Regal Care Trading Ltd

# The Hollies Rest Home

## Inspection report

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14 June 2016

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## Ratings

| Overall rating for this service | Requires Improvement |
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| 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? | **Good** |

# Summary of findings

## Overall summary

This inspection was carried out on 13 and 14 June 2016 and was unannounced. The Hollies Rest Home is a large period building set over three floors. It provides accommodation and personal care for up to 31people. The service supports older people and those who are living with dementia.

There were 20 people using the service at the time of the inspection, 17 of whom lived with dementia. Some of the people were not able to converse with us.

At our last inspection on 27 July 2015 we issued two warning notices and seven requirement notices in relation to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan detailing the improvements they would make and confirmed they would be meeting the requirements of the regulations by 26 November 2015. This inspection was carried out to follow up on compliance with these notices. At this inspection we found that the registered provider had met the requirements detailed in the warning and requirement notices and had made improvements to the culture of the service and the care people received. However these improvements needed to be sustained over time and we will check this at our next inspection.

There was a new manager in post who was registered with the Care Quality Commission (CQC) since November 2015. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

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

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

There were thorough recruitment procedures in place which included the checking of references and full employment history.  A process to fill in gaps in staff employment history records was still in progress.

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

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect.

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

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

Staff sought and obtained people's consent before they helped them. People's mental capacity was assessed when necessary about particular decisions; meetings with appropriate parties were held and recorded to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005.

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

People's individual assessments and care plans were reviewed monthly or when their needs changed. Clear information about the service, the facilities, and how to complain was provided to people and visitors.

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

People were involved in the planning of activities that responded to their individual needs. People and their relatives' feedback were actively sought at residents and family meetings, and through satisfaction surveys.

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

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

## 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 safe although improvements needed to be sustained over time.

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

Medicines were administered, stored and disposed of safely.

Staff were trained to protect people from abuse and knew the action to take if they had any concerns.

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

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

Safe recruitment procedures were followed in practice. A process to fill in gaps in staff employment history records was still in progress.

### Is the service effective?

**Requires Improvement**

The service was effective, although improvements needed to be sustained over time.

Staff had received up to date mandatory training and received additional specific training to support them in their role.

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

A new system ensured people were supported to make decisions and were asked to consent to their care and treatment. Where they were unable to make their own decisions, the principles of the Mental capacity Act were followed to protect their rights.

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

People were referred to healthcare professionals promptly when needed.

## Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness.

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

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

People and visitors were provided with clear information about the service.

## Is the service responsive?

Good

The service was responsive to people's individual needs.

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

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

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

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

## Is the service well-led?

Good

The service was well-led.

The registered manager promoted a culture that was person-centred. People, staff and relatives praised the registered

manager's approach, style of leadership and support.

Emphasis was placed on continuous improvement of the service. Improvements had been made that had enhanced people's experiences of the service. We will check at our next inspection that these improvements have been sustained over time.

# The Hollies Rest Home

**Detailed findings**

## Background to this inspection

This inspection was carried out on 13 and 14 June 2016 and was unannounced. The inspection team consisted of two inspectors.

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

The registered manager had not been asked by the CQC to provide a Provider Information Return (PIR) subsequent to our last visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before the inspection we reviewed our previous inspection reports and the provider's action plan. We noted the records that were sent to us by the registered provider and the local authority to inform us of significant changes and events.

We looked at seven people's sets of records which included those related to care and medicines. This included assessments of needs and records of the care given. We observed to check that people's care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and five staff recruitment files. We made observations of staff interaction with people, of the premises and equipment. We checked how medicines were administered. We looked at records concerning the monitoring, safety and quality of the service, the menus, the activities programme and policies and procedures.

We spoke with six people who lived in the service and six of their relatives to gather their feedback. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the operations director, the registered manager, the deputy manager, and four members of care staff. We also spoke with housekeeping, catering and maintenance staff. We obtained feedback from a local authority case manager and a GP who were involved in the care of people living in the service.

At our last inspection on 27 July 2015 we found several breaches of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service safe?

## Our findings

People told us, "Nothing bad can happen to me here, I am in good hands" and, "This is a safe place to be." Relatives told us, "We have total peace of mind and complete trust in the manager and the staff to keep our Mum safe", "Very good place, definitely safe, plenty of staff" and, "Great improvement about having more staff around, let's hope this lasts."

At our inspection in July 2015 we found that the registered provider had not ensured staffing levels were adequate to meet people's needs. We issued a warning notice in relation to this breach of regulation. At this inspection we found that improvements had been made, and sufficient numbers of competent staff were deployed to meet people's needs during the day, in the evenings and at night time. These improvements about staffing levels needed to be sustained over time.

There was sufficient staff on duty to meet people's needs. The registered manager had carried out assessments of dependency levels in November 2015 to ensure that there were sufficient staffing levels to meet people's individual needs. As a result of this review, some people with nursing or complex needs had been relocated and the needs of people who lived in the service could be fully met. We observed staff being able to provide one to one attention and care for people in a way that mattered to them. Calls for help were responded to without delay. A relative told us, "Staff are everywhere you look, they are busy but not rushing around anymore, they still have time to sit with the residents and chat with them."

Additional staff were deployed when a person needed more constant one to one attention, for example when they had an infection, when they displayed behaviour that challenged, or when they approached the end of their life. The operations director told us that staffing levels will remain in proportion to the presently reduced number of people in the home, so that staff will be increased to match any future numbers of admissions.

At our inspection in July 2015 we found that the registered provider had not taken appropriate action to identify and reduce risks to people's safety and welfare, and to ensure the premises were effectively maintained. We issued a warning notice in relation to this breach of regulation. At this inspection we found that action had been taken and that the required improvements had been made to provide a safe environment for people. However these improvements about maintenance of the environment needed to be sustained over time.

The fittings and equipment throughout the home had been checked, serviced and were scheduled for further regular checks. There was a robust system in place for logging, carrying out and monitoring repairs throughout the home. The registered manager did a daily 'walkabout' to identify any repairs or maintenance that needed to be done and monitored these until completion. Radiators were securely covered and all repairs in people's bedrooms identified at our last inspection had been carried out. Safety checks had been carried out throughout the home and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They included internal fire safety checks, equipment, first aid boxes, water temperature, Legionella testing, appliances, and portable electrical

appliances.

The lift had been improved by external engineers and was free of loud vibration, stutters or judders. The registered manager told us, "It is still quite slow but silent and smoother, much more enjoyable to use." People used this lift, accompanied by staff, whenever they wished to go back to their bedrooms on the upper floors. A person told us, "It is much better and quieter now; I think it is a different lift, I go up or down with a worker whenever I want."

The flooring in the home had been replaced throughout the premises. The new flooring was easy to clean and had been selected especially by the registered manager for its non-slip properties. People's bedrooms and communal areas were free of clutter. Equipment and wheelchairs were stored in a dedicated space when not in use and did not obstruct people's way. A security system ensured that people remained safe inside the service and people were assisted or accompanied by staff when they needed or wished to leave the building.

Some of the bedroom windows went down quite low to the ground. If a person fell against them they could potentially sustain an injury as safety glass or safety film had not been fitted. We discussed this with the manager and requested that improvement of this safety aspect be addressed. The registered manager told us a safety film will be placed on such windows.

At our inspection in July 2015 we found that safe recruitment practices were not used to ensure staff were suitable to work with people. We issued a requirement notice in relation to this breach of regulation. At this inspection we found that action had been taken and that the required improvements had been made to recruitment systems. However, a process to fill in gaps in staff employments records was still in progress and needed to be completed.

Appropriate checks had been carried out to ensure that staff recruited to work in the service were suitable and of fit character. Checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work there. Staff members had provided proof of their identity and the right to work and reside in the United Kingdom prior to starting to work at the home. References had been checked before staff were appointed and where possible references had been taken up with the previous employer. The registered manager had ensured that gaps in staff employment history had been explained and appropriately documented for newly recruited staff, and had requested other staff to update their historical records. This was not yet completed.

Staff who worked in the service were able to identify different forms of abuse and understood the procedures for reporting any concerns. There was a detailed safeguarding policy in place that reflected local authority guidance and the whistleblowing procedure. The procedures included clear information about how to report any concerns and were displayed on the staff notice board. Staff we spoke with told us they would not hesitate to report any suspected abuse or malpractice, and expressed confidence that any concerns would be addressed. The registered manager worked in collaboration with the Local Authority and participated in safeguarding meetings when necessary.

There were plans in place that detailed how people would be kept safe in case of an emergency. Each person who lived in the home had personal emergency evacuation plans in place that were updated regularly by the registered manager. These were available to staff and emergency services and showed the level of support that people required evacuating the premises. Staff had received fire training and fire drills were regularly carried out and documented in order to ensure that staff had the skills and training to respond to an emergency. An appropriate business contingency plan addressed possible emergencies such

as fire, evacuation, extreme weather and outbreak of infection. There was appropriate signage about the exits. There were regular checks of the fire warning system, fire doors, emergency exit doors, break glass points and emergency lighting.

Accidents and incidents were being monitored daily by the registered manager to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. The registered manager had scheduled weekly and monthly audits of falls to identify any possible trends or patterns. Action was taken to minimise further risks of falls, such as the provision of pressure mats to alert staff when people may get out of bed and needing assistance, of a foam bed wedge, reviews of people's medicines, and referrals to falls clinic. The registered manager told us, "We are taking preventive action against the risk of falls." Due to these measures, there has been a reduction of people's falls over the last five months.

Risk assessments were centred on the needs of the individual. Staff were aware of the risks that related to each person. There were specific risk assessments in place for a person who displayed a behaviour that challenged, for people whose weight had decreased, for a person who used the lift independently and others who may be at risk of pressure damage to their skin. Each risk assessment included clear measures instructing staff about how to keep people as safe as possible, taking in account people's individual circumstances and preferences. Staff helped people move around safely and people had the equipment and aids they needed within easy reach.

The home was clean, tidy and well presented. Communal areas looked fresh and well maintained. In each area of the home there were hand washing facilities readily available providing personal protective equipment such as gloves and aprons for staff to use. The head of housekeeping monitored cleaning schedules to ensure good standards of cleanliness and infection control were maintained. A relative told us, "There is no bad smell ever, it always smells really fresh and the place is spotless" People were kept safe from the risk of infection as laundry staff segregated and processed laundry at correct temperatures. Best practice was followed and there were separate areas for clean and soiled laundry that ensured people were not at risk of cross contamination.

We observed the dispensing of medicines and examined the provider's medicines management policy. The medicines round was well planned and organised. Staff received regular training in medicines management and updates. All staff administering medicines underwent competency checks by the registered manager to ensure good practice was maintained. Staff did not sign medicines administration records (MARs) until medicines had been taken by the person. There were no gaps in the MARs and these were appropriately completed. Each person taking 'as needed' medicines, such as pain relieving medicines were asked if they needed these medicines and were asked to describe how much pain they had. This was recorded using a pain rating scale to inform their GP at their next visit. All creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medications were safely stored in lockable cabinets. There was a lockable room for the storage of medicines. Medicines requiring refrigeration were stored in a dedicated fridge. The temperature of the room and the fridge was recorded daily and monitored by the registered manager, to ensure the safety of medicines they contained. Stocks of medicines were ordered in time to ensure continuous supply.

Requires Improvement

# Is the service effective?

## Our findings

People said staff cared for them effectively. They told us, "They are very efficient; I just had a bit of a cough and they called the doctor straight away" and, "They know what they are doing, they know what to do and when to do it." A GP and a local authority case manager who oversaw people's care in the home told us, "The changes in the building are very impressive, it is a much more welcoming environment" and, "I found the décor to be much improved since my last visit." Relatives told us, "This seems like a different home so much has been done" and, "So much improvement it is quite amazing, they have maximised the space available and made it so much more homely."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our inspection in July 2015 we found that the registered provider had not ensured that where people could not give their consent, the requirements of the MCA were consistently met. At this inspection we found that action had been taken to meet the legal requirements. The registered manager had introduced new monitoring systems concerning mental capacity. However these improvements of practice in regard to mental capacity processes needed to be sustained over time.

Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options to keep these people safe. Staff had received further training in the principles of the MCA and the DoLS and staff we spoke with understood how to apply the five main principles of the MCA in practice. Staff sought consent from people before they helped them move around or before they helped them with personal care. Their wishes and refusals were respected.

When people had been assessed as not having the mental capacity to make certain decisions, a meeting had taken place with their legal representatives to decide the way forward in people's best interest. This system ensured people's rights to make their own decisions were respected and promoted when applicable. For example, this procedure had been followed for people who chose to smoke tobacco, who used the lift independently, who needed the use of equipment to help them move around, and for people who may need hospitalisation.

At our inspection in July 2015 we found that people did not have their nutrition and hydration needs met; and that they did not receive safe care and treatment that effectively met their health needs. We issued a requirement notice in relation to these two breaches of regulation. At this inspection we found that action had been taken and that the required improvements had been made to meet people's nutritional and health needs. The registered manager had introduced new monitoring systems concerning nutrition, hydration, skin integrity and referrals to healthcare professionals. However these improvements of practice in regard to nutrition and hydration needed to be sustained over time.

The registered manager had ensured that all care plans were appropriately completed and updated regularly to reflect people's change of needs. When people were identified at being at risk of skin damage, they were checked regularly and helped with adjusting their position. People were checked at hourly intervals throughout the night and these checks were appropriately recorded. Staff used a 'person centred software' on their individual tablet computers to input any update and interventions about people's care. Updates were also recorded in people's main care files as well as on 'at a glance' care plans in their bedrooms. When people had been assessed as being at risk of malnutrition because their appetite and weights had decreased, staff completed food and fluid charts appropriately and totalled them at the end of the day. Fluid taken by people when taking their medicines was considered. These charts were checked daily by the registered manager who ensured follow up action was taken, such as referrals to people's GPs, Speech and Language therapist (SALT) or a dietician. People were given fortified, pureed or soft diet according to their needs and were monitored to ensure their health improved. People were referred to other health care professionals such as consultants, district nurses, mental health team and the local hospice palliative care team appropriately.

People were offered routine vaccination against influenza and district nurses came to help with the administration of vaccines. A chiropodist visited every six weeks to provide treatment for people who wished it. People were escorted to their optician or dentist appointments when needed and a visiting optician service was available.

People had their breakfast late in the morning as they preferred. We observed lunch being served in the dining area. The lunch was freshly cooked, hot, well balanced and in sufficient amount. People were supported by staff with eating and drinking when they needed encouragement and there were enough staff to provide one to one support for people when they need it. A care worker had cut some of the food in manageable sized portions for one person who found chewing difficult. People told us they were very satisfied with the standards of meals. They told us, "Very nice food, lovely" and, "Too good actually." A relative who had shared a meal with their loved one on occasions at the home told us, "The food is surprisingly good and nicely presented." People were consulted about their preferred menus at regular residents meetings. A list of people's allergies, dislikes and preferences was displayed in the kitchen and taken into account by the cook. People had a light lunch and a main cooked meal early evening where they were offered a choice of two main courses. Trolleys were circulated four times a day to bring cold and hot beverages, home-made cakes, fruit, biscuits and healthy snacks. People were encouraged to drink fluids throughout the day to promote their health and there were jugs filled with cold drinks on display in several areas for people to help themselves. A senior environmental health officer had inspected the service in March 2015 and had awarded a five star maximum rating in Food Hygiene standards to the service.

New care staff underwent a thorough induction when they started work. This included a three days orientation and shadowing senior care workers before staff could demonstrate their competence and work on their own. The competency of all staff administering medicines had been assessed and documented. The 'Care Certificate' had been introduced for all new staff. This certificate is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to

uphold.

The registered manager and deputy manager provided individual staff supervision every eight weeks to all care and catering staff. Practices including the administration of medicines were discussed at care staff supervision. The head of housekeeping supervised domestic staff. At these sessions, staff were encouraged to discuss any problems or difficulties they may have and gain support from the management team. One member of staff said, "I feel very well supported, these sessions are just for me and it is a good opportunity to talk about I feel about my job" All staff were scheduled to have an annual appraisal.

Staff received mandatory training that was essential for their roles. A computerised system was in place to monitor staff training and determine when they needed a refresher course. The monitoring system indicated staff were up to date with their mandatory training, which included first aid, fire safety, moving and handling, health and safety, person-centred care, mental capacity and safeguarding. The registered manager had developed professional development plans with each member of staff to identify their training needs. Staff received additional training aimed at meeting people's specific needs such as dementia care, dignity, behaviours that challenge and end of life care.

All staff were encouraged to choose and take a lead in a particular field, do research and gain further knowledge that could benefit people and the whole of the staff team. There were leads in dignity and infection control. This ensured that staff had instant access to guidance and advice in particular fields, to care for people's specific needs effectively. Some of the staff had requested and received training in epilepsy, and mental health issues such as anxiety and panic attacks. Several care workers and housekeeping staff had received advanced training in dementia care and all other staff were scheduled to follow.

Care staff were supported to study and gain qualifications for a diploma at different levels in health and social care. All care staff held a diploma in health and social care or were working towards it. One newly recruited member of staff had been encouraged to join the studies programme at the end of their six months' probation.

There was an effective system of communication between staff. Staff handed over information about people's care to the staff on the next shift. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was recorded on portable devices and shared by staff appropriately. The registered manager accessed that information on her office computer, so the management team and care staff were aware of any developments without delay. There was a communication book used by staff to record people's visits from healthcare professionals and a diary updated with people's external appointments. This system ensured effective continuity of care.

At our inspection in July 2015 we found that the home's layout, décor and facilities were not suitable for the diverse needs of people living at The Hollies. We issued a requirement notice in relation to this breach of regulation. At this inspection we found that action had been taken and that most of the required improvements had been made to meet people's environmental needs. The registered manager showed us their action plan that was still in progress. They had monitored each repair and improvement of the home to enhance people's experiences in the service. They told us, "We still have two bedrooms which are not completely finished but will be shortly; we also plan to replace every bed in the home; when the inside is totally finished we will tackle the outside of the building." We will follow this up at our next inspection.

The provider and registered manager were implementing an extensive redecorating and refurbishment

programme throughout the premises. New space had been created that provided two quiet lounges where people could relax in or talk with their families in private if they did not wish to go up to their bedrooms. A room had been converted in a hairdresser's salon including an adapted sink and a wide mirror. A person told us, "This is really lovely to have that." We observed staff escorting people in the lift to their bedrooms when they wished throughout the day. All wall surfaces throughout the premises had been redecorated in calming tones and some areas in bright colours to stimulate people's visual interest. Light fittings had been replaced throughout the home to provide more light and create a welcoming atmosphere. All floorings had been replaced with non-slip floorings that were easy to clean. Each bedroom doors had been painted in different colours and displayed people's photographs to help people find their way around. All mattresses covers and pillows had been replaced and were regularly checked by housekeeping staff. All armchairs and sofas had been replaced with comfortable furniture that was easy to maintain. The lower ground floor opened onto well-kept gardens which were accessed by a ramp. People could relax in the garden where there was garden furniture and parasols. The conservatory had been fitted with an air conditioning system to adjust temperature. A further delivery of bedrooms furniture was due in June 2016.

Good

# Is the service caring?

## Our findings

People told us they were satisfied with how the staff cared for them. They said, "All the staff are ever so kind", "They are like my family", "I like them, they are a lovely bunch and they always cheer me up" and, "They always give me choices, they are very thoughtful." Relatives described the staff in very positive terms and described them as, "Remarkable", "Wonderful" and, "Ever so caring."

At our inspection in July 2015 we found instances where people were not consistently treated with respect and compassion. We issued a requirement notice in relation to this breach of regulation. At this inspection we found that action had been taken and that the required improvements had been made to promote people's wellbeing and dignity.

As staffing levels had been increased, staff had more time to spend one to one time with people and support them. We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people. Staff treated people with kindness and addressed them respectfully by their preferred names. We observed laughter as well as gentle reassurance with appropriate body language, such as staff leading a person gently placing a hand on their arm. A member of staff sat with a person and asked questions about their past and encouraged them to recollect happy memories of them having lived abroad. Staff anticipated people's needs and asked them what they would like to do next or where they would like to go, and provided the support that was required.

Care workers showed patience when they responded to people's needs. One person had complained about the way their eggs and toast had been cooked had sent them back to the kitchen three times. On each occasion staff were polite and did much to reassure the person that it was no trouble. Another person became agitated when her hair was being washed in the hairdresser's salon. Staff took time to sit next to them and provide reassurance to that person.

People's care files included clear instructions to staff about best to communicate with people. They included how people preferred to be named, whether they had hearing or visual impairment, or whether they experienced any anxieties that needed specific communication methods. Instructions were in place for staff, for example about how to interpret a person's body language and alleviate a person's anxiety. This was applied in practice. A relative told us, "They know the signs and how to talk to her and calm her down." Staff knew how to communicate with each person. They bent down so people who were seated could see them at eye level; they checked people's hearing aids regularly. A person had hearing impairment and staff used a system of pointing and showing options for them to make their choices. All staff used positive body language and were smiling when conversing with people. We observed how staff communicated with people when they used equipment to help them move from one place to another. The staff talked clearly to the person in a reassuring tone through each stage of the procedure, ensuring the person knew what they were going to do next.

When a person had stated their preferences about being cared for by male or female staff, this was recorded in their 'at a glance' care plans in their bedroom and in the main care plans. Such preferences were respected. People were assisted discreetly with their personal care needs in a way that respected their dignity. A dedicated private space was used when people needed treatment or medical examination from health care professionals. A hairdresser's salon had been created for people's enjoyment. A privacy screen was used to preserve people's privacy in the lounge when equipment was used to help them move around.

Staff closed doors when helping people with personal care and people told us they were respectful, taking care to cover them when necessary. They used a sign on the door to prevent people from entering. Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. The area manager and registered manager had held a 'dignity meeting' with staff to discuss how people's dignity could be further improved in practice, and regular 'dignity meetings' were scheduled. Staff were routinely reminded about practice in regard to people's dignity at handovers. People's information was stored in staff hand held devices and in files that were securely kept to maintain confidentiality. With these systems in place, people could be confident that their privacy and dignity were promoted.

People's spiritual needs were met with the provision of religious services in the home. A Catholic priest visited the home every two weeks and the registered manager was in process of engaging a new local Anglican priest to maintain regular contact with people in the home.

Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. Some people needed encouragement and this was provided. A person told us, "They stay with me while I wash just to make sure I don't have any trouble, they don't take over. "People followed their preferred routine, for example some people chose to have a late breakfast, stay in bed or stay up late. One person liked to have their breakfast in bed before getting up and this was provided. Staff presented options to people so they could make informed decisions, such as what they would like to wear, to eat and to do, so that people could be in control of their day. People were enabled to maintain their independence with a positive approach to managing risk. For example a person used the lift independently. Associated risks had been assessed and discussed with them. As staff encouraged people to do as much as possible for themselves, people's independence was supported.

Each day, a resident was celebrated as 'the resident of the day'. Staff told us how, on that particular day, they made people feel 'special'. Their hair and nails were done, their room was checked in detail by maintenance staff, domestic staff tidied up their wardrobe, they were invited to cook or bake in the kitchen, and photographs of the day were taken for them to keep. A person told us, "It is a little bit like a birthday."

Clear information about the service and its facilities was provided to people and their relatives. A new brochure that provided information about the home, the services, the staff, activities, outings, and residential care was being updated. People were provided with a service user's guide that used pictorial illustrations as well as text, and which was available in a large format to help people with visual impairment. This guide gave clear information about a typical day at The Hollies, the staff, the services provided and additional services, pets, end of life care and how to lodge a complaint. The weekly programme of activities was displayed in the communal area in a pictorial format to help people understand what was on offer. There was a pictorial menu and the provider had organised for photographs of dishes to be taken and shown to people. The provider maintained an informative up to date website that was easy to navigate.

People were involved in their day to day care when they were able to and when they wished to be.

Staff built up close supportive relationships with the people they provided care for, and their family and friends. People and when applicable their legal representatives were involved in decisions about their care and in agreeing their care and support plans. A relative told us, "The registered manager sends us a letter before monthly reviews to invite us to participate."

People could be confident that best practice would be maintained for their end of life care. People or their legal representatives were consulted about how they wished the service to manage their care when they approached the end of their lives. The registered manager showed us how sensitive enquiries were made about people's wishes at the beginning of their stay. These wishes, including decisions about resuscitation, were appropriately documented in people's files. Staff were supported by a local hospice palliative team with whom they worked in collaboration.

Good

# Is the service responsive?

## Our findings

People gave us positive feedback about how the service and the staff responded to their needs. They told us, "They know me and know what I like", "There is always plenty to do, I can always join the activities in the morning or in the afternoon if I want" and, "They call the GP as soon as I feel unwell." Relatives told us, "The staff could not do more; they know each resident well and now they have more time to give them."

At our inspection in July 2015 we found people were at risk of becoming socially isolated with little activity to stimulate or interest them. We issued a requirement notice in relation to this breach of regulation. At this inspection we found that action had been taken and that the required improvements had been made to provide a programme of varied activities to suit people's needs and preferences.

A range of daily activities that were suitable for people was available. Although the service was still attempting to recruit a suitable activities coordinator, the deputy manager had devised a varied programme of activities that were suitable for people and for people who lived with dementia. These activities took place twice a day and were provided by care workers. The range of activities included word searches, quizzes, skittles, bean bag games, singing and karaoke, board games, card games, reminiscence, Bingo and art and crafts. At Easter, people had decorated Easter eggs and had participated in an Easter bonnet competition. People were encouraged to ice cakes, to place toppings on pizzas and create fruit cocktails 'smoothies'. Attention had been paid to people's life stories and hobbies, what they preferred to do, and options of activities were discussed at residents and relatives meetings. As a result of a meeting, knitting had been introduced and a person had knitted a maternity blanket for a member of staff. Two people enjoyed gardening and were potting plants from seed and cuttings. People's activities care plans reflected what they liked to do and how this was to be provided.

Staff responded to people's individual emotional needs and ensured isolation was reduced. We observed activities being provided and staff adapting the programme to suit people's mood. Each person was invited to join if they so wished. A member of staff accompanied a person who wished to dance and danced with them; another sat with two people who wished to paint cards; and other members of staff were engaging with people who preferred to watch activities rather than participating. The atmosphere was convivial and people were laughing with staff. A person told us, "They are such a good bunch, we have a laugh together, and there are plenty of things to do so we don't get bored."

External providers of activities had been commissioned to entertain people. A person came to coach 'seated Zumba' twice a month; an entertainer came to play guitar and sing with people once a week; A 'Zoo lab' and visiting dogs came to the home quarterly, and two singers came to sing songs from the forties every month. A magician had performed in the home and a ventriloquist show was scheduled.

People's relatives were welcome at any time and were able to stay and share a meal with them.
Outings were provided to maintain links with the community. People had been escorted to visit garden centres, to the coast for a day, to a farm where they could pet animals, and to a local pub for a meal. Events

took place in the home such as a 'Queen's birthday party', a 'cheese and wine afternoon' where relatives were invited; a 'pub day' with karaoke, and a 60th wedding anniversary party for a person who lived in the home and their spouse. Staff took care to decorate the home before each event and involved people in the process.

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments were comprehensive and included appraisal of people's physical wellbeing, mental state, mobility and dexterity, food preferences, communication, social interests, skin integrity and risks including falls. People were encouraged to recall their history which was shared with staff. The registered manager had started to collect each person's personal accounts of their life and experiences. This enabled staff to gain further insight and understanding of the resident's background and interests and ensures the care and support the resident received met their cultural and spiritual needs and that their lifestyle preferences were respected. An assessment of how people had been encouraged to express their wishes and contribute to their care planning was undertaken, to check that people had been involved with their assessments.

Individualised care plans about each aspect of people's care were further developed within 72 hours after their admission into the service, as staff became more acquainted with people's particular needs and their choices. People's care plans included more detailed information such as assessments of mental capacity when appropriate, nutritional needs, continence, and involvement in the planning of their care. When people had particular conditions, such as an infection, epilepsy or breathing difficulties, or when they were unwell, individual care plans were written in these domains to instruct staff how to care for people's individual needs. Staff we spoke with were aware of individual requirements and were able to describe to us how they cared for people. Their descriptions matched the instructions in people's care plans.

All care plans were routinely had been reviewed and updated by the registered manager on a monthly basis, or sooner when needed. Staff were made aware of any changes and updates. People or their legal representatives were routinely invited to be involved with the review of their care. A relative told us, "They send me a letter telling me a review is coming up and asking me if I would like to come." Relatives who lived at some distance were consulted over the phone.

People were offered choice and their wishes about when to get up, when to go to bed, what to eat and what to do were considered and acted on. For example, some people liked to go to their bedroom before supper time and eat in their rooms. They told us they could have a bath or a shower as often as they wished and that their refusals were respected. They said, "I can have a shower every day but I prefer to have it before I get my hair done" and, "I like having a bath once a week but I could ask for more and I would get it." The registered manager showed us how bathing tasks were documented and audited to ensure this was taking place.

People were aware of how to make a complaint. The complaint procedure was displayed in evidence in the communal area and was included in the 'service user's guide'. It was available in a format suitable for people with visual impairment. A person told us, "I know who the manager is and I would talk to her." A relative told us, "We have total confidence that the manager would put right whatever we would complain about." Complaints were addressed as per the service's complaint policy. Since our last inspection, one complaint had been received and remedial action had been taken to a satisfactory outcome.

Good

# Is the service well-led?

## Our findings

People, relatives and staff told us the service was well led by the new registered manager. All were complimentary about the registered manager's approach and style of leadership. People told us, "She is ever so kind"; "She is lovely and easy to talk to." Relatives told us, "The improvements that she has made to the home are plain to see, you can see how much happier this place is" and, "She is like a 'force of nature'", "It feels like a different place, not only the décor but the whole atmosphere has improved, everyone is smiling." A local authority case manager who oversaw a person's care in the home told us, "I find the manager very approachable and caring, her commitment to the residents is without doubt above and beyond what would normally be expected from a manager; she takes the time to get to know her residents."

Staff were very positive about the support they received from the registered manager. They reported that they could approach them with concerns and that they were confident that they would be listened to and supported. They told us, "She has accomplished so much; she is very energetic and gets things done straight away" and, "She really cares for the residents and also for the staff." A GP who visited the service regularly to provide treatment for people told us, "This manager is very confident, conscientious and reliable; she is the driving force behind all the improvements in the home."

The registered manager had been in post since November 2015 and was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. The registered manager described their philosophy of care as, "Making sure that each person in this home feels this is their home; treat people as a member of our own family." The registered manager promoted a culture that was person-centred. Each person we spoke with was fully aware of who the manager was and the manager knew each person by name as well as being well acquainted with their individual needs and preferences. A member of staff told us, "She leads by example and has shown us how to do things; now that staffing levels have improved we can concentrate more on each resident; everyone seem more relaxed just enjoying each other's company."

At our inspection in July 2015 we found that the monitoring systems in place were not effective and that records were not always accurate or up to date. We issued a requirement notice in relation to this breach of regulation. At this inspection we found that action had been taken by the new manager and that the required improvements had been made to ensure an effective monitoring system of the quality of the service and of relevant documentation was in place.

The provider and registered manager had written an action plan which they had followed to drive improvements in the home. The registered manager had ensured that the shortfalls we had identified at our last inspection had been remedied. The improvements that had been carried out addressed repairs and décor of the premises; the lift; staffing levels; recruitment records; activities; care records and involvement of people in the planning of their care.

The registered manager was supported by an operations director and an area manager. The area manager

did a monthly 'provider visit' to The Hollies to inspect every aspect of the service and wrote a report based on the Health and Social Care Act 2008 requirements. This report identified what action was to be taken and their level of urgency. An action plan resulted from this report, which was followed up by the registered manager. At each visit, the area manager checked that action had been effectively taken. The last action plan had led to further training in mental capacity to be scheduled for staff, and an additional 'protection plan' for a person who displayed signs of anxiety. This had been implemented.

We looked at the current provider's business development plan for The Hollies. It included a relocation of the hairdressing room, the creation of a new laundry area, a replacement of floorings, of lighting, and of furniture. Most of the proposed actions had taken place within a set time frame and their completion was appropriately monitored. A plan to maintain and redecorate the exterior of the premises was scheduled to take place. The registered manager told us, "We take care of people and of the inside first but everything that needs to be done will be done." We will follow this up at our next inspection.

The registered manager completed a wide range of audits to identify how to improve the service. An audit on falls had identified a pattern linked with the timing of people's main meals. As a result, the main meal was provided in the early evenings and a light lunch was provided during the day. The registered manager explained to us the rationale behind this decision, and as this measure had significantly reduced falls in the home, they planned to share this idea with other homes to benefit others.

Other audits included care documentation, medicines records, meals, health and safety, personnel files, infection control and findings obtained during daily 'walk rounds' of the home. During these walk rounds, the registered manager and the deputy manager checked staffing levels and staff practice, the cleanliness of rooms and communal areas, looked at medicines administration records, at food and fluid intake charts and ensured people's nutrition and hydration needs were met. They also observed people and staff at mealtime, and spoke with at least two people who lived in the home to check on their wellbeing and obtain their feedback. These checks were appropriately documented. As a result of some of these checks, senior care staff had been instructed to remain in the lounge areas while staff helped people at mealtimes; legal representatives had been invited to come and sign people's care plans; a plan had been scheduled for staff to fill in any gaps in their employment history. The registered manager had identified a need for staff to take part in team building activities and was checking their availability to schedule this. The registered manager reported their audits weekly to the operation director. These weekly reports also addressed occupancy, deaths, admissions, discharges, complaints, falls, staff sickness, and accidents and incidents.

The operations director met with regional and area managers to look at 'root cause analyses and discuss feedback from the provider visits. They also met with The Hollies registered manager and managers of sister homes every two months to discuss practice and exchange ideas.

People had been consulted about improvements in the home. For example, they had been involved in choosing colouring of the walls in the communal area, new items of furniture, which colour to decorate their bedroom door, and had chosen a wall hanging from options that were shown to them on the internet.

People had an opportunity to give their feedback about the quality of the service. Once a month, care workers sat with people individually to discuss what they liked, any concerns they may have, what they would like to see improve, and to gather their overall feedback. This was recorded in satisfaction survey questionnaires that were audited by the registered manager. The last survey indicated that people were very satisfied with the quality of the service, the food, the staff and the activities. Quarterly residents and family meetings were held to discuss as a group any possible improvements of the service. At the last meeting in April 2016, a person had expressed the wish to go out shopping; particular desserts had been suggested;

types of flowers had been suggested to plant in the garden; outings destinations had been selected. These wishes had been implemented.

Feedback from relatives was sought and acted on and the results of the last survey in April 2016 had been audited by the registered manager. Questions were asked such as, 'what are your views of The Hollies; are you made welcome by the staff; do you believe your relative is well cared for;' and their views were requested about the meals and activities. The outcome indicated that relatives were very satisfied with the improvements that had been carried out and no further improvement had been identified, although one relative had suggested encouraging their loved one to eat more fruit, and another had suggested some activities to be of a more physical nature. As a result a 'seated Zumba' activity had been introduced. Healthcare professionals who visited the home were providing their feedback and this was in progress. We noted that the feedback obtained so far included positive comments on the improvements that had been made.

The registered manager had also carried out a staff survey in April 2016 and had audited the results. Nine members of staff had chosen to participate and their comments were positive. As a few members of staff had requested their one to one supervision to take place every six months instead of two, the registered manager had scheduled to discuss this at the next team meeting.

The service's policies were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. The provider commissioned an external consultancy firm that reviewed the policies regularly and updated them appropriately.

Records were well organised, accurately completed therefore fit for purpose, kept securely and confidentially. Archived records were disposed of safely and appropriately according to legal requirements.