Dr Ramkishore Tandon and Dr Nisha MeNon

The Hollies

Inspection report

70 Canewdon Road
Westcliff-On-Sea
SS0 7NE
Tel: 01702 354744
Website:

Date of inspection visit: 30 July 2014
Date of publication: 19/01/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2012 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced. Our last scheduled inspection of this service was on the 25 October 2013 where we found no breaches of the regulations we inspected.

The Hollies Residential Care Home provides accommodation for up to 10 older people with physical and learning disabilities. Some people as a result of the ageing process had also been diagnosed with dementia. On the day of our inspection there were 8 people living at the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the

Summary of findings

law; as does the provider. At the time of our inspection a registered manager was employed at the service. The registered manager and the provider were present during this inspection.

Risks to people's health, safety and wellbeing had been assessed. However, the provider did not take steps to notify the Care Quality Commission (CQC) of notifiable incidents which affected the welfare, health and safety of people so that, where needed, investigations could take place and action could be taken.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is appropriate and in the best interest of the person. Staff had received training and demonstrated their knowledge and understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. However, the provider had failed to notify the Care Quality Commission (CQC) of an application to the authorising body to deprive a person of their liberty.

We were not assured that that the provider had considered the design, layout and access arrangements effectively to take into account the needs of people with physical disabilities.

The gardens were unkempt, insecure and not adequately maintained. Steps had not been taken by the provider to enable people easy access to safe and well maintained gardens.

There were systems in place to monitor the quality of the service. The provider told us they carried out monthly quality monitoring visits to the service. However, reports following these visits were brief and ineffective as the process had not identified the concerns we found and had not led to the necessary improvements required to ensure people's safety and wellbeing needs were met.

The provider had not taken steps to assess and provide personalised social and leisure opportunities appropriate for people with a learning disability and those living with dementia. This did support people in relation to promoting their autonomy, independence and community involvement.

The provider was not fully meeting the requirements of the Deprivation of Liberty Safeguards as CQC had not been informed of the application to deprive one person of their liberty as is required by law.

People were treated with dignity and respect. They communicated to us that they felt safe and that staff were always kind and respectful to them.

People's healthcare needs were assessed and access to healthcare professionals was provided where appropriate.

Medication practices at the service were robust and ensured that people's medicines were managed safely.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and one breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

The provider had not taken steps to maintain and provide a safe environment for people to live in.

The provider was not fully meeting the requirements of the Deprivation of Liberty Safeguards as CQC had not been informed of the application to deprive one person of their liberty as is required by law.

Staff and the provider had been trained in recognising abuse and had the required knowledge to respond in protecting people from the risk of abuse.

We were not assured that there was always sufficient numbers of staff available to meet people's individual needs.

Medication practices at the service were robust and ensured that people's medicines were managed safely.

There was an incomplete trail of staff employment histories to judge whether or not the staff employed were of good character.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were knowledgeable about the people they cared for in so far as meeting their personal care and health needs. We were not assured that staff had sufficient knowledge to understand the needs of people living with dementia, and supporting people with a learning disability. This impacted on their ability to support people's needs for social inclusion and the planning of individualised activities that promoted their independence and reduced isolation.

Staff received induction training and regular supervision support to carry out their roles.

People were provided with a choice of food and drinks. Systems were in place to screen people for the risk of malnutrition and these were regularly reviewed. People had access to health care services when required to meet their changing health care needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not demonstrate the necessary knowledge to support people in promoting their choice, autonomy and control about how they lived their lives and their views about their care, treatment and support.

Summary of findings

Staff treated people with dignity and respect. People told us they were happy with the care they received.

Staff respected people's privacy and dignity. They interacted with people in a kind and caring manner

Is the service responsive?

Requires Improvement 

The service was not consistently responsive.

The provider was not supporting people with appropriate opportunities, encouragement and support relevant for people living with a learning disability and dementia. This meant people's choice, autonomy, independence and community involvement needs had not been met.

People's personal care needs had been assessed prior to their admission to the service.

People were confident to raise concerns with the management and staff.

Is the service well-led?

Inadequate 

The service was not consistently well led.

Staff provided care which was mainly task focused on personal care needs rather than on an individual assessed basis.

Staff told us they were supported and trained appropriately to fulfil their role. They told us they enjoyed working at The Hollies and worked well as a team.

There were systems in place to monitor the quality of the service. However, we were not assured that these audits had been robust and effective in identifying the concerns we had noted during this inspection. This meant that people could not be sure their safety and wellbeing needs would be met.

The Hollies

Detailed findings

Background to this inspection

The inspection team consisted of one inspector and a specialist advisor. A specialist advisor is someone who has clinical experience and knowledge of working with people living with a learning disability.

Prior to our inspection we asked the provider to complete a Provider Information Return (PIR) which gave us information we had asked the provider to send to us prior to this inspection. This is key information about the service where the provider told us what the service does well and improvements they plan to make. We also spoke with the local authority contracts monitoring team and commissioners of the service to obtain their views.

On the day of this inspection, we spoke with three staff members, the manager and the provider. We spoke with five people who lived at the service. However, due to their limited ability to verbally communicate with us they were unable to give us detailed feedback regarding the care they received. Therefore our specialist advisor spent time over a period of three hours observing how care and support was provided to them.

Following this inspection we spoke with two social care professionals and one relative to gain their views on the care provided by the service.

We looked at the care records for three of the eight people who used the service, medication records and staff recruitment and training records. We also looked at records relating to how the service monitored quality and safety.

Is the service safe?

Our findings

The gardens were unkempt, insecure and not adequately maintained. We also noted a broken greenhouse which contained hazardous chemicals which we asked the manager to remove immediately. People did not have access to a safe well maintained garden that had a defined boundary from the road and next door garden.

The service was provided from a building which was not purpose built to meet the needs of older people living with a physical disability. The main stairway to the service was steep and we observed one person struggling to safely make their way down the stairs even with staff supporting them. There was no lift access. There were two sets of steps from the ground floor to access the communal lounge areas. This meant that people with limited mobility did not have access to these areas, which included a lack of access to the manager's office. Three bedrooms were located on the lower ground floor adjacent to the communal lounge. One person told us that they had been told by the manager they needed to move from their room downstairs to a room upstairs to accommodate and swap with another person who could no longer access the stairs.

Social care professionals we spoke with told us of their concerns regarding the lack of a passenger lift. We noted some rooms to be in need of decorating and found one toilet door without a lock. We were not assured that that the provider had considered the design, layout and access arrangements effectively to take into account the needs of people with physical disabilities. We discussed this with the provider. They told us that they were in the process of obtaining quotes to install a chair stair lift and were considering plans to level the flooring to allow for easier access for people to and from communal areas. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had received training and demonstrated their knowledge and understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. Not everyone who used the service had the capacity to make decisions about their everyday lives or to consent to their care and treatment. Care records we viewed demonstrated that each person had had their capacity to make everyday decisions about their lives assessed in line with the Mental Capacity Act (2005) code of practice to enable staff to support them appropriately.

Staff told us, and records we viewed confirmed that they had received recent training in safeguarding adults from abuse. We spoke with three members of staff who were able to tell us how they would respond to allegations or incidents of abuse. They also demonstrated their understanding of the lines for reporting to the local safeguarding authority and how to whistle blow and report to the Care Quality Commission (CQC) should they need to do so. This showed that the provider had the required knowledge to protect people from the risk of abuse.

The manager told us that three care staff were allocated on a daily basis to meet people's needs. Staff told us that there were not enough staff available at all times to meet the needs of people as one of the three staff allocated worked the majority of their shift in the kitchen preparing and cooking meals. Care staff also told us they carried out laundry tasks and domestic duties. We reviewed the staffing rota for the month of July 2014. The manager told us that they regularly worked hands on shifts to support people with their personal care needs and cover for staff vacancies. There was no formal dependency assessment tool in place which would enable staffing levels to be adjusted according to people's changing needs. We were not assured that there was always sufficient numbers of staff available to meet people's individual needs given that two staff were required to support people with mobilising. The manager told us that they had recognised this as a shortfall and were in the process of recruiting further staff to ensure that at least four care staff would be available on a daily basis.

One person we spoke with had limited verbal communication. When asked if they felt safe at The Hollies, they communicated with us by using the 'thumbs up' sign in answer to our question. They also communicated to us when asked, who they would go to if they were ever worried or concerned about anything, by pointing to the manager whilst smiling and again using the thumbs up sign to express their contentment.

One relative we spoke with told us that they were happy with the care provided and that they felt their relative was safe. They told us that if they had any concerns they would have confidence to raise this with the manager who they felt would take their concerns seriously.

Medicines were stored safely and records kept of medicines received and administered. We looked at the medication

Is the service safe?

records and carried out an audit of stock for three of the eight people who lived at the service. Stocks of medicines balanced with administration records. This indicated that people had received their medicines as prescribed.

We looked at the recruitment records of four staff. Records showed that the provider had carried out a number of checks on staff before that were employed to work at the service. These included checking their identification, health and checks to ensure that they were safe to work with vulnerable adults. Two of the four staff files we reviewed, not all gaps in employment had been explored in the staff member's employment history. The provider had not fully taken the steps required to sufficiently protect people from the risk of employing staff who were unsuitable.

Is the service effective?

Our findings

The staff we spoke with told us they had access to a range of training to equip them with the skills to meet the needs of the people who lived at the service. They told us that the majority of training had been provided in-house by the provider.

Staff had been provided with emergency first aid training directly from the provider. We noted from staff training certificates that training for staff in emergency first aid at work had been carried out by the provider. We asked the provider what evidence they had to of their qualifications and competency to safely deliver this training to staff. They told us that they had been trained as a trainer and had been assessed as competent to do so. They agreed to provide us with the evidence of this. Despite repeated requests to do so a week after our inspection the provider failed to do so. The Health and Safety Executive guidance states that, 'It is the employer's duty to ensure that any training provided for delivery of 'emergency first aid at work training' should be provided by someone who is qualified and has been regularly assessed as competent to deliver this training. We were therefore not assured that people had their health and welfare needs met by competent staff to respond to the safety needs of people in a medical emergency. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with were knowledgeable about the people they cared for in so far as meeting their personal care needs. We were not assured however, that staff had sufficient knowledge to understand the needs of people living with dementia, and supporting people with a learning disability. This impacted on their ability to support people's needs for social inclusion and the planning of activities that promoted their independence and reduced isolation.

Staff confirmed that they received regular supervision and annual appraisals. This was evidenced from staff records we reviewed. This meant that staff had been provided with opportunities to discuss their training and development needs.

We observed that people were provided with a choice of food and drink which was offered to them regularly throughout the day. People's risk of malnutrition had been assessed and recorded and their weight regularly monitored. Malnutrition screening tools had been completed and those at risk of malnutrition had been identified. Action plans had been put in place to reduce the risk of people becoming malnourished.

To support people with limited communication ability, picture menus had been produced. Staff described to us how they supported people to use these when planning weekly menus. This enabled people to communicate their preferred choice of meals.

A relative told us that staff contacted them if they were concerned about their family member and if there had been in changes in their health care needs. They also told that they felt the service responded promptly when health concerns had been identified. Records confirmed that people had been seen by their GP when required and that other specialists such as chiropodists, community nurses and clinical psychologists had been consulted when required.

Is the service caring?

Our findings

Staff interacted with people in a kind and caring manner. Staff responded to choices people made and explained what they were going to do prior to providing them with care and support. For example, when supporting people with eating their meals or accessing the toilet. People indicated to us that staff were always kind and respectful to them.

During the inspection we observed care provided to people within the communal lounge. The majority of people spent the day in the lounge sitting with little social stimulation provided. It was a warm sunny day and we did not see staff asking people whether or not they wanted to go outside into the garden. When staff did engage with people, we saw that this was done so in a respectful and kind way. Staff communicated with people in a respectful manner. For example, asking people if they required assistance with accessing the toilet or with eating their meal. People looked relaxed and comfortable with the care and support they received from staff. One person who was able to give us their feedback told us, "I love it here. They are kind to me." People with limited ability to verbally communicate expressed through their body language their comfort and ease in the presence of staff. Staff interacted with people cheerfully and with kindness.

The service had the use of a vehicle to enable people to access the local community. However, only one staff member was insured to drive this vehicle and we were told by the manager that they were currently away on leave for one month. This impacted on people's ability to be able to go out and take part in community activities according to their individualised choice.

Staff respected people's privacy and dignity. For example, we saw one staff member discreetly ask on person if they wanted to use the toilet. When people used the bathroom facilities, the door was always shut to protect people's privacy. Staff knocked on people's doors before entering.

Staff were able to tell us about people's individual personal care needs including what they liked to eat and when they liked to get up and go to bed. However, when asked, they could not demonstrate that they had a good understanding of the person's life history, leisure interests and hobbies. This meant that staff may not have the necessary knowledge to support people in promoting their choice, autonomy and control about how they lived their lives and their views about their care, treatment and support.

Where people were unable to make their own decisions, we saw that the next of kin for some people had been consulted. A relative we spoke with told us they had been involved in the reviewing of their family members care during their annual review. The majority of people did not however have any next of kin. We saw evidence that an advocacy service had recently visited the service to provide support for two people. One advocate we spoke with told us that the local authority had recognised the need for these people to access advocacy support during their annual care reviews. The also told us that the manager was supportive of this which enabled people to access this support when needed.

Is the service responsive?

Our findings

Other than one person who attended a day service people did not have access to a range of individualised, social and leisure opportunities to promote their independence, autonomy and choice. One person whom staff told us was registered blind sat in an armchair throughout the day of our inspection with little interaction from staff apart from when supported with accessing support with personal care and eating their meal at lunchtime. This person's care plan recorded how they liked to listen to music and play on the Karaoke machine. The TV was turned on all day in the lounge and was tuned into a music channel, but was without sound for the majority of the time.

Care provided was in the main task focused and not personalised care. There was as a lack of appropriate activities and stimulation offered to people. Staff told us there was not always enough staff to support people who required one to one support to access community activities and enjoy the benefits of social stimulation. Social care professionals also expressed concerns regarding the lack of individualised activities and opportunities for people to go out. They told us how they did not feel that people received adequate stimulation to enable them to enjoy a good quality of life.

We were therefore not assured that the service had adequately assessed and responded to people's individual needs, wishes and preferences.

We asked the manager how activities were scheduled and people supported to access appropriate education and opportunities to stay in contact with their local community. They told us that the weekly activities planner on the wall in the lounge was out of date and did not relate to any actual activities provided on a daily basis. The manager also told us that people in general were not interested in participating in any hobbies or community involvement apart from one person who attended a weekly day service and club on one evening each week. This meant that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The three care plans we reviewed took into account information regarding people's health care needs. For example, one person diagnosed with diabetes had a detailed action plan to support this person with reference to their special dietary requirements and support with their medication. Care plans gave staff guidance on how to support people with their personal care needs, nutrition, how to prevent pressure sores and action to take to support people safely and appropriately with distressed reactions to the environment and others.

We observed staff struggling to support one person from an armchair to a standing position due to their limited ability to move. Staff did not have access to electric or manual hoists to support people safely and appropriately. This did not enable staff to support people who may be at risk of falls. We discussed this with the provider who told us that they would take immediate action to provide a hoist.

We asked people if they were confident to raise any concerns or complaints if they were unhappy with anything. Two people who were able to verbally communicate with us told us they would go to the manager and that they did not have any complaints. The manager told us that there had been no complaints received within the last year. Staff we spoke with demonstrated their knowledge in how to respond to complaints in accordance with the provider's policy.

Is the service well-led?

Our findings

The manager told us that one person was currently being deprived of their liberty in their best interests and was subject to a deprivation of liberty safeguard. Authorisation had been obtained from the correct authority to allow the service to do this. However, the provider had not notified the CQC of this application to deprive this person of their liberty as is required by law.

One social care professional told us that they had become aware of one person who lived at the service who had been admitted to hospital after they had sustained a broken leg following a fall down stairs in January 2014. We discussed this with the manager who confirmed that they had not, following this incident sent to the Care Quality Commission (CQC) a notification of this incident as is required by law. We asked the provider what steps they had taken to investigate this incident. They told us that other than action taken to move this person to a ground floor room to avoid the need for them to use the stairs no other investigative action had been taken. For example, no formal assessment of the environmental risks had been carried out and no attempt to access specialist advice to prevent further occurrences to ensure that no other person would be at risk of a similar incident. We also noted that the provider had not made reference to this incident in their quality and safety monitoring of the service. This meant that people who used the service could not be assured that the provider took steps to report important events that affect their welfare, health and safety so that, where needed, investigations could take place and action could be taken. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Activities) Regulations 2009.

We spoke with three members of staff who told us that they felt valued and supported by the manager. Staff told us that the manager was approachable and that they enjoyed working at the service. Comments from staff included, “The manager is firm but fair”, “This is a nice place to work but could do with some money spent on it to improve the environment.”, “We work well as a team together.”

We asked the manager and provider how they sought the views of people who used the service, relatives and stakeholders. They told us that they did not carry out satisfaction surveys but did however; hold resident’s meetings every three months. We noted from a review of these meeting minutes that people were asked if they were happy living at The Hollies and the responses from people were all positive.

The manager carried out monthly audits of medication administration charts and checks of medicines stock. This meant that there were systems in place to identify medication errors.

The provider told us that they visited the service on a monthly basis to monitor the quality of the service. They also told us that they produced reports of their findings from these visits. We asked the provider for copies of their audit reports for the last year. We noted that the last monitoring visit recorded was October 2013. This meant there had been a 10 month gap since the last audit of the service. We noted that monitoring reports were brief in detail. For example, the report for September 2013 only recorded; ‘Care plan audits in place’, ‘Home looks generally neat and tidy’, ‘Staff happy’ and ‘some maintenance issues noted and instructed manager to take action accordingly.’ The provider had not produced action plans with timescales for completion when they identified shortfalls in the service. We were not assured that these audits had been robust and effective in identifying the concerns we had noted during this inspection. There was no evidence to assure us that action had been taken by the provider which would have led to the necessary improvements required to ensure people’s safety and wellbeing. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers There was a failure to identify, assess and manage risks to people's welfare and safety. The provider did not notify the Care Quality Commission of applications to deprive people of their liberty as is required. The provider did not take steps to report important events that affected the welfare, health and safety of service users so that, where needed, action could be taken. Regulation 10 (1)(a)(b) (2)(ii)(v)(c) (d)(i)(ii) (e) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person did not ensure that people had access to adequately maintained premises that were suitable for their needs and protected them against the risks associated with unsafe or unsuitable premises. Regulation 15 (1)(b)(c)(i)(ii) HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider failed to notify the Care Quality Commission of an injury to a service user that required hospital treatment to a broken bone. Regulation 18 (2) (a) (b) (ii) The provider had failed to notify the Care Quality commission of applications to deprive a person of their liberty. Regulation 18 (2) (c)
	The registered person did not provide appropriate opportunities, encouragement and support to people in relation to promoting their autonomy, independence and community involvement. Regulation 17 (2)(g) HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users.

This section is primarily information for the provider

Enforcement actions

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