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Hollin Knowle 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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection was carried out on the 23 and 30 September 2015. Hollin Knowle

provides accommodation and personal care for up to 19 older people. At the time of the inspection there were 17 people living in the home. Most of the people had physical difficulties and memory loss.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the last inspection carried out in June 2014 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 These were

Summary of findings

in relation to ensuring people gave consent to their care and ensuring the safety of people in relation to recording incidents. At this inspection we found action had been taken and these issues had been addressed.

Some people's health was not always promoted because medication was not administered, recorded, and managed appropriately. This was a breach of the Health and Social Care Act and you can see what actions we told the provider to take at the back of the full version of this report.

People were protected from avoidable risks and staff were aware of their duty of care to protect people. Staff were trained to recognise and respond to signs of abuse. Risk assessments of people's health and welfare and the safety of the environment were carried out and reviewed regularly.

The staff had appropriate training, supervision and support, and they had some understanding of their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional and dietary requirements were met and a nutritionally balanced diet was provided. However there were no meal choices available. We noted that people appeared to enjoy their food.

People were not supported to pursue their hobbies or interests and they were not stimulated. People we spoke with said they were bored.

People were supported to access other health and social care professionals when required, and encouraged to continue their relationships with their family members and friends.

Staff were caring, kind and compassionate and cared for people in a manner that promoted their privacy and dignity. People felt listened to and had their views and choices respected. However people who needed assistance with eating were not always assisted in a manner that promoted their dignity.

People were involved in making decisions about their care and support. Individual care plans provided information for staff on how to assist and support people in meeting their needs. The care plans were reviewed and updated regularly.

The home was managed in an inclusive manner that invited people, their relatives and staff.to have an input into to how the home was run and managed. There were systems in place to assess, review and evaluate the quality of service provision. However these were not always effective.

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?

Requires improvement

The service was not always safe.

People and their relatives told us that the home was safe but medicines were not managed safely.

Staff were trained to appropriately meet people's needs. There were enough staff to provide the support people needed.

Safeguarding and whistleblowing guidance enabled staff to raise concerns when people were at risk of abuse.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had some understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the associated Deprivation of Liberty Safeguards (DoLS).

People received sufficient nutritious food and drink. However they were not offered a choice of dishes or second helpings.

People had timely access to appropriate health and social care support.

Staff received appropriate training to enable them to care for people. They received regular supervision to enable them to effectively meet the needs of the people they supported.

Is the service caring?

Good

The service was caring.

The staff respected people's wishes and choices and promoted their privacy and dignity.

We observed positive and respectful interactions between the staff and people who used the service.

Staff knew the people they supported and understood their individual care needs.

Relatives were encouraged to visit whenever they wanted. There was an advocacy service available to those who needed it.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs had been assessed and reviewed in a timely manner, however they were not supported to follow their interests or hobbies and many people told us that they were bored.

Summary of findings

Care plans were accurate, up to date and contained clear information for staff to help ensure people received consistent support to meet their care needs. There was a complaints process in place.	
Is the service well-led? The service was not always well led. The quality monitoring systems in place had not always identified areas for improvement. People were enabled to routinely share their experiences of the service and the provider used this information to further improve on the service. Staff were motivated and felt that their views were listened to and respected	**Requires improvement** 

Hollin Knowle 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 was 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 inspection took place on 23 and 30 September 2015 and was unannounced. The inspection team consisted of one inspector.

We reviewed the information available to us about the home, such as notifications and information about the home that had been provided by staff and members of the public. A notification is information about important events which the provider is required to send us by law.

We used our short observational framework for inspection (SOFI). SOFI is a way of observing care specifically to help us understand the experience of people who could not talk to us.

We spoke with four people who used the service, one relative, three care staff and the registered manager. We also observed how care was being provided in communal areas of the home.

We looked at the care records for four people who used the service and reviewed the provider's recruitment processes. We also looked at the training information for all the staff employed by the service, and information on how the service was managed.

Requires improvement

Is the service safe?

Our findings

At our last inspection in June 2014, people were not fully protected from risk of unsafe care because they were not being safeguarded against the risk of abuse. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2010. Following that inspection, the provider told us what action they were going to take to rectify the breach and at this inspection we found that improvements had been made.

At this inspection we found there was no thorough process in place to ensure people were given their medicines as prescribed. People who were prescribed blood thinning medication, (Warfarin) did not have their intake accurately recorded. This is important as the prescribed amount of Warfarin can change on a daily basis and should be recorded in a separate record as well as on the Medication Administration Record (MAR). A review of records showed that the prescription, MAR charts, the Warfarin book and the remaining medicine could not be reconciled. This meant that the there was no way of knowing if people were receiving this medicine as prescribed.

Medicines were not always signed for when they were given. We observed unexplained gaps in the MAR charts. There was no clear reason recorded as to why these gaps existed. The MAR chart had directions for staff to follow should a person refuse their medicines. These were not followed. This meant that the registered manager had no way of monitoring why medicines were refused. This is important because the person may have needed a re-assessment of their medicines. For example if people were refusing their medication because they found it difficult to swallow. By not fully completing the MAR the home had no effective way of monitoring why medicines were refused and if this could be addressed.

On the day of our visit one person had been without their medicines for a fourth day. This had not been addressed until we asked for it to be done. Therefore people could not be sure they got their medicines as prescribed.

The registered manager said they would review how people were given their medicines and ensure the staff who administered it would have additional training if necessary.

This was a breach of Regulation 12Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

All the people we spoke with said that they felt safe living in the home. One person said, “What a silly question as if I would be here if it wasn’t safe.” Another said, “It’s as safe as houses.”

Staff we spoke with told us that they had received training on keeping people safe and were able to demonstrate that they had a good understanding of how to keep people safe. All the staff we spoke with knew the procedures to follow if they suspected abuse had occurred. They assured us that they would follow up on concerns they had until they were sure the issues had been dealt with. We noted that the registered manager had reported relevant incidents of concern to the local authority and to the Care Quality Commission.

People had individualised risk assessments. Each assessment identified the risk to them, the steps in place to minimise the risk and the steps staff should take should an incident occur. For example the risk to people, while assisting them to move, was identified and addressed in the risk assessment. The risks were reviewed regularly and updated when people’s needs and interests changed. The care plans also contained action plans to help prevent accidents such as falls from being repeated. People were supported to take reasonable risks. One person we spoke with told us that they were free to take risks to promote their independence. The risks were discussed with them to endure they understood how to minimise risk while giving them control over their life. We saw another person was at risk of cramp and discomfort from their posture while sitting. We saw their care plan identified this was their choice and directions were given to staff on how to minimise their discomfort.

Staff were aware of and followed risk assessment to ensure the safety of people. This included assisting people to move using a hoist and walking frames. We saw staff assist people to move safely. This meant that the risk to people was recognised and where possible reduced while still encouraging people to be as independent as possible.

People were protected from risk in the environment because the provider had carried out assessments to identify and address any risks posed to people by the environment. These included checks of hot water and fire systems. However, areas of the home were dark as some

Requires improvement

Is the service safe?

bulbs had blown and had not been replaced. This meant that the areas were dark and could prove hazardous for people with poor sight. The provider assured us that they would address this as a matter of urgency.

There were sufficient staff on duty to respond to people's needs in a timely manner. People told us that the staff were good at responding to requests for assistance. One person said that "They are always there when you need them." Another said "Oh yes there is always someone around." Our observations supported this. We saw staff check on people on a regular basis. People told us that call bells were answered in a reasonable time and we saw that staff responded to call bells promptly.

The provider protected people by having a thorough procedure in place for the recruitment of staff. Discussions with staff and a review of records showed identity and security checks had been carried out on staff before they stared working in the home. This included establishing a full work history of the staff member and verifying the information given on pervious employment. Disclosure and Barring Service (DBS) certificates had been obtained for all staff prior to starting to work in the home. This ensured that only people who were suited to work with vulnerable people were appointed. Staff confirmed that they did not take up employment until the appropriate checks such as, proof of identity, references, satisfactory Disclosure and Barring Service (DBS) certificates had been obtained.

Staff told us that there were formal emergency plans with contact numbers available for emergencies to do with the building, such as a gas or water leak. However, they needed more detail on how much assistance people need to be safely evacuated should there be an emergency such as a fire.

Requires improvement

Is the service effective?

Our findings

At our last inspection in June 2014, people were not fully protected from risk of receiving care without appropriate consent or authorisation. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2010. Following that inspection, the provider told us what action they were going to take to rectify the breach and at this inspection we found that improvements had been made.

Some staff had received training in the key principles of the Mental Capacity Act 2005 (MCA) and followed this. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this. Some people were not always able to consent to their care because of their health conditions. People's care plans showed an appropriate assessment of their mental capacity and a record of any decisions about their care and support, made in their best interests. The staff we spoke with were not able to show they understood and related people's care to their responsibilities under the Act. However this did not affect the quality of the care delivered as staff met people's needs.

Where people did not have mental capacity their families or representatives were consulted to ensure the provider acted in their best interests. This meant that people's rights were promoted.

Some people's freedom was being restricted in a way that was necessary to keep them safe, known as a Deprivation of Liberty Safeguard (DoLS). For example, they were not able to independently choose whether or not to live at the home. Records showed that DoLS were formally authorised when required by the relevant local authority, which the provider notified us about. This meant that the registered manager knew their responsibilities in relation to keeping people safe while promoting their legal rights. Care was assessed and delivered in line with the Act staff showed some understanding of it and how and why it operates.

The registered manager said they would assess staffs' training to ensure they were fully aware of their duty of care to people under the Act.

People told us that they had confidence in how their care was delivered. One person said, "They always seem to know what they are doing." Another said, "I was nervous when I first came here, but it's clear they know what they are doing."

People were protected against the risk of poor or ineffective care because staff had been trained to meet their needs. Conversations with staff and our observations showed staff were aware of people's specific needs and met those needs in a patient and skilled manner. For example we saw staff escort people from room to room. We saw staff allowed the person they were assisting to set the pace and not rush them or make them feel they were slow. Another staff saw one person was sitting in an uncomfortable position. Staff took care to ask them if they wanted to move and them to make them more comfortable. This meant that people were receiving the support they needed.

There was a training matrix in place. This identified when staff's identified training was due and completed. The training covered all aspects care delivery. The provider also had staff development plans in place. All staff had completed training the provider considered necessary. In addition to this some staff were considering taking advanced qualification in caring for people.

New staff had an induction period and spent time shadowing experienced staff. However one new staff member had not yet completed all of their mandatory training. This included assisting people to move safely. We were told that they did not carry out tasks such as assisting people to move using a hoist. This approach to training ensured people were kept safe from foreseeable harm.

People said the food was, "not bad", another said, "It's what I like." People did not have input into menu planning. We noted that people were not offered a snack with their morning drink. When we enquired why the provider/ registered manager said they had stopped offering people a snack because it impacted on their appetite for lunch. They were not able to show us how people had been consulted on this or were happy with it.

Lunch was plated in the kitchen. There was no way of keeping food hot as it was taken uncovered to the dining room on an unheated trolley. Staff said that because the kitchen was so close this was not a problem. There was no choice of main course. However we noted people enjoyed

Requires improvement

Is the service effective?

their food. The portion size was the same for all and no one, even those who scraped their plates, were offered additional portions. We discussed this with the registered manager who told us that they would review the whole process from menu planning, delivery of food and portion size to ensure people were involved in menu planning and staff were aware of different nutritional needs and wishes.

Drinks were available within easy reach of people. People who were at risk of poor nutrition were referred to appropriate health care professionals such as dieticians. Food was served in a manner that allowed people to eat it. This included people who needed a soft diet and those who needed their food pureed so they could eat it safely. Food supplements were available for those who had it prescribed.

People were supported to have optimum health. Records demonstrated that referrals were made to relevant health care professionals such as dentists, opticians and nursing care as required. Staff said any concerns were raised and discussed with the person's GP. People were able to retain their own GP if they preferred. This was supported by health care professions we spoke with, who confirmed they were happy with the care delivered to people. They said there had been improvements in the care of people over the past few years. This approach to health care ensured that people's health and welfare was promoted.

Good

Is the service caring?

Our findings

People told us that the staff and management treated them with respect, dignity and compassion. The staff ensured people's needs were met and this was reflected in the care practices we saw. Staff were courteous, discreet and respectful at all times. People said given as they could not be in their own home they enjoyed living there. One person said, "We have staff here from all over, they are all so caring, I wouldn't change any of them." We saw that consent was obtained before care was delivered. People had their care delivered in private behind closed doors. We saw staff knocked on people's doors and waited to be invited in before entering the room.

People said that staff listened to them and tried really hard to make sure they were comfortable and had what they needed for the day including glasses and hearing aids. This meant that people were prepared for the day ahead.

People told us that were given enough information to enable them to choices on how they wish to live. One person prefers to stay in their own room and this is respected. Another said that "Yes I am given choices on how I want to spend my day. My family regularly come and take me out. I know why I am here and the staff make my life here as close to how I want it as possible." Another said, "The staff come in regularly to check on me and to make sure I have all I need." Rooms were personalised and contained furniture and items that people had brought from home. This meant that rooms represented people's individuality and were homely.

People who did not have representatives had access to an advocacy service to ensure there was independent input into how their needs and wishes were responded to.

All the people we spoke with said staff were respectful to them and treated them in a dignified manner. One person said, "The girls are so lovely, so kind and caring." Another said, "They are nice." During the visit we saw numerous positive interactions with staff spending time engaging with people whenever they wanted a chat.

However, people who needed assistance with eating did not have this done in a discreet and dignified manner. Staff did not sit down and create a pleasant and relaxing atmosphere. Instead they stood over the person and offered food before they had swallowed what was in their mouth. This meant that the experience for the person they were assisting was not relaxed and unhurried. The registered manager said they would address this as a matter of urgency and would review how people were assisted to eat.

People and relatives we spoke with told us that friends and relatives could visit at any time. One relative told us, "We were here most of yesterday and are here again today." Another said, "We can come any time during the day or evening." The provider said that relatives were welcome to stay as long as they chose. In times of an emergency they provided tea and sandwiches for visitors. This meant that people who used the service could be sure their relatives were welcomed to the home and their relationships outside the home were promoted.

Requires improvement

Is the service responsive?

Our findings

We saw that staff had a good understanding of, and were knowledgeable about, people's individual needs. They were able to tell us about people and what their care and support needs were. However, people were not offered meaningful occupation of their choice. The communal rooms did not contain objects of stimulation or comfort such as magazines, newspapers or tactile objects. These are important to keep people stimulated and engaged with their surroundings. People said they were bored. We saw that people were not stimulated as during the day we didn't see any structured activities for people, either individually or in groups.

The television was on in one lounge and some people were sitting at an angle where they could not see the screen. The second lounge had nothing for people to engage with. One person said "Without my puzzle book I would be lost." Another said "Without my family I would have nothing to do." Staff we spoke with did not always understand the need to offer stimulation to people. We were told "They prefer to sit and watch." However they were unable tell us what activities people had been offered. This meant that people did not have the opportunity to promote their mental health through mental stimulation.

One person told us "I have come on no end since I came here." Another said "Although it's boring here the day passes quickly enough." A third said "I would like to go into the town more."

None of the people we spoke with had been asked what their interests were and none of the care plans we looked at had details of people's hobbies or interests. This approach to care left people unstimulated and bored. We spoke to the registered manager about this and they undertook to explore options on how to engage and stimulate people.

All the people living at the home had an assessment of their physical health needs and wishes. Care plans had clear personal information in them. People had their care needs documented in their care plans. Care plans were detailed and provided staff with specific information for staff on how to recognise and meet people's health care needs. Some of the staff we spoke with had not read all the care plans. However they knew people's individual needs and wishes. We saw that care plans were reviewed and when there was a change in people needs they had been updated. This meant that people had care that was up to date and met their physical needs and wishes.

The provider had systems in place to ensure people who used the service and/or their representatives had the opportunity to offer feedback on how the service was delivered. The provider sent out a questionnaire once a month. We saw that there was a good response to the questionnaire and the comments were mainly very positive.

The provider had a complaints policy in place and we saw that it had been followed in responding to the only complaint received since the last inspection. The complaint had been resolved to the satisfaction of the complainant.

Requires improvement

Is the service well-led?

Our findings

There was a quality assurance system in place to identify areas that required improvement and areas where the home was performing well. Care plans had been audited and where there was conflicting information it was clarified and directions to staff rewritten.

The quality assurance system the registered manager had in place had not identified medication errors identified during this inspection. However, most of the errors had occurred in the previous week. The registered manager said that they would have been picked up at the next audit. However they said they would put a system in place to have the MAR reviewed each time medicines were administered by staff. The registered manager undertook to complete a full audit of medicines in the home. The medicines had been audited by their supplying pharmacy and suggestions made on how to improve the delivery had been adopted.

The quality assurance process had also not identified and addressed the issue that people were bored and lacked stimulation during the day. The registered manager said that this had not been part of their quality assurance audit. They said that in future it would be included as they understood it was important in keeping people healthy and stimulated. The registered manager had notified us of incidents they are required to by law.

The provider had a clear vision for how they wanted the home to operate. Their priority was to create a homely environment. This was evident in soft furnishings, fresh flowers and personalised bedrooms.

People, their relatives and staff told us there was an open door policy that made them feel comfortable in approaching the registered manager and the provider. One person told us, “Any problems whatever they are, [registered manager] is always around to chat about things and to sort them out.”

The service is required to have, and did have a registered manager in place. Staff told us that the registered manager led by example and was often seen to deliver care to people. It was clear that the registered manager knew all the people who used the service and was able to tell us their particular needs. This approach to management meant that problems were identified and solved before they became an issue. For example the call bell system was not working at the beginning of the inspection. The provider was contacted and the issue was resolved in a short time.

Staff said that the registered manager was easy to talk to and was very supportive. Staff had been supervised according to the provider’s policy. Staff acknowledged this and said they were well supported and that morale in the home was good. There was a low staff turnover, with a core group of staff who had worked in the home for many years this created a stable environment in the home.

Staff were aware of their role and were able to tell us what their responsibilities were. Staff were aware of who they should report their concerns to. All staff were aware of the whistleblowing policy and the registered manager understood and supported the policy. This open approach to management meant that staff were encouraged to have input into the service and have their views respected. This meant that information was captured and used to improve their care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service could not be sure they would get their medicine as prescribed by their GP.