confide in. I have confidence in the registered manager." In addition, staff understood the processes for reporting concerns externally if there was a need to do so.

We looked at how the service managed risk. Risks were addressed within people's care plans. A variety of risk assessments were in place. These included falls risk assessments and assessments for supporting people with personal care and health conditions. We saw action was sometimes taken when risks were presented. For example, positioning charts had been implemented when a person was at risk of developing a pressure ulcer.

Although risk was sometimes addressed within care plans we found risks were not always formally documented within the risk assessment. For example, we were informed by a staff member that one person was deemed at risk of choking and had to have a specific diet. They said a family member would sometimes offer the person foods which could present as a choking risk and for this reason had to be monitored. This was not made clear within the care plan and risk assessment. We brought this to the attention of the registered manager who took immediate action to ensure it was clearly documented.

We looked at how behaviours which challenged the service were managed. People at risk of displaying behaviours which challenged had support plans which reflected good practice guidance. We saw actions taken to manage the behaviours were the least restrictive and were discussed with health professionals with an expertise in managing such behaviours.

People who lived at the home praised the standards of cleanliness at the home. We looked around the home and found it was clean, tidy and maintained. The home employed a part time member of domestic staff to carry out cleaning tasks. In addition, the registered provider had an identified infection prevention and control (IPC) champion who ensured good practice guidance was followed within the home. The registered manager said the IPC champion carried out monthly audits of the home to ensure good practice was considered at all times. We saw infection prevention and control processes were considered at all times. This included prompting a person to wash their hands after they had used the bathroom.

We looked at accidents and incidents that had occurred at the home. The registered manager kept a record of all accidents and incidents. Accident reports were descriptive and showed actions taken after significant incidents. Monthly analysis of all accidents and incidents took place so lessons could be learned and improvements made to reduce the likelihood of accidents re-occurring. The registered manager told us they had reviewed accidents and incidents that had occurred in bedrooms and as a result the registered provider had purchased new beds which could be lowered to the ground. The registered manager said the purchase of these beds had resulted in a decrease in the number of falls within bedrooms. We looked at accidents and incident records and noted this was the case.

We looked at how fire safety was promoted at the home. We found suitable checks took place to maintain a safe environment. Personal evacuation plans were in place for all people who lived at the home and there was an up to date fire risk assessment.

We carried out a visual inspection of the home. We saw windows had restrictors on them and radiators were covered to minimise the risk of burns. During the inspection visit we checked taps had controls upon them to ensure water temperature was restricted to prevent scalds. We found one tap in an unused bedroom did not have a control upon it. This meant water running from the tap was hot and uncomfortable to touch. We highlighted this to the registered manager who agreed to take action.

We also looked at documentation relating to the health and safety of the home. All required certification was up to date, regular maintenance checks took place and comprehensive records were maintained.

Good

Is the service effective?

Our findings

All the people who lived at the home said they staff were knowledgeable about their healthcare needs and were assured these needs were consistently met. They told us doctors were on hand when required. One person said, "There is a doctor here every Friday and nursing staff nearly every day". Another person told us, "I can see a doctor whenever I want one."

Relatives we spoke with commended the ways in which their family member's health care needs had been addressed. Two relatives said they had seen an improvement in their family member's health since they moved into the home. One relative said, "My [family member] was living by himself but now they are here their medication is being managed properly, and regularly, which has improved their health."

We saw evidence of input from a variety of health and social care professionals in order to promote people's health. This included general practitioners, dietitians and community nursing teams. Individual care records showed health care needs were monitored and action taken to ensure optimal health was maintained. For example, staff had consulted with a district nursing team when one person was identified as being at risk from a pressure sore.

The registered manager said they had reviewed access to healthcare and had spoken with people who lived at the home about GP (doctor) access. As a result people had been supported and encouraged to register with one GP practice within the area. The GP surgery facilitated one open surgery at the home on a weekly basis so people with non-urgent ailments could be seen without leaving the home. The registered manager said this had improved health outcomes for people and promoted some consistency. They confirmed that should people not wish to participate in this, they still had the right to choose their own GP.

We saw good practice guidance was referred to and used when providing people with care and support. For example, we saw patient information stored within people's files advising how certain health conditions should be managed. This information promoted good health and enabled staff to be aware of the health condition.

We looked at how people's nutritional needs were met by the service. People who lived at the home gave us positive feedback about the food provided. Feedback included, "Most choices are 'A' or 'B' but if neither 'A' nor 'B' appeals, you can have sandwiches – which I do regularly." And, "You could never go hungry or thirsty because you can have anything you want - you just have to ask."

We observed lunch being served. We noted there was a relaxed atmosphere at lunchtime. The dining areas were pleasantly set to enhance the meal time experience. People had the opportunity of where they would like to eat meals. We observed people eating lunch in different areas around the home. One person decided they wanted to eat alone in the lounge. Staff accommodated this request. This showed us that staff worked flexibly to meet the needs of people who lived at the home.

Drinks and snacks were readily available throughout the day. One person told a member of staff they were

hungry and the staff member happily agreed to bring the person some food. Additionally there was a bowl of fruit available in a communal area. We observed people helping themselves to fruit from the bowl.

When people were at risk of malnourishment assessments were in place to monitor people's weights. In addition, referrals had been made to health professionals in a timely manner, for advice and guidance regarding weight management. This showed us that action was taken in a timely manner to ensure peoples diet and nutritional needs were met.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.
At the last inspection carried out in December 2016, we recommended the registered provider reviewed best interest decision making processes and consent processes at the home.

We looked at this inspection visit to see if recommendations had been acted upon. We found some improvements had been made for example, we saw best interest meetings had been held with relevant professionals when people lacked capacity. Documentation had been maintained to evidence the decision making process and the decision outcome. In addition, consideration had been made to ensure restrictions placed upon people were reviewed regularly to ensure they were the least restrictive option.

Although some improvements had been made we found care records lacked decision specific mental capacity assessments. We discussed this with the registered manager and the trainee manager. The trainee manager said they were planning to work with the registered provider to review all processes for documenting mental capacity assessments to ensure they were decision specific.

We spoke with the registered manager about the Deprivation of Liberty Standards. (DoLs.) The registered manager demonstrated a good understanding of DoLs and this was reflected in the organisations documentation processes. We saw applications had been made to deprive people of their liberty when restrictions were required within people's lives to keep them safe.

As part of the inspection process we reviewed the environment to ensure it was suitable for all people who lived at the home. We found some consideration had been taken to ensure the home was accessible and promoted independence for people. For example, toilet doors had been painted blue so they could be identifiable to people living with dementia.

At the last inspection visit we recommended the registered provider reviewed staff training to ensure staff received regular updates. We used this inspection process to see if recommendations had been acted upon. The registered manager told us the registered provider had invested in a new on line training system. In addition, they had reviewed the staff training requirements and were in the process of monitoring all staff training to ensure it was up to date. The registered manager said staff were being allocated 30 minutes each day to complete some of the training. This was being monitored by the area manager to ensure staff

completed their training in a timely manner.

In addition to on line training we were informed by the registered manager that training was also sought from professionals in a classroom environment. They told us they had recently received training from a health professional in relation to tissue viability. This showed us the registered manager was proactive at ensuring staff had the correct skills to promote good health.

Staff praised the training provided. One staff member said, "The training is good. I have done a refresher for moving and handling and infection control. We do a lot of on line training.

We looked to ensure staff were provided with a suitable induction at the outset of their employment. We spoke with a member of staff who had recently been recruited. They told us they undertook an induction period at the start of their employment. This involved completing on line mandatory training and shadowing more senior members of staff. They told us they were happy with the induction process and the support provided.

We spoke with staff about supervision. Staff confirmed they received supervision from the registered manager. We looked at supervision records and noted any concerns about staff performance was openly discussed and addressed within supervisions. This showed us that staff were appropriately supported by a senior member of staff within their employment.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from people about the staff who worked at the home. Feedback included, "In general terms, yes staff are caring." And, "The majority of them are caring." Also, "Generally here the staff are very caring." And, "Some more than others." And, "I pick my moments as to which staff I ask– some of the staff are extremely helpful. Some it appears far too much trouble! I have had them walk away in the middle of a sentence".

We spoke with relatives to see if they considered the staff caring. We received mixed feedback. Feedback included, "Generally here the staff are very caring." Also, "Every member of staff is friendly." And, "The staff are very friendly, supportive and caring."

We asked a visiting health professional their opinions of the care team. They told us staff really cared about people who lived at the home but said relationships were limited because of the workloads staff faced. This was also reflected by two relatives. They told us positive relationships were sometimes hindered by the lack of staff available. Feedback included, "I do not think they have time to talk to people as they are always on the go." And, "There are different levels. The staff here are task orientated and do not think at a lower level to give my [family member] a better quality of life."

People who lived at the home told us communication with staff was sometimes difficult. They told us there were a number of staff who worked at the home who did not have English as their first language. People said this sometimes posed problems as there was a breakdown in communication. On the first day of inspection we observed a person trying to communicate with a staff member. The member of staff could not understand what the person was trying to say and simply smiled at the person and disregarded what they were saying. The person looked frustrated at trying to communicate and then looked disheartened when the staff member changed the subject. We highlighted this to the registered manager. They told us the person had only recently moved into the home and staff were not yet fully aware of their needs. They agreed to provide the staff member with more training so they could improve their communication skills.

The registered provider considered people's spiritual beliefs and ensured these were addressed as part of the service provision. On the second day of the inspection visit we noted a visitor from a local church was attending the home to offer holy communion to two people. In addition, they told us a priest visited the home on a monthly basis. The registered manager said they would also support people to attend places of worship if they requested this. This demonstrated people's spiritual needs were addressed and met.

We observed staff responding to people when they were in need. We observed staff bringing a person a blanket when they said they were feeling cold. The person thanked the staff for the blanket.

During the inspection visit we observed one person talking to a staff member. The person spoke fondly of the member of staff. They said, "Oh you are nice. I love getting hugs off people like this. I've thought about you all night."

We looked at how equality and diversity was achieved at the home. The registered manager said they had an equal opportunities policy. In addition staff were expected to complete equality and diversity training. When asked staff were able to tell us how they would ensure people's rights and beliefs would be supported and promoted.

Staff had an understanding of protecting and respecting people's human rights. They were aware of the importance of respecting each person as an individual whilst promoting dignity and respect. People who lived at the home told us they were treated with dignity and respect at all times. On one occasion we observed a person leaving a bathroom with their dignity compromised. Staff swiftly responded and supported the person back into the bathroom to protect their dignity.

We observed staff promoting and encouraging independence. For example, people were encouraged to choose what they would like to eat at meal times. Staff brought people different foods to act as a visual prompt so people could choose what they would like to eat. Staff were patient when people could not make up their minds what they would like. We noted some written positive feedback from one health professional. They commended the ways in which staff had considered and promoted one person's independence.

We observed staff laughing and joking with people who lived at the home. On one occasion we saw a staff member responding to a person who said they had not had any breakfast. (The person had forgotten they had just eaten.) The staff laughed and joked with the person and said, "Oh you have hollow legs!" The person laughed at this comment. One relative told us staffs sense of humour promoted a good relationship with their family member. They said, "Staff have a good sense of humour and [family member] responds to this."

When people required support with decision making we saw evidence of advocacy services being accessed. This showed us the registered provider was aware of the importance of empowering people and promoting people's voice.

People who lived at the home and relatives consistently described the home as welcoming and home like. People looked comfortable in their surroundings. We observed one person lying on a settee with a blanket over them. We saw that people had been able to personalise their rooms with their own belongings to make their rooms homely and comfortable.

During the inspection visits we observed visitors at the home. Relatives were able to access communal areas and family member's bedrooms. They told us they were welcomed at the home. One relative said, "The home is very welcoming."

Good

Is the service responsive?

Our findings

People who lived at the home told us they had a care plan which detailed their needs and told us they were involved in developing it. Feedback included, "I have a care plan and the staff are always asking me questions about it." Also, ""I have agreed my care plan and it is due to be reviewed soon."

We looked at care records relating to six people who lived at the home. We saw evidence pre-assessment checks took place prior to a service being provided. One relative praised the pre-assessment process. They said, "[Registered Manager] asked all the right questions." We found care records were person centred and contained detailed information surrounding people's likes, preferences and daily routines. For example, one person had a care plan which detailed their night time routine which included their preferences.

Care plans were detailed, up to date and addressed a number of topics including managing health conditions, personal hygiene, diet and nutrition needs and hobbies and interests. Care plans detailed people's own abilities as a means to promote independence. Professionals were involved wherever appropriate, in developing the care plan. We saw evidence records were updated when people's needs changed.

We saw evidence peoples consent was sought throughout the care planning process. When people had refused to sign to give consent this was documented with a reason as to why they had refused to sign. This demonstrated the registered provider was aware for the need to try to gain consent from people in order to provide care and support.

During the inspection visit we were shown a new electronic care planning system that had been recently introduced at the home. The registered manager was in the process of transferring all care plans into the new electronic system. In addition to developing electronic care plans, the system worked using mobile technology which staff carried upon them at all times. Every interaction with each resident was to be inputted onto the system at point of delivery. This enabled the manager to have access to real time data evidencing what care and support had been provided that day.

The registered manager said the real time data could be supplied securely to other health professionals who may need access to the information, such as GP's or hospitals. They said in addition, if relatives had Lasting Power of Attorney for people's health and welfare they could also access the information to see what care and support had been provided. This demonstrated the registered provider was working proactively with technology to improve health outcomes for people who lived at the home.

We looked at activities on offer at the home to ensure people were offered appropriate stimulation throughout the day. An activities coordinator was employed to work four days a week. They told us they supported people to carry out activities with people who lived at the home.

On the first day of inspection we observed people taking part in a game of bingo and a quiz. People responded positively to the activities provided. We also reviewed an activities file which the activities

coordinator maintained. We saw that people had taken part in creative and varied activities. Consideration had been taken to people's likes and dislikes. We saw evidence of people participating in arts and crafts, dancing, cake making and flower arranging. In addition, local schools had visited people who lived at the home and entertained them. One person had commented on the positive effect this had had upon their well-being. This demonstrated activities were provided which met people's individual preferences.

Technology had also been utilised within the home to entertain people. We saw a photo of a person wearing a virtual reality headset. The activities coordinator explained they had supported people to experience what it felt like being on a rollercoaster. This showed us that activities were sometimes innovative. In addition, a relative told us the home had Wi-Fi fitted. This had been used to enable the family to use technology to keep in touch with their relative and allow them to participate in significant events from the comfort of the home. The relative said, "They have Wi-Fi, so we facetimed for their birthday." This demonstrated the registered provider used technology to maintain important relationships and reduce the risk of social isolation.

The activities coordinator said they encouraged the people to be active citizens within their communities. People had raised monies for other charities and the local radio station had visited the home on one fundraising occasion. This demonstrated that people were encouraged to be part of the wider community.

As part of the inspection process we looked at how complaints were managed by the registered provider. We saw there was a complaint policy and suggestions box in the main entrance where people could post any concerns.

People who lived at the home were aware of their rights to raise complaints and were aware of who was responsible for dealing with complaints. Feedback included, "I am a person who voices their opinions. I have complained and the staff reacted straight away and sorted things out." Also, "Yes I do know how to complain but I have never had to."

We spoke with the registered manager about complaints. They confirmed they had received one formal complaint since the last inspection visit. We looked at documentation surrounding the complaint and noted the registered provider had taken action upon receipt of the complaint to ensure things were corrected. As part of the inspection process we spoke with the relative who had raised the complaint. They told us they were happy with the way in which the complaint was handled. This demonstrated the registered provider took complaints seriously and acted positively on receipt of complaints.

We reviewed systems for end of life care for people who lived at the home. Care plans sometimes included peoples and relative's final wishes as to how they wished to be supported and cared for in the latter stages of their life. The registered manager said they supported people at the end of their life in partnership with the district nursing team to ensure end of life care needs were met. We spoke with one relative whose family member had passed away at Holly Bank Care Home. They said, "My [family member] died here. We were both here when it happened. It was very special. They set up a palliative care package." This showed us the registered provider was supportive in ensuring people had a comfortable and dignified death.

Requires Improvement

Is the service well-led?

Our findings

People who lived at the home were aware of who managed the home. Feedback included, ""I do see the manager often - she comes round when she can." And, "I know who the manager is; they sometimes do my medication for me."

Relatives told us they considered the home to be well-led. We were informed, "The home is well managed." And, "[Registered manager] is a good manager." Also, "I will not have a bad thing said about this home."

Although relatives considered the home well-led during our inspection visit carried out in February 2018, we identified some shortfalls in the way the home was managed. We found paperwork was sometimes inaccurate, out of date and incomplete. For example, on the first day of the inspection visit we found positioning charts for one person had not been consistently completed. Another person's care plan did not have all risks documented within it. In addition, DNAR forms for two people had expired and had not been identified by the registered provider until we pointed this out. Also, personal evacuation plans had not been updated when people's needs had changed. We fed these concerns back to the registered manager at the end of the first day. The registered manager said, "We have already acknowledged that paperwork needs an overhaul." The registered manager took immediate action to remedy these concerns and all required information had been updated by our second visit.

The registered manager stated the new care planning system which was in the process of being implemented would automatically highlight some of these concerns and would prompt actions for staff to complete. They said they hoped the new system would improve documentation and said they envisaged having this in place by the end of March 2018.

We looked at auditing systems in place at the home. Auditing systems are an important aspect of good governance as they allow services to monitor their effectiveness. We saw there was an auditing system in place which included auditing accidents and incidents, falls and care plans. Although auditing systems were in place, audits had failed to identify the concerns we picked up during the inspection process. For example, concerns with recruitment processes and the accuracy of documentation.

We spoke with the registered manager about the frequency of auditing of care records. The registered manager told us care records were audited monthly be the staff member responsible for updating the care plan and were reviewed at least once every three months by a manager. However, it was documented within a quarterly management review that care records had not been audited during the period July 2017 to September 2017, 'due to lack of staff on the floor.'

The above matters demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure a robust process was implemented to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

We spoke with staff who worked at the home. We received mixed feedback about the morale at the home. Whilst staff said team work was good, staff members said they were concerned about staff turnover and the heavy workloads placed upon them. They said this sometimes impacted upon the quality of care delivered. We fed this back to the Registered Manager. They told us they were having a meeting with senior managers and would report this back. They said they had agreed in the interim period not to admit any more people to the home.

Staff spoke positively about the skills of the registered manager. They described them as caring and approachable. All staff said they had confidence in the registered manager.

Staff told us team meetings took place. They said they could contribute to team meetings. We looked at minutes of a team meeting that had taken place and noted a variety of topics were addressed to ensure the smooth running of the home. The registered manager said they often held impromptu meetings with the team if the home was quiet. They said this often worked better as staff learned more in an informal environment.

We saw evidence of partnership working. The registered manager attended internal manager meetings with other managers within the company to discuss concerns and share ideas. Additionally, they said they also networked with other providers and within forums to ensure good practice was considered and implemented at the home. The registered manager said they had volunteered to take part in pilot projects such as the safeguarding champion's project and a pilot regarding managing continence. The registered manager said they valued these meetings as it allowed managers to come together to learn new things. This showed us the registered manager was committed to continuous improvement.

We looked at how the registered provider engaged with people who lived at the home and their relatives. Although people told us they were not encouraged to provide feedback we saw the home carried out regular residents meetings where people could express their views. In addition, we were informed by the registered manager people could be involved in recruiting new staff. This demonstrated people were invited to give feedback and influence the service provided.

The registered manager said feedback was sought from people every two months. They said questionnaires were sent out randomly to people who lived at the home and relatives. We reviewed feedback received between September 2017 and November 2017 and noted comments received were mainly positive. Feedback included, "We always find staff welcoming and helpful." And "Even when staff were always busy they were pleasant and caring."

We looked at compliments received at the home since the last inspection visit. Compliments had been received in relation to the high quality care provided. One family had commented, They never lost their cheerful smile and their interest in what was happening around them was due to your kindfulness (sic) and thoughtfulness in looking after them."

We asked the registered manager what improvements had been made since the last inspection visit. They told us that as well as investments in training and technology, the registered provider had made improvements within the building. This had included updating the fire alarm, repairing the lift and on-going refurbishments within the building.

As part of the inspection process we looked to ensure the registered provider had their performance assessment on view as set out in the 2008 Health and Social Care Act. We saw the performance assessment was on view as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to ensure a robust process was implemented to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. 17 (1) (2) A

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to ensure recruitment procedures were established and operated effectively to ensure fit and proper persons were employed 19 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure appropriate numbers of staff were suitably deployed to meet the needs of people who lived at the home. 18 (1)