The Hollies Nursing And Residential Home Limited

Hollies Nursing and Residential Home Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 22 and 23 January 2018. The first day of the inspection was unannounced. The service was last inspected in February 2016 when it was rated Good.

Hollies Nursing and Residential Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home is a large detached property and accommodates up to 39 older people on two floors. At the time of the inspection there were 31 people accommodated in the home.

At the time of this inspection the home did not have 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 who was in post at the time of the last inspection had left the home in January 2018. A new manager had been in post for four weeks but they had not yet submitted an application to register with CQC.

During this inspection we identified three breaches of regulations. These were in relation to the management of medicines, recruitment procedures and systems to monitor the quality and safety of the service. This is the first time the service has been rated as Requires Improvement.

We found one of the rooms used to store people's medicines was not clean. Another room used was not fit for purpose and people's medicines were accessible to non-trained staff. There were no photographs or allergies noted on the medicines administration records for four people; this meant there was a risk people might be given medicines which were not prescribed for them or unsafe for them to take. Staff told us they had not done any recent training in the safe handling of medicines.

We found one person had been appointed to work at the Hollies without completing an application form. Another person's application form only documented employment details for the previous 10 years. This meant the provider had been unable to verify people's full employment history.

Although there were systems in place to monitor the quality and safety of the service these had not been sufficiently robust; this had led to some of the shortfalls we identified during this inspection. Some audits had not been completed for several months. Completed audits did not clearly identify who was responsible for addressing any required actions.

We received mixed feedback from people about staffing levels in the home. Staff told us they rarely had time to sit and spend meaningful time with people who lived in the home. Senior staff told us that the increasingly complex needs of people who lived in the home was placing a strain on them due to the

additional responsibilities they had for the completion of paperwork, administration of medicines and contact with health professionals. A visiting health professional told us they were concerned about staffing levels in the home. They told us there was a lack of continuity of care due to the reliance on agency nurses.

We have therefore recommended the provider ensures that a recognised tool is introduced to determine how many staff are required on each shift to safely meet the needs of people accommodated in the home.

During the inspection we noted poor practice in relation to health and safety and infection control, with cleaning equipment/signs left in corridors, drinks bottles on handrails and uncovered clean incontinence pads on trolleys. We also noted the door to the sluice was unlocked. This meant cleaning materials were accessible to anyone who entered. In addition, arrangements in the laundry room did not easily support best practice in infection control measures. The manager told us they considered infection control was a key area which required improvement.

We found people's care records did not always identify their wishes and preferences in relation to how their care needs should be met. Although care plans had been regularly reviewed, it was not always easy to find the most up to date information. This was because staff did not routinely rewrite care plans when people's needs changed.

Staff spoken with told us that, with the exception of medicines administration and first aid, they were up to date with all required training. The manager told us that since she had started work at the service, the staff training matrix had been updated and training sessions booked in February and March 2018 with an external provider. We looked at the list of training sessions booked and noted it included fire awareness, dignity in care, food hygiene, moving and handling as well as dementia awareness. Staff told us they were aware that the manager was arranging training for everyone.

Staff had received training in the Mental Capacity Act (MCA) 2005. They were able to tell us how they supported people to make their own decisions and choices, wherever possible. The manager was aware of their responsibility under the MCA and the Deprivation of Liberty Safeguards (DoLS) to ensure that people's rights were considered and protected. Nine applications had been submitted to authorise the care arrangements for people who were unable to consent to their care in the Hollies; two of these applications had been authorised by the local authority.

People told us they felt safe living in the Hollies and had not experienced any discrimination. Staff had received training in safeguarding adults and knew the correct action to take to protect people from abuse.

People's health and communication needs were clearly documented within their care records. Staff worked in partnership with a number of health professionals to help ensure people had access to appropriate healthcare services.

We were told there was an on-going plan of refurbishment in the home, including the redecoration of some bedrooms and upgrading bathrooms. We were shown a set of plans to improve the environment to make it more appropriate to the needs of people living with a dementia.

Staff spoken with demonstrated a good understanding of people's diverse needs and preferences. People told us staff were kind, caring and responsive to their needs. They told us staff always respected their dignity and privacy when providing care.

People had opportunities to comment on the care they received. People spoken with told us they were

aware of the complaints procedure, although they had not been required to use it. They told us they were confident action would be taken should they have cause to raise any concerns.

People told us they were satisfied with the range of activities provided. The manager told us they were currently in the process of recruiting two activity coordinators so that activities could be provided seven days a week.

The majority of staff spoken with told us they enjoyed working in the home. They told us they had found the new manager to be approachable and were confident that they would improve how the home was run. During the inspection we found the manager to be committed to service improvements as well as transparent about the shortfalls they had identified since they commenced employment at the home.

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 told us they had no concerns about their safety in the home.

Improvements needed to be made to the way medicines were handled in the home.

We received mixed feedback about staffing levels in the home. Staff told us they did not have time to spend with people other than when providing care.

Recruitment processes needed to be improved.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Action needed to be taken to ensure care records reflected people's wishes in relation to their preferred daily routines and how they wanted their care needs to be met.

Some staff had not completed recent medicines management or first aid training.

Staff worked in partnership with healthcare professionals and people had access to a range of services to help ensure their health needs were met.

Is the service caring?

Good

The service was caring.

People were complimentary about staff. People who lived in the home told us staff always respected their dignity and privacy when providing care.

Staff demonstrated a good understanding of people's diverse needs, wishes and preferences.

Is the service responsive?

Good

The service was responsive.

People told us staff were always responsive to their needs.

A range of activities were provided in the home to help promote people's sense of well-being.

People had opportunities to provide feedback on the care they received. Any complaints were fully investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although there was a manager in place, they had joined the home less than a month prior to the inspection. They had begun to identify where improvements were necessary and had a plan to address these.

Most staff spoken with told us they were confident that the new manager would improve the way the home was run.

The systems in place to monitor the quality and safety of the service were not sufficiently robust. This had led to the shortfalls identified during this inspection.

Hollies Nursing and Residential Home Limited

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 22 and 23 January 2018; the first day of the inspection was unannounced. The inspection team on 22 January 2018 comprised of one adult social care inspector, a specialist advisor in the care of people living with dementia 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. One adult social care inspector returned on 23 January 2018 to undertake the final day of the inspection.

In preparation for our visit we contacted Healthwatch, the local authority contracting unit and safeguarding team for feedback and checked the information we held about the service and the provider. This included statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

When planning the inspection we used 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.

During our inspection, we spent time in communal areas observing how staff provided support for people to help us better understand their experiences of the care they received.

During the inspection, we spoke with six people who lived in the home, four visiting relatives/friends, the manager, two of the directors of the company which owned the service, a registered nurse employed by the home, the administrator, the chef and four members of care staff. We also spoke with a visiting healthcare

professional and a fire safety consultant who had been commissioned by the service to produce a fire risk assessment.

We had a tour of the premises and looked at a range of documents and written records including a detailed examination of five people's care files, the medicines administration records (MARs) for nine people, five staff personnel files and staff training records. We also looked at a sample of policies and procedures, complaints records, accident and incident documentation, meeting minutes and records relating to the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found medicines were not safely handled. At our inspection in February 2016 we had identified a lack of records to demonstrate that all staff responsible for the administration of medicines had received appropriate training. At that time, we were told training was planned and would be followed by checks on practice to ensure staff were competent to administer medicines. Staff spoken with during this inspection told us they had still not received any training in the safe handling of medicines. One staff member commented, "I have not received medication training for over five years. I mentioned it to the previous manager but nothing happened." We also could not find evidence that any competency checks had been carried out to check staff practice since the last inspection. When we spoke with the new manager they told us they had already highlighted the administration of medicines as an area which required improvement. As a result they had arranged a date for staff to complete training in medicines administration. They confirmed medicines competency assessments would be carried out following this training.

We asked to see a copy of the medicines policy used by staff in the home. However, we were told this could not be found. This meant staff did not have access to guidance to ensure they were handling medicines correctly. We also found there were no protocols in place to guide staff when people were prescribed medicines on an 'as required' basis.

We looked at the medication administration record (MAR) charts for nine people. We saw that four people's MAR charts did not contain a photo or any record of allergies to which they were susceptible; this meant there was a risk that people would be given the incorrect medicines or medicines which might cause them harm. We also noted two people's MAR charts had a number of missing signatures. When we checked the stock of medicines held for these two people, we found these did not correspond with MAR charts; this meant we could not be certain people had received their medicines as prescribed. In addition, one person's records showed that staff had not given the prescribed amount of a laxative on 15 occasions. There was no evidence that this change in dose had been discussed with the person's GP which meant there was a risk the person's health could have been adversely affected.

Two people's care records indicated a medicine prescribed in capsule form was sometimes opened and given in drink. We did not see any assessments as to whether the people concerned were able to consent to this arrangement. We also found there were no risk assessments in place to help keep people safe when medicines were administered in this way.

We looked at the arrangements in place for the storage of medicines. We saw that a clinic room was used by nursing staff. However, this room was not clean as we noted there were cobwebs on the wall close to the ceiling. We noted there was a cleaning schedule in place for the room, although this did not include any high level cleaning. However, this had not been fully completed for a number of weeks.

We checked the storage of controlled drugs in the clinic room; these are medicines which require additional safeguards to be in place due to the risk of misuse. We saw the controlled drugs book was properly

completed. We checked the stock of two controlled drugs and found these corresponded accurately with the register. However, we found the lock on the cupboard in which the controlled drugs storage unit was kept was not functioning correctly; this was rectified by the provider before the end of the inspection.

We were told that medicines for people who did not require nursing care were kept in a room which had previously been used as a lounge on the top floor of the home. This room was locked but we were told it contained records which needed to be accessed by the administrator. Within the room, we saw a large amount of medicines which were due to be returned to the dispensing pharmacist, although the details of these medicines had not yet been entered into the returns book; this meant there was a risk medicines could be inappropriately removed without any audit trail record being maintained. There was also a small cupboard used to store stocks of medicines which was not locked or fixed to the wall, as required under current guidelines. A lockable fridge was in the room to store some medicines but we noted the key was not removed; this meant it was accessible to anyone who entered the room. In addition, no record was kept of the temperature of the room; this is important to ensure medicines are stored at correct temperatures.

The manager told us they were considering the introduction of individual locked medicine cupboards people's rooms to help address the lack of appropriate storage facilities in the home.

There was a lack of appropriate arrangements to help ensure the safe handling of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the systems in place to ensure staff were safely recruited. We looked at the recruitment files for five staff. All files contained at least two references and an enhanced check carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. In addition, procedures were in place to ensure nurses employed in the home were appropriately registered with the Nursing and Midwifery Council (NMC).

We found one of the personnel files we reviewed did not contain a completed application form; this meant the manager had not been able to check the employment history of the person or the reasons for leaving their previous employer. Another staff file only contained employment records for the past 10 years, rather than a full employment history. The current regulations require employers to gain a full employment history together with a satisfactory explanation of any gaps. The lack of documented evidence to support this process meant people who used the service might be placed at risk from unsuitable staff. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with during the inspection told us they felt safe in the home. Comments people made included, "Yes, the place is safe enough", "Yes, it's very nice; the staff look after you" and "I feel safe and cared for."

We saw that there were policies and procedures in place to protect people using the service from the risks of abuse and avoidable harm. Records confirmed that staff had received training on safeguarding adults from abuse. When we spoke with staff they demonstrated their understanding of the types of abuse that could occur and the signs they would look for. They were also aware of the action to take if they thought someone was at risk of abuse, including external agencies they could contact if they considered their concerns had not been addressed by the manager. A staff member told us, "I always body map any injuries which occur and also inform families as well as reporting to the manager."

We received mixed feedback about staffing levels from people who lived in the home and their visitors. Nine

people told us there were always enough staff on duty. Three people commented that they were sometimes concerned about staffing levels at night and at weekends. In addition to these comments, all of the staff we spoke with told us felt at least one more staff member should be on the rota each day. They told us they rarely had time to sit and spend meaningful time with people who lived in the home. During both days of the inspection, two senior staff told us they had worked until the afternoon without a break. We were advised that the increasingly complex needs of people who lived in the home was placing a strain on senior staff who had additional responsibilities for the completion of paperwork, administration of medicines and contact with health professionals.

The manager told us they were aware that sickness levels had been an issue at weekends. They advised us plans were in place to recruit additional bank staff who could cover for sickness and holidays. They had also been using agency nurses due to difficulty in recruiting nurses on a permanent basis. As the manager had only recently joined the service, they told us they were still in the process of reviewing the dependency levels of people who lived in the home to help ensure appropriate staffing was in place. We noted that, at the last inspection, the previous registered manager had told us they would look into introducing a recognised staffing tool to help determine required number of staff but there was no evidence that this had been done.

A visiting health professional told us they were concerned about staffing levels in the home and also a lack of continuity of care due to the reliance on agency nurses.

We therefore recommend the provider ensures that a recognised tool is introduced to determine how many staff are required on each shift.

We looked at how the service managed risk. Individual risks had been identified in people's care plans and kept under review. Records were kept of any accidents and incidents that had taken place at the service. This information was reviewed on a monthly basis to check for any patterns or trends. Staff told us they had also received additional training on how to keep people safe that included moving and handling, the use of equipment, fire safety and infection control.

People spoken with told us the home was clean. This was supported by our observations during the inspection, with the exception of the clinic room. However, we noted poor practice in relation to health and safety and infection control, with cleaning equipment/signs left in corridors, drinks bottles on handrails and uncovered clean incontinence pads on trolleys. We also noted the door to the sluice was unlocked. This meant cleaning materials were accessible to anyone who entered. In addition, arrangements in the laundry room did not easily support best practice in infection control measures. The manager told us they considered infection control was a key area which required improvement. In order to support this process, following the inspection we made a referral to the local authority infection prevention team to request an audit visit and more specialist advice. The manager was in support of this referral being made.

With the exception of wheelchair checks, records we reviewed showed that the equipment used within the Hollies was serviced and maintained in accordance with the manufacturers' instructions. We saw that regular maintenance checks were carried out and action taken where necessary to address any issues found. We spoke with the director responsible for maintenance in the home who told us they would ensure wheelchair checks were included in the monthly checklist.

During the inspection we spoke with a fire safety consultant who had been commissioned by the home to carry out a fire risk assessment. They told us that, apart from a few minor signage changes which were required, they had no concerns regarding the fire safety arrangements in place.

We asked to see the business continuity plan in place; this document should advise staff of the correct procedure to follow in the event of utility failures or other emergencies that could affect the provision of care. The document we were shown included information about emergencies relating to the failure of gas or electric. However, there were no details about how staff should keep people safe in the event of a lift breakdown, staffing difficulties or flood. The director responsible for maintenance told us the document would be updated as a matter of urgency.

Requires Improvement

Is the service effective?

Our findings

We checked the systems in place to help ensure staff were properly trained and supported. Prior to the inspection, we had received feedback from the local authority contract monitoring team and the clinical commissioning group that their visits had shown the required number of staff had not received training in core areas, including infection control, first aid and health and safety. The manager told us that since she had started work at the service, the staff training matrix had been updated and training sessions booked in February and March 2018 with an external provider. We looked at the list of training sessions booked and noted it included fire awareness, dignity in care, food hygiene, moving and handling as well as dementia awareness. A separate medicines administration training session had also been arranged.

Staff spoken with told us that, with the exception of medication administration and first aid, they were up to date with all required training. The training matrix clearly identified when training had been completed and dates refresher training was due. Staff told us they were aware that the manager was arranging training for everyone. One staff member commented, "We have had a lot of training recently. The trainer who comes in is good and the training is interesting and informative."

Although staff told us they had not received regular supervision since the last inspection, records we reviewed showed most staff had received an appraisal of their performance in November 2017. We saw the appraisal process had been used to discuss required training for staff. The manager told us they were in the process of compiling a matrix to record dates when they held supervision meetings with staff; this should help to ensure all staff received supervision at regular intervals.

All the staff we spoke with during the inspection had been employed at the home for a number of years. We therefore looked at records to check what induction procedures were in place for new staff. We saw that new staff completed an induction period during which they were supported by a more experienced staff member. During this period new staff were informed about the routines, practices and policies of the home. In addition, a more detailed induction was in place for nurses employed by the home. Agency nurses employed to cover gaps on the rota were required to sign a document to say they had been informed of people's needs and were also aware of fire safety procedures in the home.

We looked at how the service addressed people's mental capacity. 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 authorisation 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.

Records we reviewed showed that nine applications had been made for people's care arrangements to be authorised under DoLS and that two of these had been authorised. We checked the care records for one of the people where there was a DoLS authorisation in place. We noted there was a care plan in relation to the MCA which advised staff that they must act in the person's best interests when making decisions about the person's care needs and that care must be carried out in the least restrictive way; this was in line with the principles of the MCA.

Staff told us that, wherever possible, they supported people to make decisions about how they wished their care to be provided. This was confirmed by our conversations with people who lived in the home. They told us staff always respected their rights and preferences. Comments people made to us included, "They [staff] always say 'do you mind if we help you with this?'", "I have choices yes; the- only restriction is that you can't go into other people's bedrooms" and "I have a bed bath every two to three days which is my choice."

Records we reviewed showed an assessment was completed before people moved into the home. This assessment was then used to formulate a draft care plan. Once people were settled in the home, more detailed care plans were then drawn up to address how their needs should be met. We noted care plans were reviewed on a monthly basis and any changes documented on the care plan evaluation sheet. However, staff did not routinely re-write care plans when a person's needs changed; this meant it could be difficult to find the most up to date information. In addition, care plans lacked detail about people's wishes and preferences about their daily routines and how they wanted their care needs to be met. In particular, we noticed a number of bedroom doors were propped open during the day; this meant people visiting the home were able to see people who were asleep or resting in their bedrooms. When asked, staff were unsure as to whether people had consented to this arrangement. We were also unable to find any evidence in care records that people affected by this practice had been asked for their consent, or if a best interest decision had been made that the arrangement was necessary to monitor the condition of certain individuals. The manager told us they would take action to improve the content of care records to include people's preferred routines.

We looked at how the service supported people with eating and drinking. Care records included information about people's dietary needs and risk assessments were in place to address any concerns about a person's nutrition or hydration. We noted that referrals had been made to dieticians and speech and language teams (SALT) for specialist advice as necessary.

We noted one person's care records stated they should be weighed weekly. As this person was cared for in bed, their weight could only be monitored by using a weighing hoist. The records documented that this hoist was kept at another home, owned by the providers, and it had therefore been impossible to weigh the person on a weekly basis. When we discussed this with the manager they told us they had already taken action to order a weighing hoist for the home.

People told us the quality of food in the Hollies was good. Comments people made included, "The food is good – A1. There is always a lot of choice. The chef is very good and will make you something else if you don't like what's on" and "I enjoyed my lunch today. We can get food and drink anytime." We saw that in the most recent residents meeting, people had commented positively about the fact they were able to have a cooked breakfast every day of the week if they wished.

We observed the lunch time experience on the first day of the inspection. We noted care staff were calm, supportive, and respectful and tried to offer different alternatives when people didn't want the food options

on offer. We observed warm interactions between staff and people who lived in the home. Staff also demonstrated they had a good knowledge of people's preferences. Reassurance was offered to people who were unable to communicate verbally and everyone was referred to by their name and with dignity and respect. However, staff told us they struggled to meet the needs of people who required individual assistance to eat their meal, due to staffing levels. We have made a recommendation with regard to staffing in the Safe section of this report.

We looked at how people were supported with their healthcare needs. People's care records included information about their medical history and any needs or risks related to their health. We found evidence that appropriate referrals were made to a variety of healthcare agencies including GPs, district nurses and opticians.

The manager told us the home utilised an online assessment system called 'Telemedicine' if they had any concerns about people's health. This service was available 24 hours a day and was managed by registered nurses from the local NHS service. Telemedicine provides a remote clinical service between the home and a healthcare provider, using electronic audio and visual means. This helped to provide prompt and appropriate advice and treatment.

We looked at how people's needs were met by the design and decoration of the home. The provider's website for the home stated there was a dedicated unit for people living with a dementia. However, we were told that this was no longer the case and there was a mix of people living on each floor of the home.

We were told there was an on-going plan of refurbishment in the home, including the redecoration of some bedrooms and upgrading bathrooms. We noted some effort had been made to differentiate between some bedrooms on the second floor, previously used as the dementia unit, with doors being painted in different colours. However, it was not clear if the colours used had any significance for the people who occupied the bedrooms. There was also a lack of signage to help orientate people within the home and promote their independence in accessing toilets and bathrooms. We were told by the manager and the providers that the intention for the future was to focus on developing the home to provide a specialist service for people living with dementia. However, it was acknowledged that, in order to achieve this, the environment needed to be further improved. We were shown a set of plans which had been drawn up in order to achieve this.

Good

Is the service caring?

Our findings

People spoken with told us they found staff to be kind and caring. Comments people made to us included, "We have a bit of fun together", "They [staff] are really good with you here. They're lovely and do anything for you. I couldn't wish for anybody better" and "It takes a lot of getting used to but I'm being looked after well and things are getting better and better." We noted that a number of 'Thank You' cards had been received at the home, all of which praised the caring nature of staff.

We asked people if staff respected their dignity and privacy when providing care and the responses we received included, "I have a bed bath. They shut the door and curtains and cover me up as best they can" and "Yes, they knock on my bedroom door."

When we completed a tour of the building at the start of the inspection, we noted one person's bedroom window looked out onto the courtyard area. We saw this window did not have any blinds or film to protect the dignity and privacy of the individual concerned. When we mentioned this to the director responsible for maintenance, we noted they took immediate action to rectify the situation. They also checked other bedrooms on the ground floor to ensure people's dignity and privacy were properly protected. The director told us they would ensure issues of dignity and privacy would always be included in the monthly room checks which were carried out in the home.

During the inspection we observed warm and friendly interactions between staff and people who lived in the home. On some occasions we heard staff use terms of endearment, including 'sweetie' and 'treacle'. Although we did not see evidence that people were offended by this, we discussed with the manager that staff should be reminded to use each individual's preferred name.

We observed one occasion when a staff member responded to a person who had become distressed. They were calm and reassuring in their approach and took the time to sit next to the person and hold their hand until they felt calmer. They then further distracted the person by offering to take them to get a cup of tea. The person who lived in the home told us they thought the staff were wonderful.

We looked at a sample of care records and found staff wrote about people's needs and care in a respectful manner. There were policies and procedures for staff about caring for people in a dignified way. In addition, all staff were bound by contractual arrangements to respect people's dignity, equality and rights.

Staff told us they would always encourage people who lived in the home to be as independent as possible. Care records we reviewed also supported this approach. For example, the records of one person who had limited movements, reminded staff that they should give the person their hairbrush and toothbrush in their left hand so that they could use them independently.

The staff we spoke with told us they had a detailed knowledge of the needs and preferences of people who lived in the home. A staff member commented, "It's nice to know the personal side of someone and their little ways. If you don't know these then you will get things wrong." The manager told us they were intending

to reintroduce the role of keyworker; this person usually takes a particular interest in ensuring individuals they care for have everything they need in the home.

People were able to express views about their care during day to day conversations with staff. The new manager told us they intended to meet with people individually to discuss their care needs as part of their staffing review.

During the inspection we asked people about the use of advocacy services. These services provide independent support to help individuals express their views in relation to their care and support needs. No one spoken with had used advocacy services but our conversations with the manager showed they were aware of how to contact these services should they be required. The manager told us they would contact the local advocacy provider to ask for publicity materials to put on display in the home.

Good

Is the service responsive?

Our findings

People who lived in the home and their relatives/friends told us they felt staff were responsive and met people's needs with an individual approach. Comments people made included, "Staff are always willing to help you if struggling with anything" and "The staff are really good; they will come and ask you are you all right."

People who lived in the home told us they would speak with staff if they wanted to discuss their care needs. Resident meetings were also used to gather feedback from people about how they were cared for in the home. All the visitors spoken with told us they had been involved in care plan reviews, although we did not see any documented evidence of this on the records we looked at. One relative told us, "Anything we suggest, they execute. We asked staff about drinking as she finds it difficult to swallow. Staff taught us how to help her drink."

We checked whether the provider was following the Accessible information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The manager told us they were unaware of this standard but that people's communication needs were always considered as part of the assessment and care planning process. They told us they would check the requirements of the AIS to ensure the service was compliant with them.

Care records we looked at included information about how people communicated and whether any communication aids were used. One person's care records advised staff to use flash cards as the individual had limited verbal communication. Some staff we spoke with told us they would use these cards but other staff said they felt they had sufficient understanding of the person's non-verbal communication and that these cards were not usually needed.

Staff told us there was a handover at the start of each shift. This meeting was used to discuss people's needs and any changes in their health so that staff were aware of the care each individual required. On the first day of the inspection, we noted one staff member was in the process of updating the sheet used to record the information discussed in the handover; this meant all staff, particularly those employed via an agency, would have more detailed information about people's medical conditions as well as their needs and risks.

Records we reviewed included information about how people wished to be cared for at the end of their life. Advance care plans had also been completed by some people. The provider worked in partnership with specialist services such as Macmillan nurses to help ensure people receiving end of life care had access to appropriate equipment and pain relief medicines.

We asked about the activities available to people who lived in the home. The manager told us they were currently recruiting for two activity coordinators so that activities could be provided seven days a week. We were told the previous coordinator had left some months previously. A member of care staff had been

providing some activities in the interim period but this was no longer happening.

People who lived in the home did not raise any concerns about the range of activities provided. Comments people made to us included, "I'm ok watching TV", "We have rides out on a coach. We went to Blackpool for the lights. We have sing-songs" and "If they have time, staff will stay and spend time with you – cut your nails, wash your hair, chat." Visitors told us, "They had a singer in a few months ago and children in singing carols at Christmas. They decorate the home at Christmas, Easter and Halloween" and "Staff call in to talk to her, wave as they pass. They tried one-to-one activities with her but she didn't want to know."

We looked at how the service managed complaints. There was a complaints' procedure in place that was included in the guide provided to people when they were admitted to the home. The policy informed people of the timescales in which a response would be provided to any complaints received. Details were also included for other organisations people could contact in the event they were unsatisfied with the way their complaint had been handled by the provider.

We reviewed the complaints file and noted that no complaints had been documented since October 2016. The manager was unable to tell us if this was an accurate record of all complaints received as they had only recently joined the service. Records showed that all documented complaints had been fully investigated and a response provided to the complainant.

People spoken with during the inspection told us they had no complaints but would be happy to discuss any concerns they might have with staff and the manager. Comments made to us included, "I have no complaints at all. I would ask staff if I had a complaint. I have no worries about [name of relative] at all" and "I would go straight to the manager. Overall the home is ok with us as a family. We have no complaints whatsoever."

Requires Improvement

Is the service well-led?

Our findings

We looked at the systems in place to monitor the quality and safety of the service. We saw that some audits had been carried out in relation to care plans, catering, infection control and medicines management. However, records we reviewed showed the most recent care plan audit was in August 2017. All of the care plans audited had required significant improvements to be made but we did not see any evidence that any follow up audit had taken place. It was also unclear on any of the audits we reviewed who was responsible for addressing identified shortfalls and the timescale for completion. We also the most recent audits in relation to medicines management and infection control had been completed in May 2017 and December 2016 respectively; none of the shortfalls we identified during this inspection had been noted during these audits.

There was a lack of robust systems to monitor the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager of the home had been in post for less than one month prior to the inspection. They told us they intended to apply to the Care Quality Commission to register as manager. The manager told us there had been a short handover period between them and the departing registered manager.

Most people we spoke with during the inspection were aware of the new manager and had been introduced to them. Comments people made included, "The new manager is lovely", "The new manager has been in to see me once a week", "The new manager has been very good. She listens to us and informs us what's going on. We are more than satisfied with the way the home is caring for [name of relative]" and "I was talking to the new manager on the phone. She asked me to call in and see her. She answered my questions and was very helpful. I've peace of mind here. When I go home I know [name of relative] is cared for."

During the inspection the manager was open and transparent about their findings since they had started work at the home. They told us they had identified areas for improvement that included infection control and training. They told us their observations had shown the standard of care people received was good. Throughout the inspection, the manager demonstrated a commitment to service improvement which was also shared by the directors we spoke with.

During our inspection our checks confirmed that the provider was meeting the requirement to display their most recent CQC rating both in the home and on the provider's website. This was to inform people of the outcome of our last inspection.

We saw that a Quality Business Manager, employed by the providers, was undertaking regular monitoring visits to the home. We looked at the report from the most recent visit in December 2017 and saw it included discussions with people who lived in the home to check they were happy with the care they received. We noted no concerns had been raised and people spoken with were very complimentary about their experience in the home. One person who had been at the Hollies on respite care and their relative said they would use the home again in the future.

All staff we spoke with were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any emergency or concern. There were policies and procedures in place relating to the running of the service. Staff were made aware of the policies at the time of their induction and signed to say they understood their content and the responsibilities placed on them.

The majority of staff spoken with told us they enjoyed working in the home. Most staff were positive about the new manager and had confidence that they would improve how the home was run. One staff member told us, "The new manager is very nice. She wants things to be right and is trying to put everything in place." Another staff member commented, "I am optimistic that things will improve under the new manager."

Records we reviewed showed the manager had already held one staff meeting since they started work at the home. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the service and giving them an opportunity to discuss good practice. A staff member told us this recent meeting had been an improvement on ones held previously as there was an agenda in place prior to the meeting; this meant that staff had prior knowledge of areas to be discussed at the meeting.

The manager told us they had plans to introduce an 'employee of the month' award to help motivate and reward staff. They also intended to introduce a staff award night towards the end of 2018. We saw that both of these initiatives had been discussed with staff at the most recent staff meeting.

We looked at the satisfaction surveys sent out by the provider to people who lived in the home and their relatives. We saw 17 responses had been received to one survey but could not tell how recent this was as the survey was undated. We were advised by the provider that it had been undertaken in 2017. Within the survey people were asked about the approachability of the manager, as well as questions about the care they received. We noted all the responses were very positive.

We noted the Hollies had been awarded Investors in People status (standard version) in November 2017. This award recognises best practice in people management.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate an effective system for assessing, monitoring and improving the service. Regulation 17 (1) (2) (a) (d) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The safety of people who used the service was placed at risk as the provider's recruitment system was not robust enough to protect them from being cared for by unsuitable staff.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. Regulation 12 (g).

The enforcement action we took:

We issued a warning notice.