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Holly House Residential Care Home

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on the 10 and 11 September 2015 and was unannounced. We last inspected the service on the 9 and 16 January 2015 and found that they were not meeting the required standards. At this inspection we found that they had not made the required improvements and were in breach of Regulation 12, 14 17 and 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Holly House is a residential care home which provides accommodation for up to ten people with mental health needs. At the time of the inspection there were ten people living at the home. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are

Summary of findings

'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 provider did not have appropriate systems in place to ensure there were adequate staffing levels to meet people's needs, and to keep people safe at all times. This meant that people who used the service did not always have their needs met in a timely or safe way.

People told us they felt safe living at Holly house. Staff told us they knew how to keep people safe. However risks to people's safety and well-being were not always managed effectively.

There was a robust recruitment process in place which helped to ensure that staff employed at the service to support people were fit to do so. However the service had not been able to recruit staff to work at the service in recent months and this had led to inadequate staffing levels.

There were arrangements in place for the safe storage, management and disposal of people's medicines. However there had been a recent incident involving an 'overdose' of medicines. This had been reported to the local authority safeguarding team who were investigating this incident.

People were not always protected from abuse although they told us they felt safe at the home. Staff were knowledgeable about the risk of abuse and the service had appropriate reporting procedures in place.

The staff supported people to participate in some activities which included people attending events in the community. However activities were sometimes postponed or cancelled due to lack of staff

The manager told us they had recently introduced 'co-production meetings' where people who used the service, their care coordinators and staff from Holly house attended and discussed a variety of topics related to the service.

The CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of our inspection no applications had been made to the local authority in relation to people who lived at Holly House.

There was little information relating to quality audits or the monitoring of the service. We found that the information that was available was ineffective and was not used as a tool to improve the service.

People had access to healthcare professionals, including GP's dentists and the local community mental health team (CMHT). People's health was monitored regularly. People were encouraged to be as independent as possible and were supported when possible to go out into the community. However this was subject to the availability of staff.

At this inspection we found the provider to be in breach of Regulation 12, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were insufficient staff to keep people safe.

Staff understood how to recognise signs of abuse and report any incidents and concerns.

There were appropriate recruitment practices in place.

Medicines were not always managed safely.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff had a good understanding of the Mental Capacity Act 2005.

People's nutritional needs were not always met and were not monitored effectively.

People's individual needs were not always met by the adaptation, design and decoration of the environment.

Requires improvement

Is the service caring?
The service was caring.

People were mostly happy with the care they received.

Support staff were knowledgeable about people's needs and preferences.

People were not always treated with dignity and respect.

People did not always have choices and did not always have their care delivered in a way that suited them.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People were not always involved with the planning and reviewing their care needs.

People knew how to complain, however they did not feel comfortable doing so and did not feel 'listened to'.

People were not routinely involved in making decisions and had limited choices.

Requires improvement

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

The working relationship between the manager and the provider was not effective.

Audits and surveys were not effective in identifying shortfalls in the quality of the service.

There was no evidence of learning, development or improvement of the service.

There was a lack of an open and transparent approach to some aspects of the service.

Holly House Residential 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 inspection took place on 10 and 11 September 2015 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we looked at the previous inspection records, we also reviewed other information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with the registered manager, four people who used the service, the provider, and four care staff. We also requested feedback from commissioners of the service, the local funding authority.

We observed care and support being provided throughout the two days of our inspection. We also reviewed care records for three people who used the service and three staff recruitment files. We looked at information about recruitment processes, induction, training records, supervisions and appraisals. We also looked at the general maintenance in the home, communal areas, including the kitchen and food storage areas. We sought permission to look in people's bedrooms and bathrooms.

Requires improvement

Is the service safe?

Our findings

People told us that they liked the staff and felt safe living at the home. However people and staff told us that they felt there was not enough staff at all times. We saw that a number of tasks were not completed regularly including supporting people to attend activities at the community centre, support for people with the cleaning of people's bedrooms and other household tasks and supporting people on a one to one sessions. This lack of adequate staff meant that people missed out on opportunities to pursue hobbies and they lived in an environment which was not clean and hygienic and were at risk of eating food that was out of date because these tasks had not been completed.

We saw that staff had received safeguarding training and were able to describe different types of abuse and also the procedure that was in place in the home to protect people from avoidable harm.

The manager and staff told us and records confirmed staffing levels and the skills mix of staff were not adequate to meet the assessed needs of people in a timely way. This meant that people's care and support needs were not always met when they were needed. People told us this happened on a regular basis and one person said "we don't bother to ask if there's only one on duty we wait until they are free".

We spoke to the provider and asked how they determined staffing levels. The provider said they did not use a 'dependency tool' to assess staffing levels. The provider and registered manager were on duty Monday to Friday during the day. The manager worked alongside the support staff as well as completing managerial duties. Staff told us they were often left to work shifts on their own; although on occasions the manager and provider were at the home they were busy and not able to support staff.

There was only one staff member on duty during the night. Staff spoken with told us they did not feel this was adequate to keep people safe. When the member of staff was attending to one person they were unable to support the other people. For example some people living at the home often went out socialising and returned to the home under the influence of alcohol. This was not conducive to their health conditions and conflicted with their treatment.

Staff told us they did not feel confident being alone in this situation. Staff told us that their safety was compromised because other people living at Holly house were disturbed and this cause them to react negatively

Staff told us that the shortage of staffing meant that they were not providing care in a planned way. For example staff were required to provide one to one support to enable people to discuss their feelings and review and manage triggers associated with their mental health conditions but they explained that this did not always happen. The provider confirmed that they were rarely able to provide one to one support due to financial constraints. One person told us, "There is not enough staff here and sometimes we can't go to the leisure centre".

The lack of sufficient staff meant that people were not always supported in a way that ensured their continued safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. There had been a recent incident where a person living at Holly house had accessed the medicines trolley and removed and consumed a number of tablets. At the time of the incident there was only one member of staff on duty and they were completing a medicines administration (MAR) record chart but had not secured the medicines within the trolley. The staff member had contacted the provider to advise them of the situation and had requested support however the provider had not attended the home to support the worker. The incident went undetected as the staff member was not aware that the person had consumed the tablets until the next day when a member of staff observed the person concerned to be sluggish and less responsive than usual. Staff then took remedial action to support the person. The time delay in detecting this incident meant that the person was exposed to an unacceptable delay in seeking professional help.

This incident demonstrated that medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider told us they have being trying to recruit additional support staff but "nothing had materialised". The provider said people were not interested in working at the home. However we did not see evidence of the

Requires improvement

Is the service safe?

recruitment programme. The provider told us they had spoken to a few 'contacts' but had no paperwork and no details of people who had been contacted. The provider said they may have to consider contacting the job centre to see if they were able to assist with the recruitment process. We looked at staffing files and found that correct recruitment procedures had been followed for staff currently employed at the service.

The provider told us they do not use agency staff as it was too difficult for them to be briefed on the needs of the people who used the service.

Staff told us they were often contacted at short notice and asked to cover additional shifts. However there were only Seven regular staff employed at the service and this meant that people were often working long days, and also working without adequate time off. We asked the provider what had been done to manage the staff shortages. The provider told us they relied on existing staff to cover the additional shifts'.

Staff and the manager said that when they were short staffed other tasks that were not considered a 'priority' did not always get done, such as cleaning and food rotation. A member of staff told us that although the provider did the shopping they did not check the food in the fridge and cupboards to ensure it was still in date. For example we found a pot of beans in the fridge dated as being opened on 13 July 2015 which had fur and mould growing on it, other food items were also found to be out of date. We found people's bedrooms were not cleaned or maintained and posed a risk to people's health.

We found that risks to people's health and well-being were identified and detailed in people's care plans. However the risk assessments did not say how risks were managed or mitigated. For example a person had current risks recorded regarding a planned holiday, but their risk assessment did not say staff should support the person to ensure their safety and that of others or how additional supervision would be provided in a new environment away from the home.

This meant that people were not protected from the risks of unsafe care as the plans for managing risks had not been addressed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although there were contingency plans in place to deal with emergencies within the home, in reality they did not work. For example, in the event of an incident or emergency at the home the provider told us they were on call. However, we found a recent example where staff had requested additional support from the provider but this had not been given resulting in only one staff member being left on duty.

The contingency arrangements for a planned holiday involved the manager and or a member of support staff driving almost two hundred miles to support the emergency situation. This would not suffice as the time lapse would be approximately 6 hours.

The provider did not have adequate arrangements in place to respond appropriately to peoples changing needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

People told us that they felt some of the staff had the skills required for the job.

We found staff were knowledgeable about people's individual care and support needs. They were able to describe people as individuals. Staff knew about people' likes dislikes and preferences. However staff and people who used the service said they were not always supported with their choices by the provider. One person said, "They [provider] always had the last word".

People told us that the food was good sometimes but they did not always have a choice. We saw that people's weight was not monitored effectively. For example the manager told us that a person was at risk of diabetes due to weight gain was being encouraged to eat healthier meals. However there was no evidence of this and when we spoke to the person they told us they regularly buy take aways as the food that was available in the home was not always what they liked to eat.

We saw that another person who we were told drank excessive amounts of fluids did not have clear instructions recorded in their care plan for staff on how to support this person and manage the situation effectively to reduce the risk of the person becoming unwell. Two people told us that the home had been without an oven for almost two weeks and during that time they had to have what was available that did not require heating in the oven. On one occasion two Quiches were offered for dinner between 10 people which staff and people told us was not enough.

Another person said they did not always have a choice about what food they ate and said "it depends on what is available".

People did not receive the appropriate support to ensure they were able to eat and drink sufficient amounts to maintain their health and wellbeing. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us about the training they had completed to make sure that they had the skills to provide the individual care and support people needed. We reviewed the providers training matrix and staff confirmed that they had completed an induction when they commenced working at Holly house and had received on-going training with skills for care.

The provider's training matrix showed that staff had received a range of training courses relevant to supporting people with mental health conditions such as challenging behaviour and mental health awareness and safeguarding adults from abuse. Staff told us that most training was IT based, although external trainers were used occasionally. The manager had an overview of the results of the post training tests and if staff did not achieve an adequate pass mark they had to redo the training to ensure the training had been effective. Staff had been trained in the safe administration of medicines. However following a recent incident, there had been a change of process to ensure that two people administered medicines to reduce the risk of another incident. People told us they received their medication on a regular basis.

Staff told us they were supported and received regular supervisions. We spoke with staff and the manager about staff supervision and appraisal. We found that some staff had received supervision and others were being planned. Staff spoken with during our inspection told us the manager was supportive and they could approach them should they feel they needed supervision, support or guidance.

People told us that staff obtained their consent before supporting them and explained what they were going to do, before they done anything. One person said, "the staff asked me if I want help with doing my laundry". Staff told us they sought people's consent before providing support or assistance.

The manager told us they had recently arranged co-production meetings so that all the people who lived at Holly house and staff and care co-ordinators could get together to discuss things within the home. People who used this felt it was positive and gave people the opportunity to express their views.

We observed that Staff supported people in a way that promoted and respected their dignity. For example when a person walked into the room the attention of the staff turned to the person and they were immediately involved

Requires improvement

Is the service effective?

in conversations. They were asked to join them and were offered a cup of tea. On another occasion when a person appeared distressed staff intervened promptly to reassure the person.

One person told us, "There have been many changes here, it has been better since the new manager came but things don't always work so well here." Another person expressed how pleased they were to be offered more choice about their life, but were sometimes left disappointed when things changed at short notice or staff were not available to assist them at the agreed time.

Staff had received MCA 2005 and DoLS training. Most staff were able to demonstrate a good understanding and could explain how the requirements worked in practice. However, not everyone had a clear understanding of the MCA 2005.

Capacity assessments were carried out by people's care coordinators and not the staff employed at Holly House. The provider told us that they managed some people's finances. However capacity assessments had not been completed in all instances. We spoke to the provider and manager about this to ensure people had access to their finances, and were being managed in a way that supported the person, until the mental capacity assessment had been completed.

People were supported to access and attend healthcare services when required. The local community mental health team also supported people at the service. People were encouraged to attend dental appointments when needed.

Requires improvement

Is the service caring?

Our findings

People generally spoke positively about the care and support they received at Holly House. However, one person said, "I think most of the staff are alright but some are not so nice". Another said, "The provider does not always acknowledge you and that it makes you feel bad". For example the person said "it's always about what they want you to do and you don't always feel valued or get choices". Another person told us, "The staff are good but the owner is unfriendly". Other people said, "They are all very helpful and do the best they can. They are caring, considerate staff." We observed staff to be kind and compassionate when dealing with people and noted they addressed people in individual ways which demonstrated they knew them well.

We saw several people talking together with staff and we saw that people were encouraged and supported with getting their views across and to have their opinion. Staff told us that they were aware that caring for people with fluctuating mental health conditions required patience and understanding. One staff member said "I will always speak to the person and tell them what I am doing. I'll check that everything is ok for them and go at their own pace."

People who used the service had good relationships with staff and those who were more able asked staff for help or support when they needed it. Staff told us about the people they supported and demonstrated an interest in the wellbeing of people. For example they said they felt frustrated when they were unable to support people with activities and also with meeting personal objectives and goals as they recognised how important these things were to the individuals concerned. Staff told us they wanted to achieve the best for the people they supported and they all had a part to play to achieve the best outcomes for people.

We asked staff how they support people to meet their cultural or religious beliefs or to express their sexuality. One staff member explained it was important to support people in a dignified way, especially with expressing their sexuality. People told us they were not aware of any specific cultural needs within the home, but were confident that these would be met by the staff working at Holly House.

People told us they could talk to staff about any concerns they might have. Staff and the manager told us that people had regular contact and support from their care coordinators at the community mental health team. Care coordinators supported people's placements at Holly House they met or spoke with people regularly to support them. Care plans were also reviewed periodically. People were involved in this process as much as they were able too.

Each person was assigned a key worker. Staff told us people were supposed to have one to one sessions with their key workers to discuss any issues they had. However people and staff told us this did not happen. Any significant events were documented in the each person's progress notes; however changes to care, support or risks were supposed to be recorded in peoples support plans. This process was to ensure important changes and or events were documented and improved communication. However staff told us this was not routinely done and they relied on handovers and progress notes for up to date information.

People were not always supported in a way that maintained their dignity. For example the lack of attention to the cleanliness and hygiene in the home. People also told us they had limited choices about how their care and support was provided. However people told us staff did respect their privacy and knocked on the door before entering and ensured any personal conversations were in private. People did have access to advocacy service sand were supported to be in regular contact with their care coordinators at the community mental health team.

We saw that people's personal information and other documents were stored safely in locked cabinets in the office. This meant peoples personal details were stored appropriately and ensured personal information were made available only to people who had a right to access them.

Requires improvement

Is the service responsive?

Our findings

People's care was not always responsive to their needs. We saw some people's care plans did not always reflect what care, support or treatment people required to enable staff to be able to respond appropriately. For example sometimes support was delayed due to the unavailability of staff. Care was not always person centred for the same reasons. We saw that care records were detailed and were person centred. However some of the care and support plans said that the person required regular one to one support or time to reflect on particular situation. Staff and people who used the service told us that one to one support did not happen in a planned way because there was just not enough staff.

Care plans were reviewed periodically, however these reviews had not identified where changes to people's care had been entered, the date of the changes and had not been dated or signed to identify this was the most up to date information for staff to follow. We also found that people`s care plans in some instances was historic or incorrect or did not clearly identify the support required. In one person's care plan, the activity support plan detailed a range of activities; however the person told us they have never been involved in the range of activities recorded.

We also found that there was inconsistency around what was documented in people's files. Some people had many years of life histories and others had much less. Staff said they did not always refer to the full care and support documents as they knew the people who lived at Holly house relatively well. Staff also said they had 'handovers at the beginning and end of each shift and also completed progress notes which detailed important events that had happened during that shift. This ensured that communication was effective and staff were aware of any developments and were in a position to respond to changes in people's condition.

People told us they could not remember if they had been involved in discussions about their care and how this would be delivered. The manager told us they set objectives and goals which had been agreed and these were reviewed with their key worker. People who used the service told us they felt disengaged at times and sometimes due to their fluctuating mental health found it difficult to engage with the set objectives. The manager told us that the home supported 'recovery' with the long term goal for people to become as independent as possible. However we were not given any examples of this during our inspection. This included setting short and long tern goals and objectives which people hoped to achieve. People and staff told us that they were encouraged to maintain relationships with people and had regular contact with their families.

The range and type of activities for each resident did not reflect their choice, but was dependent on the availability of staff. We saw people who during the course of our inspection had no social interaction or activity provided for them and many people had chosen to stay in bed telling us, "There is nothing to get up for."

Whilst people spoke positively about staff they felt that care was sometimes focused on the task and not the person. People felt their basic care needs were met but staff sometimes did not have the time to stop and chat to them. One person told us, "They are as good as they can be but are always under pressure." Staff told us that some of the home based activities are to support people with everyday living tasks including things like budgeting, shopping, laundry cooking and cleaning. However people were rarely supported with these tasks and they just did not get done.

We found the home to be very dirty, food out of date, laundry was not managed effectively. This lack of a planned approach demonstrated that the service did not always respond to people's needs effectively.

There was a system in place to manage complaints. A complaints procedure was available for people living in the home. Several people said they saw little point in complaining about anything as things were not dealt with. People said that they would speak to the manager or support staff but would not feel comfortable speaking with the owner. People told us that a visitor to the service on occasions became involved in responding to concerns which they felt had a negative impact.

Inadequate

Is the service well-led?

Our findings

During our previous inspection we identified that the provider was not meeting the required standards. An action plan was submitted detailing the remedial actions to ensure the required improvements were made. However during this inspection we found that the improvements had not been made, and also there was little evidence that things had improved. The only completed action was the recruitment of a new registered manager. The registered manager has since left the service on 21 September 2015 but was present for the inspection process.

We found that the service was not well led and there were ineffective governance arrangements in place. We observed and were told there was conflict between the provider and the manager and staff which people and staff told us meant they were given mixed messages and conflicting information. A person who was formally employed at the service continued to visit the location regularly and people who lived at Holly house and staff told us they spoke 'inappropriately' to them which they found distressing.

Information was shared on a minimal basis and the manger was often not aware of situations until staff informed them. For example the provider was responsible for doing the staff rotas and staff had been asked to cover shifts without the registered manager being informed and without rotas being updated to reflect these changes. There were minimal staff on duty. There were gaps in the rota and staff were regularly contacted at short notice to cover shifts. There was no evidence of a long term recruitment or contingency plan and staff working at the service felt demotivated and undervalued by the provider/directors.

We saw no evidence of current audits or quality monitoring records. We had requested this information and were provided with an historic quality management improvement plan.

There were systems in place to monitor the cleanliness of the home, however these were ineffective and the home was very dirty at the time of our inspection. We saw that these issues had not been identified, for example in relation to the cleanliness issue, and also with regard to food rotation when food was found to be out of date. We did not see any audits relating to the quality of the service or for care plans, risk assessments, medicines or maintenance checks around the home had not identified issues we found during the inspection. Therefore the systems in place were not always effective in identifying concerns or improving the service. People had not been asked if they were happy with the standard of care they received and there was no facility in place to obtain feedback from people through other forums such as residents meetings.

We reviewed three people's care and support records. Whilst these had been reviewed regularly we found the files to be chaotic and information was difficult to decipher and to locate what was the most current information. Risk assessments had been completed however details of how risks should be managed or mitigated were not recorded so the risk assessment was incomplete.

There were poor governance arrangements in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Roles and responsibilities were unclear and the manager told us that their time was often spent assisting people with 'hands on support' and they were not able to carry out managerial tasks like audit and quality monitoring of the service. We observed that household tasks and supporting people with cleaning did not take place and there was no plan to address who was responsible for these tasks or when they needed to be done.

The manager told us they felt unable to make decisions as these were often challenged or changed by the provider. Staff told us that there was a lack of openness and transparency at the home. People who used the service told us they did not feel listened to and at times found that they had limited choices about what they wanted to do.

Communication between staff and people who used the service and the manager had improved but this was still meeting resistance from the provider. The manager told us that she had tried to introduce regular support meetings for people who used the service staff and the provider, however the provider was not supporting these meetings and decisions could not be agreed. The provider then had individual conversations with people and people interpreted the conversations and actions differently. People who lived at Holly house told us this made them feel awkward, and caused an unpleasant atmosphere.

Responsibilities of different staff roles were not clearly identified, and these were being reviewed by the manager.

Inadequate

Is the service well-led?

Staff told us they were expected to undertake an unmanageable amount of tasks as part of their role which had become untenable. Staff told us that a visitor to the home (who was a former employee) often visited the service and was abusive to them when they were not able to achieve and complete all the tasks. For example on the morning of the second day of the inspection the person was verbally abusive to staff and two people who used the service had heard them shouting at staff, they told a member of staff that this made them feel very uncomfortable.

The manager had a clear understanding of the changes and improvements that were required within the service. They told us that although there were many challenges, they were optimistic that these could be achieved if everybody had clearly defined areas of responsibility. We found that there was no improvement plan in place for the home.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider had not informed the CQC of significant events in a timely way. For example we were not informed that the home would be closed down for five days during a planned holiday. The provider had told us "they were getting some maintenance work done as well as a deep clean".

We found that the rotas did not demonstrate staffing numbers and records were inconsistent for example rotas had gaps, so staff who were asked to cover shifts at short notice were not detailed on the rotas. Also the rotas did not demonstrate whether people were off work, on holiday or off sick. The signing in book hours recorded differed from the rotas on the payroll records and also did not reconcile to actual staffing hours worked. We were told by the Provider that there were two/three staff on duty during the day, two during the evening and one staff member at night. However this was not reflected in the rotas and the two/three members of day staff included the provider and the registered manager.