HICA

The Hollies - 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?	**Requires Improvement**

Summary of findings

Overall summary

About the service: The Hollies is a residential care home. The service offers accommodation and personal care to people aged 65 and over and people living with dementia. At the time of the inspection 43 people were using the service.

People's experience of using this service: People did not always receive their medication as prescribed. Risks to people were not effectively mitigated. The nurse call system was not in working order meaning people's sensors mat could not work effectively. This meant people could be left at risk of harm as staff would not be alerted.
Accident and incidents were not recorded and logged correctly meaning they could not be effectively monitored. At times, people were unsupervised, and we observed them carrying out unsafe activity. This was not observed by staff, as they were busy elsewhere. There was concern from staff about staffing levels, however people who used the service told us there was enough staff available.

We have made a recommendation about staffing.

Further work was required to help people with dementia make choices regarding their meals. Monitoring records were not consistently completed, meaning effective monitoring could not take place. People were supported by staff who were trained and supported in their roles he premises were designed and decorated taking account of the needs of people with dementia.

We observed mixed interactions between staff and people who lived at the service. We saw some staff offering people reassurance in a caring manner. However, we also saw some staff supporting people with tasks and not speaking to the person first. People told us staff were kind and caring.

Care plans were not regularly reviewed and did not always reflect people's needs. Activities were available to people if they chose to participate.

Meetings were held with people, staff and relatives to engage them in the running of the service. Feedback was gathered from people in surveys, however it was not always correctly analysed. Governance systems had failed to address areas of concern identified at inspection. The provider had developed an action plan, although extensive it had failed to address all areas identified at inspection.

Details of the action we have asked the provider to take can be found at the end of this report.

Rating at last inspection: At the last inspection the service was rated good (Published 18 April 2018).

Why we inspected: This inspection was brought forward due to information of risk and concern.

Enforcement: We identified two breaches of the Health and Social Care Act (Regulated Activities)

Regulations 2014. Please see 'the action we have told the provider to take' section towards the end of the report.

Follow up: We have asked the provider to send us an action plan telling us what steps they are to take to make the improvements needed. We will continue to monitor the service through the information we receive until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Hollies - Care Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by two notifications of incidents where people using the service sustained a serious injury. These incidents may be subject to a criminal investigation and as a result this inspection did not examine the circumstances of them.

The information shared with CQC about the incidents indicated potential concerns about the management of risk. This inspection examined those risks.

Inspection team: The first day of inspection was carried out by an inspector, assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by one inspector. The third day of inspection was carried out by two inspectors.

Service and service type: The Hollies is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did:
Before the inspection we looked at information we held about the service such as notifications we had received from the registered manager. A notification is information about important events, which the service is required to send us by law. We did not ask the service to complete a Provider Information Return

before this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, senior home manager, regional director, regional manager, quality assurance manager, quality assurance advisor. We spoke with six staff, the activities coordinator, three people using the service and four relatives. We looked at the care records for four people who used the service. We reviewed medication administration records. We looked at a range of documentation used for the management of the service such as staff rotas, training and supervision records, quality audits, cleaning schedules, records of meetings and maintenance of equipment. We completed a check of the environment.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; Using medicines safely

- Safety equipment was not in working order. For example, the nurse call system was not working so safety equipment could not be used effectively. This meant staff would not be alerted when people required support.
- People's care plans detailed the requirement for regular checks on sensor mats to be carried out. These checks were not taking place.
- Risk assessments were not always followed to mitigate risks to people. For example, one person's risk assessment stated they should only use the wheelchair for transferring. However, on one occasion, daily notes and charts showed this person had been left in their wheelchair for a number of hours.
- Risks were not always mitigated in relation to pressure care. People who required repositioning every two hours, did not always receive this support in a timely manner.
- Care plans and risk assessments were not always in place to guide staff how to deliver safe care when supporting people with tasks such as bathing.
- Detailed assessments were carried out prior to people moving to the service. However, the risks identified in assessments were not always safely managed. For example, one person's assessment identified the risk of absconding but there was no risk assessment in place. This person had left the building putting them at risk.
- Medication was not always administered as prescribed.
- Medication prescribed for use 'as and when required', such as anti-psychotic medication, was administered when this was not required. For example, one person received lorazepam and their daily notes reflected this was not required.
- Medical advice was not sought when people were not taking their prescribed medication.
- Covert medication plans were not in place to advise staff how to administer this medication.
- It was not clear from medicine administration records that staff had applied people's prescribed creams as required.
- People's medication care plans lacked detail. This meant staff did not have information about how people preferred to take their medication.

The failure to operate safe medication systems and to effectively assess and mitigate risk to people is a breach of Regulation 12(2)(g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The regional director assured us the concerns regarding medication would be addressed and arranged for immediate training for staff following our inspection.

Staffing and recruitment

● The provider had a tool to assess the number of staff required, based on people's support needs. Staffing was provided in line with this. However, on one day of the inspection we observed people were not supervised in the lounge area and were left carrying out unsafe tasks.
● We also observed during the early morning people were not able to have support they requested as staff were not available.
● Staff told us, "When two of us are supporting someone with personal care in their room there is no-one else in the lounge, it's really difficult. When we've got so many people with behaviours. The senior can be doing medication and then there's us left, but some people need two staff, so we can't help them. We can't do anything until there's someone else free."
● People told us there was adequate staff, Comments included, "Yes I get support when I need it, I can't praise them enough" and "You only have to call out and someone would be here."
● Recruitment checks had been carried out prior to staff been employed.

We recommend the provider review staffing levels and deployment in line with people's needs and best practice.

● The regional director informed us a full review of staffing levels and deployment would be conducted.

Preventing and controlling infection
● The home was clean throughout the inspection. The service had domestic staff and cleaning schedules in place.
● Staff used personal protective equipment to help prevent the spread of infections.
● Some infection control practices needed improving. For example, tooth brushes where sometimes stored with nail brushes, meaning there was a risk of spread of infection. Some people's toilets did not have pedal bins in. These issues were addressed during the inspection.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding applications had been submitted. However, the records for these were not always available.
● Staff had knowledge of safeguarding procedures.

Learning lessons when things go wrong
● Accidents and incidents were not monitored effectively to identify any trends. For example, on the accident and incident database the times were not correctly recorded.
● Accident and incident databases were sent to senior management to be reviewed. However, we noted not all accidents were recorded on this. This meant the information about some accident and incidents was not passed onto the senior management team.
● Recording on accident reports was not always completed correctly. For instance, it was not always clear the time of accidents, so people were unable to monitor the times of accidents effectively.
● Some accident reports contained insufficient detail.
● A new policy and associated documents had recently been introduced to try eliminate the concerns with accident reporting and monitoring.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Supporting people to eat and drink enough to maintain a balanced diet
- People at high risk of malnutrition could not be effectively monitored as records regarding their fluid and diet intake were not accurately completed.
- People with dementia were not always fully supported to make choice of their meals. One relative told us, "When choices are given it's a bit irritating; like meal choices it's just words, they would benefit from pictures."
- One person's care plan stated, 'staff are to choose this person's meal from what they like'. However, the care plan did not detail what this person liked.
- People told us the food was nice. One person told us, "The food is beautifully cooked."
- A variety of food and drink was readily available to people at all times.

Staff support: induction, training, skills and experience
- Staff received induction prior to starting work at the service.
- Staff told us they received regular training and supervision. One staff told us, "The training is very good. They keep you up to date because it pops up on the computer when you're going out of date."

Adapting service, design, decoration to meet people's needs
- The service was signposted for people with dementia. Doors had been painted different colours to support people to identify rooms.
- There were themed areas of interest allocated throughout the service, providing people with quiet spaces to spend time.
- People could freely access and enjoy outdoor areas.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
- Detailed assessments were carried out prior to people moving to the service. However, some risks had not been identified.
- People were supported to access health care services.
- When advice had been given from health professionals, this advice was not always clearly recorded in people's care plans and there was not always evidence in monitoring records to confirm if the advice was being followed.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Capacity assessments and best interest decisions had been carried out for a variety of decisions. However, we saw some people who had sensor mats in place did not have best interest decisions in place.
- People's care plan had details of people who had the legal authority to make decisions on their behalf. However, one care plan contained conflicting information.
- Deprivation of liberty applications had been submitted. However, some records were not always available.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Not all staff treated people with dignity and respect. We observed both positive and negative interactions during the inspection. For example, we saw staff offering reassurance to people and putting people first rather than tasks. However, we also observed some staff talking about people like they were not there.
- Staff were not always able to be responsive to people's needs. For example, we observed one person asking to be supported with different tasks, such as having a shave and to be taken to their room. This person asked on numerous occasions, but staff were either not present or busy.
- People and their relatives told us staff were kind and caring. Comments included, "They are more than caring, they really are, they treat me just like a friend." When asked if staff were caring, a relative confirmed, "Very much so, [person] thinks the world of them."
- Staff had received equality and diversity training. People's religious needs were recorded in their care plans.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives were involved in the development of their care plan. People had consented to their care plans if they agreed with their care.
- Resident and relative's meetings took place for people to express their views.
- The registered manager told us nobody who used the service currently required an independent advocate. Family members were involved to support people with making decisions. Information was available in the service if people required an advocate.

Respecting and promoting people's privacy, dignity and independence

- People told us their privacy and dignity were respected. One person told us, "I was nervous at first about having support, but staff are kind, so I don't get embarrassed. It's a woman washing a woman, I can't speak highly enough of the staff."
- We observe staff respecting people's dignity during the inspection. However, we also observed staff standing whilst supporting people to eat their meals, which did not maintain people's dignity. This was addressed by the registered manager during the inspection.
- People were supported to maintain and develop relationships with those close to them. Family and friends visited throughout the inspection and there was a family room and drinks available to visitors.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
- Care plans were not regularly reviewed, so did not always reflect people's needs.
- Care plans were inconsistent in quality. Some care plans contained person-centred information but others were brief and lacked detail.
- Care plans and risk assessments were not always in place to guide staff on how people like to be supported with personal care tasks, such as bathing.
- Most staff knew people and their needs, but this was not reflected in care planning.
- Monitoring records were not completed consistently, to show that people received care in line with their needs and preferences.
- The service had an activity coordinator on shift every day. We observed a variety of activities taking place during the inspection.
- People told us activities were regularly available. One person told us, "I like reading, they're going to arrange some trips. There are activities, something on every day, I enjoy them."
- The provider had purchased equipment to support people to participate in sensory activities.
- The activity coordinator was trained to provided fitness classes and these were available for people to participate in on a regular basis.

Improving care quality in response to complaints or concerns
- Complaints had been responded to in line with policies and procedures.
- Relatives told us they were able to raise concerns and that these were dealt with. One person commented, "Not had to raise a complaint, raised certain matters and they were corrected straight away."
- The complaints procedure was displayed in the building.

End of life care and support
- Nobody was receiving end of life care at the time of the inspection.
- There was limited information about people's end of life wishes in care plans. The registered manager told us this was something the service was looking at improving.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service was not maximising opportunities to continuously learn and improve because monitoring systems were not used effectively. For example, the accident report database did not contain accurate information to enable effective monitoring.
- Governance systems had failed to identify and address the concerns we identified with regards to identifying and mitigating risks to people and medicines practices.
- Systems had failed to ensure accurate and contemporaneous records of each person were kept. For example, some people's care plans and risk assessments had not been reviewed and did not accurately reflect people's needs. Records about the care people received did not always contain adequate detail. Monitoring charts in place were ineffective as they were not consistently and accurately completed.
- Quality assurance systems had failed to ensure regular checks were carried out on equipment such as sensor mats.
- Accident and incident records were not accurate so could not be effectively monitored.

The failure to operate effective systems to improve the quality and safety of the service and to keep accurate and complete records was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The senior management team recognised the service needed improvement and was working with the heads of department and local authority. They had developed an action plan; although extensive it had failed to identify all areas found at inspection. Following our visit the regional director sent us an updated action plan which included the additional areas identified at inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Surveys had been carried out to gain peoples feedback. However, the figures on the analysis did not always match the information received. It was not clear how people's feedback was used to develop the service.
- Records reflected health professionals had been contacted when required. However, it was not always evidenced their advice was followed.
- Meetings were held with people, their relatives and staff.

● People's relatives provided positive feedback about the management team. Comments included, "The management team are approachable" and "The registered manager is pleasant and approachable".
● The senior management team was very open and transparent throughout the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people had not been effectively mitigated. Systems for the proper and safe management of medicines were not operated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems had failed to effectively monitor and improve the quality and safety of the service. Systems had failed to ensure an accurate, complete and contemporaneous record was maintained in respect of each service user.