

KN & S Ramdany

Holly Grange Residential Home

Inspection report

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Thatcham
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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 ●

Summary of findings

Overall summary

About the service

Holly Grange Residential Home is a care home providing personal care for up to 19 people aged 65 and over, some of whom may be living with dementia. At the time of inspection, the service was supporting nine people in one extended and adapted building on the ground and first floor of three storeys.

People's experience of using this service and what we found

The delivery of high-quality care was not assured by the registered person's leadership, governance or culture. This had led to widespread shortfalls in the quality and safety of the service, resulting in continued breaches of regulation. Quality assurance processes were unreliable and had not identified emerging risks to people or managed them safely. Professionals had raised concerns regarding the registered person's competence and capability to manage the service effectively.

The registered person had a track record of failing to provide good standards of safety, which placed people at risk of harm. The registered person did not regularly review people's dependency in relation to safe staffing levels to make sure that staff were able to respond to people's changing needs. This meant enough suitable staff were not always deployed to keep people safe. Professionals raised concerns about staff competence to move and transfer people safely using supportive equipment, in line with their training and manufacturers guidance. The registered person did not always ensure risks to people were assessed and mitigated to keep people safe when they were receiving care. Staff managed medicines safely and effectively and followed the provider's infection prevention and control procedures.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Staff did not always follow correct procedures to obtain lawful consent and offer people choices before providing care to people. Staff understood the different strategies to encourage and support people to eat a healthy diet and the importance of remaining well hydrated. Visiting healthcare professionals told us that people they supported had experienced successful outcomes in relation to the management of their diabetes and mental well-being.

During the inspection we observed warm and meaningful interactions between people and staff. Staff provided reassurance patiently providing information and explanations to people, whilst delivering their care. For example, supporting people to move and become more comfortable. The kind and compassionate nature of staff visibly cheered people and had a positive impact their mood and well-being.

Since our last inspection the provision of meaningful stimulating activities had deteriorated due to the unforeseen absence of the activities' coordinator. A new activities coordinator was appointed in October 2022 and people now experienced a wide range of activities, which had improved their mobility and coordination. People and relatives told us that staff supported people to maintain relationships that were important to them. People and relatives knew what to do and who they would talk to if they had any

concerns. They were confident action would be taken if they did raise concerns.

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

Rating at last inspection and update

The last rating for this service was requires improvement (report published 2 November 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance, safe care and treatment, safeguarding, staffing and notification of other incidents. This service has been rated requires improvement or inadequate for six of the last seven inspections and requires improvement for three consecutive inspections.

Why we inspected

We undertook an unannounced comprehensive inspection of this service on 31 May 2022. Multiple breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance, safe care and treatment, safeguarding, staffing and notification of other incidents.

We undertook this focused inspection to check the registered person had followed their action plan and to confirm they now met legal requirements. This report covers our findings in relation to the Key Questions Safe, Effective, Caring, Responsive and Well-led which contain those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Holly Grange Residential Home on our website at www.cqc.org.uk.

Enforcement

We have identified continued breaches in relation to good governance, safe care and treatment, staffing and notification of other incidents. We have identified a new breach in relation to consent to care.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Holly Grange Residential 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

This inspection was completed by one inspector.

Service and service type

Holly Grange Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

The registered provider is a partnership of two individuals. One of these partners (the primary partner) is also registered with the Care Quality Commission as the manager of the service. This means that both the primary partner and the second partner are legally responsible for how the service is run and for the quality and safety of the care provided. In this report, where we use the term 'the provider' we mean the partnership of K N & S Ramdany. Where we use the term 'registered person' we mean the registered provider partnership and the registered manager.

Notice of inspection

This inspection was unannounced on the first day and was announced on the second day.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service since the last inspection, including notifications received from the provider. The law requires providers to send us notifications about certain events that happen during the running of a service. We sought feedback from the local authority and community professionals who work with the service. We also reviewed the provider's action plan sent to us after the last inspection. We used all this information to plan our inspection.

During the inspection

We spoke with three people who use the service and two visiting relatives about their experience of the care provided. We spoke with 13 members of staff, including the registered person, the compliance manager, the cook, the activities co-ordinator, three senior support workers, four support workers and two agency staff. We spoke with three visiting health professionals including a diabetes nurse educator and two community mental health nurses.

We reviewed a range of records. This included three people's care records, each person's medicine records and daily notes. We looked at five files in relation to the recruitment and supervision of new staff appointed since our last inspection. We examined a variety of records relating to the management of the service, including the provider's new safeguarding and quality assurance tools, policies, procedures, quality assurance audits, and health and safety records. We observed staff interactions with people whilst delivering care and support in communal areas during mealtimes, medicines administration and provision of activities.

After the inspection

We continued to seek clarification from the registered person to validate evidence found. We looked at training data and quality assurance records. We spoke with six health and social care professionals and seven people's relatives.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the registered person did not consistently ensure there were enough suitably qualified, competent, skilled and experienced staff deployed to support people to stay safe and meet their needs. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in continued breach of regulation 18.

- The registered person did not regularly review staffing levels to make sure that staff were able to respond to people's changing needs.
- The service had not always deployed enough staff with the right skills, competence or experience to support people to stay safe.
- After our last two inspections the registered manager sent us an action plan, detailing improvements they would make. These improvements included the completion and regular update of a dependency assessment tool, to ensure appropriate staffing levels were deployed to meet people's needs and achieve successful outcomes.
- At the time of this inspection, the registered manager still could not provide evidence to demonstrate dependency assessments had been completed to inform the staffing needs analysis.
- At our last two inspections there were not enough staff deployed on the night shift to follow emergency evacuation procedures and assure people's safety. The registered person stated in their initial action plan they would recruit and deploy an extra waking night staff by 3 September 2021, to ensure people were evacuated safely in the event of a fire.
- We reviewed rotas between 26 June 2022 and 19 November 2022. No rotas had been completed after 19 November 2022.
- On 31 July 2022 and 1 August 2022, the rota did not show any staff allocated during the night.
- Rotas supplied by the provider, showed the registered person had failed to recruit extra night staff until 15 August 2022 and had failed to consistently deploy enough night staff to follow emergency evacuation procedures and assure people's safety if required.
- Rotas showed the registered person had not deployed two waking night staff until 15 September 2022.
- Between 25 June 2022 and 15 September 2022, rotas evidenced the registered person deployed a single night staff. On 40 out of 79 occasions during this period, the single waking night staff was provided by an

agency. This meant the registered person had failed to deploy sufficient night staff and could not assure the staff who were deployed knew the people's needs. This exposed people to the risk of experiencing harm from receiving unsafe care.

- Night staff consistently told that they were frequently unable to complete enhanced cleaning tasks when lone working.
- At our last inspection the registered person was deploying an activities coordinator two times per week, although they were often deflected to support colleagues with care tasks. However, between 10 August 2022 and 11 September 2022 there was no activity coordinator available. This meant people were not supported to engage in fulfilling, meaningful activities which enriched the quality of their lives. The absence of the activity coordinator meant there was no resilience to support care staff, who were then always task driven.
- Most people required support with their mobility, particularly to stand and transfer from chairs and beds, using supportive equipment such as a hoist. Two people required two staff to support them to transfer safely. When such transfers were taking place in areas other than the communal lounge, this meant other people could be left unsupported, with no staff available to make sure they were safe. A new activities coordinator was recently appointed. Whilst the activities co-ordinator afforded some resilience in this respect, they only worked on weekdays between 10am and 2pm. This meant there was limited activities provision or support for care staff on the weekend.
- At 2.40 pm, 8 November 2022, after the activities coordinator had finished their shift, we observed a person being supported to visit a communal toilet. This person displayed extreme anxieties and required a high level of reassurance from the staff member. This person continued to scream "Help me" whilst being compassionately reassured by the staff member in the communal toilet. At this time an alarm activated in the nearby bedroom of a person who was prone to falling. There was no immediate response to the alarm, so the staff member went to ensure the person had not fallen. Having confirmed the person in the bedroom was safe, the staff member returned to support the person in the communal toilet. On this occasion the person, who was prone to falling and had two different alarms in place to alert staff to their movement, was safe and using their commode.
- We immediately told the registered person who told us the staff member should have remained with the person they were supporting and awaited other staff to respond, including themselves. At this time the other staff member working was supporting other people in the lounge. Whilst the registered person explained they were available, they agreed they had not responded.
- On 9 November 2022, the afternoon shift was covered by one support worker recruited at the end of July 2022 and a new support worker appointed on 1 September 2022 still completing their induction process. The mix of skills, knowledge about people, experience and competence of the staffing deployed at this time increased the risk of people being exposed to unsafe care.
- The registered manager had failed to recruit a cleaner to the service since 28 July 2021. A cleaner supplied by an agency was deployed five days per week with no cleaner deployed on the weekends.
- Staff consistently told us they did not have time to complete cleaning tasks or provide people with stimulating activities on weekends, due to the absence of a cleaner or activities coordinator.
- Rotas for the period reviewed demonstrated no cleaners worked during the weekend and on 13 occasions during the week no cleaner was rostered.
- The registered manager had recruited five new staff members since our last inspection and the level of dependency on agency staffing had reduced. However, on 15 June 2022, a person was discharged to an alternative provider more suitable to meet their increasing nursing needs. The alternative provider raised concerns regarding multiple old bruises found on the person during their admission.
- The registered person commissioned an external investigation into the cause of the bruising by an independent clinical lead. One of the conclusions of this investigation identified that continuity of the person's care may have been compromised due to the heavy use of agency care staff.

The registered person's failure to consistently ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to support people to stay safe and meet their needs was a continued breach of Regulation 18 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered person had completed relevant pre-employment checks to ensure staff were suitable and had the necessary skills and character to work with older people. These included prospective staff's full employment histories, including exploration of any gaps and their conduct in previous care roles, together with their reason for leaving. The registered person had also completed Disclosure and Barring Service checks (DBS). DBS checks provide information including details about prospective staff convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management

At our last inspection the registered person had not consistently ensured staff provided safe care, by planning and delivering care to mitigate identified risks and to meet people's changing needs. The registered person had not consistently investigated incidents to identify the necessary learning to ensure people were protected from future risks or harm. These circumstances amounted to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in continued breach of regulation 12.

- The registered person has a track record of failing to provide good standards of safety which placed people at risk of harm and did not always protect them from actual harm.
- The registered person had not assured people' safe care and treatment by ensuring that staff had the competence, skills and experience to deliver their care safely.
- On 18 May 2022 an occupational therapist completed a moving and positioning plan detailing how a person should be supported to move safely, using designated transfer equipment.
- On 17 August 2022, staff had their moving and handling training refreshed.
- On 30 August 2022, staff were observed by a visiting occupational therapist supporting a person to move, using the approved transferring equipment.
- During the observation staff failed to follow vital, basic safety procedures. For example, staff had fitted a belt, an integral part of the equipment, upside down and had failed to apply the brakes to stabilise the equipment. This meant the operation of the equipment was not supporting the person but was pulling them forcefully.
- The staff failure to follow the manufacturer's vital, basic safety procedures had exposed the person to the potential risk of serious harm and injury.
- Staff failure to support the person safely meant the registered person had failed to effectively assure staff competence to deliver the person's care in accordance with their care plan and the manufacturer's guidance in relation to the safe use of the equipment.
- On 26 October 2022, staff were observed by a visiting occupational therapist supporting a different person to move using approved transferring equipment.
- During the observation staff failed to follow vital, basic safety procedures. For example, staff had fitted a belt upside down and were pulling the person up using handles on the belt. This meant the equipment was not supporting the person but staff were pulling them forcefully.
- The staff failure to follow the manufacturer's vital, basic safety procedures had exposed the person to the

potential risk of serious harm and injury.

- Staff failure to support the person safely meant the registered person had failed to effectively assure staff competence to deliver the person's care in accordance with their care plan and the manufacturer's guidance in relation to the safe use of the equipment.
- Professionals consistently raised concerns about staff competence to use supportive equipment safely, in line with their training and manufacturers guidance in relation to the proper use of the equipment. For example, a professional told us, "This is a regular occurrence. Whenever I visit [Holly Grange Residential Home], regardless of what the purpose is, I guarantee I will witness equipment not being used properly" and "In my opinion, the staff are kind to the clients [people], but they lack confidence and don't seem to know the clients [people] and what they should be doing."
- As previously stated, on 15 June 2022, an alternative provider raised concerns regarding multiple old bruises found on a person during their admission from Holly Grange. The independent clinical lead conducting an investigation into the bruising reported, "The 'skin intact reports' suggest that the bruises were treated as normal and part of the frailty of [person] and therefore no care staff reported or recorded the bruises as an incident and did not record a body map. There were no reports or notes available during handovers according to care staff. We reviewed the person's care records and could find no such evidence."
- The independent, external clinical lead concluded, "From my meeting with the care staff and the registered manager at Holly Grange Home, I can only conclude that there are issues that need to be addressed as a matter of urgency; to encourage best practices during moving and handling and the need to risk assess as part of a care review if and when are changes in residents' [people'] health and well-being, taking into account their age, frailty and medical conditions."
- Since our last inspection we had received six notifications in relation to injuries and bruising which may have been related to poor moving and handling technique. For example, one person experienced a skin tear to their shin, whilst being supported in their wheelchair. Staff immediately received further training in relation to how to support people safely with the use of a wheelchair.
- The registered person was able to demonstrate that staff completed face to face moving and handling training in response to the external investigation conclusions.
- At 10:10 pm on 3 September 2022 a person diagnosed with type one diabetes experienced an unwitnessed fall in their bedroom. The lone working senior care staff supported the person appropriately in accordance with the provider's falls management protocol and contacted NHS 111 for further guidance. NHS 111 is a free number to call when people have an urgent healthcare need that isn't a life-threatening situation.
- This call caused the call receiver to raise safeguarding concerns about the staff member's knowledge, in relation to the administration of insulin and use of blood glucose monitoring. Blood glucose monitoring allows staff to identify if a person has high or low blood glucose (sugar) so they can provide the appropriate treatment to keep them safe. During the conversation the staff member could not provide information in relation to blood glucose monitoring of the person.
- The staff member and other staff confirmed they were unaware of the blood glucose monitoring equipment available within the home. Staff told us that the diabetes nurse attended daily to administer insulin to the person and check their blood glucose levels but kept their own records.
- We reviewed the person's diabetes support plan. There was no guidance for staff in relation to blood glucose monitoring. The registered person was eventually able to find blood glucose monitoring equipment.
- On the first day of inspection, staff completed further diabetes training delivered by a specialist diabetes nurse. During the training staff were not able to demonstrate sound understanding in relation to blood glucose monitoring. Staff we spoke with later demonstrated a good understanding after the training they had received in relation to diabetes, blood glucose monitoring and action to take to keep people safe.
- Whilst Holly Grange residential home is not a nursing home there is still an expectation that staff had the knowledge, skill and equipment to effectively monitor people's blood glucose levels. The lack of staff

awareness in relation to blood glucose monitoring prior to the training during inspection had exposed people to an increased potential risk in relation to the safe management of their diabetes.

- During our inspection relating to food safety, we found that the temperatures of cooked food had not been recorded for two months between August and September 2022. The cook told us they were awaiting new recording forms from the registered person. They confirmed they had checked the food temperatures but had failed to record them between 25 August and 25 October 2022.
- However, the cook had every Friday off and their absence was covered by a senior support worker. No food temperature checks were completed on these days.
- Staff preparing food in care homes must check to ensure all cooked food has reached a safe minimum internal temperature, so that is hot enough to kill harmful germs that cause food poisoning. We were not assured the registered person had ensured that people had been protected from the risk of contracting food poisoning by checking hot food had reached the safe minimum temperature.
- We spoke with a professional and two relatives of a person, who raised concerns that whilst visiting their family member there was a fire alarm. After the fire alarm had been dealt with the relatives were concerned that the front door of the home was left insecure. They told us they were concerned people may be able to walk out into the cold night air or strangers could just walk in.
- Throughout our inspection we checked doors secured with key codes to ensure they were secure. On several occasions we found a door affording access outside the home to be insecure. These insecurities increased the risk of people venturing outside without the required support to keep them safe.
- After our last inspection the provider's compliance manager undertook to review and update each person's care plans and risk assessments. The compliance manager told us that due to an unforeseen absence, they still had to fully complete reviews of two people. The compliance manager told us they had reviewed risk assessments for these two people and confirmed they contained the required information and guidance for staff but need to be amended to make them more person centred.

The registered person had not consistently provided safe care, by planning and delivering care to mitigate identified risks and to meet people's changing needs. These circumstances amounted to a breach of regulation 12 (1)(2)(a)(b)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
At our last inspection the registered person's failure to act with all due diligence to effectively investigate, immediately upon becoming aware of evidence of avoidable harm and the failure to refer the circumstances to the appropriate safeguarding authority was a breach of regulation 13 (1)(3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

- At this inspection we found the registered person had acted diligently upon becoming aware of evidence of avoidable harm and had referred the circumstances to the appropriate safeguarding authority in a timely manner.
- On 17 August 2022 the registered person and staff had completed further training in relation to safeguarding and the reporting and recording of accidents and incidents.
- We reviewed accident and incident records which accurately recorded what had happened, the action taken and any identified learning to improve the service.
- The compliance manager had developed and implemented a safeguarding tracker which recorded all potential safeguarding incidents, where information was recorded, any action taken and details of the relevant notifications to us and the local safeguarding authority.

- The safeguarding tracker also identified any necessary learning and the action taken to implement this learning. For example, one safeguarding report tracked by the compliance manager identified that the investigation completed by the registered person had not been comprehensively completed. In response to this issue, the local authority safeguarding team will provide training in relation record keeping from their perspective.

Using medicines safely

- Staff managed medicines safely and involved people, and where appropriate their representatives, in medicines reviews and risk assessments.
- Staff had completed the safe management of medicines training and had their competency to administer medicines assessed annually by the provider's external trainer. People who lived with diabetes were supported by district nurses who visited daily to administer their insulin injections.
- Staff were aware of the action to take if a mistake was made, to ensure potential harm and risk of future recurrence was minimised.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using personal protective equipment effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- People, relatives and visiting professionals consistently told us the home was very clean with no unpleasant odours. During inspection the interior of the home was clean, tidy and clutter free.
- Visiting within the home was in line with government guidance in place at the time.

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.

At our last inspection we rated this key question good. At this inspection the rating for this key question had changed to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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. In care homes 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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The registered person had not always ensured the service was working within the principles of the MCA and consent to people's care and treatment had always been obtained in line with law and guidance and the service
- When a person is asked for their consent, information about the proposed care and treatment must be provided in a way that they can understand. This should include information about the risks, complications and any alternatives. A person with the necessary knowledge and understanding of the care and treatment should provide this information so that they can answer any questions about it to help the person consent to it.
- In September 2022, relatives raised concerns with a visiting health professional that their family member, who had been discharged from hospital to receive respite care, was in bed by 6pm. They were concerned their family member who had been diagnosed with dementia, was constrained in bed by the use of bedrails and was just staring vacantly up at the bedroom ceiling.
- Relatives asked their family member why they were in bed so early to which they replied, "I had no choice." Relatives returned two days later and again found their family member in bed staring up at the ceiling, with the bedrails up.

- Bed rails, also known as side rails or cot sides, are widely used to reduce the risk of falls. Although not suitable for everyone, they can be very effective when used with the right bed, in the right way, for the right person. Bed rails need careful management to mitigate recognised risks associated with their use. Bed rails must only be provided when they are the right solution to prevent falls and a risk assessment has been carried out by a person competent and qualified to do so.
- The visiting health professional, who was an occupational therapist, reviewed the circumstances surrounding the use of full-length bedrails. They told us the use of the bedrails had not been assessed and were not appropriate. The health professional raised a safeguarding alert in relation to the circumstances.
- In response to the safeguarding investigation the registered person confirmed they had not completed an assessment or relevant documentation to demonstrate the use of bedrails had been lawfully authorised.
- The registered person agreed they would request a full assessment by an occupational therapist if they thought bedrails were needed in future.
- In mitigation the registered person referred to the use of bedrails in hospital prior to the person's discharge to Holly Grange Residential Home allied to the person's admission being for a period of respite care.
- The compliance manager completed the service safeguarding tracker in relation to these circumstances. Under lessons learned they identified the registered person had not used the provider's capacity framework to explore whether the person had capacity to consent or whether a best interest decision making process was required.
- There were no daily records available detailing the circumstances surrounding the use of bedrails or reasons for the person being in bed at 6pm.
- In relation to the safeguarding investigation into these circumstances the registered person said, "I admit [person] has been to bed early a few times" and "I am sure the staff felt that [person] would be more comfortable in bed, but [person] should have been given a choice."

The registered person had failed to ensure people's care and treatment was always provided with the consent of the relevant person. This was a breach of regulation 11 (1)(2)(3)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Experienced staff had completed the required training on the MCA and DoLS, which they followed in practice, to protect people's rights. Newly recruited staff had their MCA and DoLS training scheduled and had received personal guidance from the registered person and compliance manager in relation to the MCA and DoLS.
- Staff understood the principles of mental capacity and how to promote maximum choice and control in people's everyday lives. People were mostly offered suitable choices in all aspects of their care.
- Staff knew the relevant people who needed to be involved in decisions about people's care and how each person communicated their wishes and preferences. The provider's own staff knowledge and understanding enabled the service to be responsive and flexible to changes in people's capacity. There was a risk this could be compromised if agency staff were being deployed.
- We observed staff seeking consent from people using simple questions and giving them time to respond. Staff supported people to make as many decisions as possible.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The registered person carried out pre-admission assessments to make sure they understood and were able to meet people's health, care and medical needs.
- People's needs had been assessed, and their care, treatment and support were mostly delivered to achieve effective outcomes.
- However, professional concerns had been raised in relation to staff competence to deliver safe moving

and positioning support in line with best practice.

- All staff had completed face to face moving and positioning training with an external trainer on 17 August 2022, but professional concerns continued to be raised after this training. The registered person had engaged with the local authority and an accredited external trainer to ensure staff were competent to move and position people safely, particularly in relation to the use of people's supportive equipment.
- The compliance manager had established a competency framework to assure all care was delivered in line with standards, best practice guidance and the law. The compliance manager had scheduled a programme of observed spot-check, one to one supervision and had completed supervisions with staff in line with the provider's policy.
- At this inspection it was too early to assess whether the culture of quality assurance focussed on ensuring the delivery of high quality, safe care to achieve successful outcomes had become embedded and sustained. The compliance manager told us the improvements initiated since their appointment had stalled briefly, during a period of unforeseen absence but were now being driven forward.

Staff support: induction, training, skills and experience

- The registered person and compliance manager operated a system of training, competency assessments, supervision and appraisals. This enabled staff to develop and maintain the required skills and knowledge to support people according to their needs.
- Supervision records demonstrated the compliance manager had open conversations with staff about performance and practice. Staff told us during supervisions the compliance manager encouraged reflection and learning and to consider their own personal development and ambitions.
- Established staff had completed the provider's training in line with core subjects advised by Skills for Care and the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
- New staff completed an induction process where they completed the provider's mandatory training and shadowing experienced senior support workers. Five new staff were being supported to complete their care certificate.
- An external trainer had been employed to deliver face to face training in relation to subjects prioritised through supervisions, staff requests and the competency framework. For example, staff had recently completed training in relation to the reporting and recording of incidents, accidents, falls management, safeguarding and moving and handling.
- Staff consistently told us their training fully prepared them to meet the needs of people.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to have enough to eat and drink and were encouraged to maintain a healthy balanced diet.
- People and relatives consistently told us they enjoyed the cook's meals, which included their favourite choices. The cook compiled a menu based on people's cultural choices. People confirmed the cook would make something else if they did not wish any of the options available.
- People were protected from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions because staff consistently followed guidance from relevant healthcare professionals. For example, people identified to be at risk due to weight loss had been successfully supported by staff to achieve their desired outcomes.
- The cook understood how to safely support a person's management of their diabetes with a healthy diet.
- When required, staff had completed food and fluid charts and people's weight was monitored monthly. If there were significant changes referrals were made to relevant healthcare professionals.
- We observed staff regularly encouraging people to have their preferred hot and cold drinks, to protect them from the risk of dehydration. Mealtimes were an enjoyable social experience for people.

- We observed one staff member take time to encourage and support a person with poor appetite to eat their meal. The person told us, "I don't normally eat that much."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked with healthcare professionals to make sure care and treatment met people's changing needs. Staff had made referrals to GPs, specialist nurses and other relevant healthcare services, in response to people's changing needs.
- Three visiting healthcare professionals told us that people they supported had experienced successful outcomes in relation to the management of their diabetes and mental well-being.

Adapting service, design, decoration to meet people's needs

- At our last inspection required improvements to the premises interior to ensure the environment was more suitable for people living with dementia and those who required support with their orientation had been made.
- Implemented changes to the decoration and design of the environment had been embedded and sustained.
- Relatives told us the adaptations made had provided a more supportive environment for people living with dementia, particularly the lighting.
- People's individual rooms were identifiable by people's photographs, their names, numbers, door colours and objects of reference.
- Bathrooms had been updated with colour contrasting toilet seats and grabs rails, which helped people living with dementia.

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.

At our last inspection we rated this key question good. At this inspection the rating for this key question had changed to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Most people and relatives told us they consistently received care which promoted their independence and respected their dignity.
- However, one relative told us they were upset one evening, when their family member was not supported to use the toilet when they asked. The unknown staff member responded to the person saying, "We do that when you go to bed [Person]."
- This concern was eventually raised by another family member. The registered person immediately apologised and undertook an investigation. The registered person was unable to identify the staff member involved. The registered person completed individual staff supervisions and held a group staff supervision to ensure people were treated with dignity and received care which met their needs.
- Care plans were written using respectful language, promoting people's dignity and choice. Care plans and risk assessments had been subject to review by the compliance manager. People's new care records had been improved to be more person centred and tailored to the particular individual. We were assured the final two records would be fully reviewed before the end of November 2022.
- People's needs were regularly reviewed and any change in their independence was noted. People and relatives told us staff encouraged them to be as independent as they could be.
- Staff encouraged people to be independent and followed care plans detailing how to achieve this; for example, patiently supporting people to mobilise slowly, whilst being available if they required help.
- Care plans provided staff with guidance about how to promote people's dignity. Staff were able to describe how they supported people to maintain their privacy, whilst ensuring they remained safe. For example, whilst supporting them with their personal care.
- During the inspection, we consistently observed warm and meaningful interaction between people and staff. Staff provided reassurance patiently providing information and explanations to people, whilst delivering their care. For example, supporting people to move and become more comfortable. The kind and compassionate nature of staff visibly cheered people and had a positive impact their mood and well-being. One person told us, "She [staff] always cheers me up."
- Staff knew how to comfort each person in different ways. For example, some people preferred to have a chat with people whilst others were contented by having their hand held.
- When people were confused or disorientated staff compassionately reassured people. For example by speaking more slowly and clearly, giving people time find their bearings and to understand where they were, what was happening and to make them feel safe and happy.
- Where people experienced sensory impairments, staff enabled them to express their wishes. We observed

staff engage people with kindness and empathy, in accordance with people's communication support plans.

- Staff had completed training and understood their responsibility to maintain the confidentiality of people's care records to protect their privacy. Staff gave examples of how they maintained people's dignity and privacy, not just in relation to personal care but also in relation to sharing personal information.

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

- Staff were highly motivated and told us they were inspired by people to deliver support that was caring and compassionate, which we observed in practice. One staff member told us, "Whenever they [people] look up at you and they smile at you, it is the best feeling, well you just can't describe it. It just makes you want to do your very best." A new staff member with experience of other care services told us, "This [Holly Grange Residential Home] is like a real home, it is such a lovely place to work because everyone [people and staff] are so friendly."

- People experienced meaningful relationships with staff who treated them with kindness in their everyday care. One person told us, "I get on with all the nurses [staff] and they know what I like."

- Relatives consistently made positive comments about the homely and friendly atmosphere within the home. For example, one relative told us, "It's [Holly Grange Residential Home] lovely, the thing I like is it always feels like a family home. I visit regularly and I've never seen anything but kindness."

- People and relatives told us staff were conscientious and focussed on caring for them, although sometimes staffing levels meant they were often task driven. One person told us, "The staff are all very kind but sometimes they are really busy."

- People's diverse needs were detailed in their care plans and staff provided support to meet them, including those related to disability, gender, and faith.

- All staff were able to tell us how they promoted people's dignity and independence, for example; how they encouraged people to maintain their mobility by continuing to walk independently, whilst being aware of their risk of falling and measures required to mitigate these."

- Visiting health and social care professionals told us that they observed sensitive staff interactions with people, which were consistently kind. For example, two visiting mental health professionals told us how they were impressed with the support provided to a person who experienced living with advanced dementia. One professional told us, "It is really good to see they way [registered person and staff] engage with [person]. It is good to see the positive way staff interact with [person] and see [person] not just the illness."

- The management team assessed and monitored the delivery of care and support by staff whilst delivering daily care to people to ensure it was delivered in a caring manner.

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

- Care plans were developed with people, their relatives and where appropriate, relevant professionals. The compliance manager involved staff in the creation of people's updated care plans, using their knowledge of each person gained from working closely with them.

- Relatives told us they were involved in decisions about all aspects of people's care and support. One relative told us, "We are involved in [person's care planning. We talk it through with [registered person and senior care staff]. Relatives told us [senior staff] were good at explaining options in a way people could understand and their preferences and choices were respected."

- Since our last inspection the registered person and compliance manager had completed regular reviews and quality assurance surveys where people and relatives were able to share their experience about the quality of their care and suggest areas for improvement.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement.

This meant people's needs were not always met.

Support to follow interests and to take part in activities that are socially and culturally relevant to them;
Supporting people to develop and maintain relationships to avoid social isolation

- Prior to our last inspection a health and social care professional raised concerns that people had limited choices in terms of activities.
- At our last inspection the registered person did not enable staff to consistently support people to follow their interests or encourage them to take part in social activities relevant to their interests.
- The registered person had deployed an activities co-ordinator (ACO) two days per week, who engaged people in group activities in the communal lounge. Activities included, arts and crafts, word and board games, singing, music and associated song, dance and movement. However, the activity coordinator was continually distracted and called upon to provide people's care.
- Observations identified that people's choice of activities was limited, and the television was on constantly with people not watching it.
- Since our last inspection people had experienced a deterioration in the provision of stimulating activities. This was due to the absence of the ACO for extended periods in July, August and September, during which time there was no organised activities provision.
- Staff told us due to the staffing levels at that time it was difficult to engage people in activities due and they often felt task driven.
- Staff consistently told us they believed that activities would be more stimulating and beneficial to people's wellbeing, if there were more staff available to support the ACO.
- On 17 October 2022 a new activity coordinator was appointed, who provided activities on weekdays between 10am and 2pm.
- Most people enjoyed and engaged in these activities although the ACO was mostly unaccompanied, supporting up to eight people.
- Relatives consistently praised the ACO and staff efforts to provide activities but were concerned about the level of stimulating activities when the ACO was not working.
- The new ACO was a psychologist in their country of origin and qualified in the use of techniques relating to mindfulness, stress and attention coordination exercise. The ACO was able to demonstrate how such activities had developed a person's poor coordination to the extent that they were now able to catch a ball.
- At this inspection provision of activities since the appointment of the ACO had improved the quality of people's lives. However, it was too early to assess whether the improvements would become embedded and sustained.
- People and relatives told us that staff supported people to maintain relationships that were important to

them.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The registered person and staff mostly planned personal care to ensure people had choice and control over their care.
- Circumstances regarding a person going to bed early without being offered a choice had been explored. Staff were endeavouring to protect a person from the risk of injury sliding from a chair when they fell asleep. The registered person completed an investigation and the person's support plan was personalised to ensure they were supported safely in their chair and only supported to go to bed if they requested to do so. All staff had their training refreshed to ensuring people were always offered choices.
- Most people and their relatives told us they felt staff had a good understanding of people's needs, personal preferences, cultural background and individual needs. One person said, "Yes they know me and talk to me to see if I'm okay and if I would like to do something."
- People and those important to them were involved in developing support plans to meet their needs, which reflected their preferences and choices. Staff assumed responsibility to work with people, to include and engage them as much as possible as this was "their home".
- People's changing physical and mental health needs were assessed to ensure that support provided met these needs. The compliance manager had reviewed and updated people's assessments, which now contained more person-centred information.
- People's cultural and religious needs were explored with them and the service ensured these were met.
- Two visiting professionals were impressed that whenever they visited staff knew why they had been called and the current position regarding the person's care and wellbeing.
- Most relatives praised the registered person and staff for ensuring they were well informed about their family member's life in between their personal visits.
- Staff supported people to develop bonds and friendships within the home. People and relatives consistently told us that staff made sure that people were supported to maintain relationships that were important to them, particularly during the pandemic. Relatives told us how staff arranged calls using technological solutions, such as the service tablet and mobile phone. This helped to protect them from the risk of social isolation and loneliness as social contact and companionship was encouraged.
- Relatives consistently told us they had been kept abreast of the service infection prevention and control measures and visiting policy during the pandemic, by the registered manager.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The registered person and staff had taken measures to comply with the AIS. Staff had identified the individual information and communication needs of people, living with sensory impairments such as sight and hearing loss.
- Communication support plans provided guidance to enable staff to meet people's specific communication needs and share information with them effectively. For example, we observed staff supporting people with a visual impairment in line with their communication and mobility support plans.

Improving care quality in response to complaints or concerns

- The provider had an appropriate complaints policy and procedure, as well as information which was provided to people and their relatives when they moved in.
- People and families felt able to make complaints if they wished. People and their relatives knew the registered person and senior staff by name and saw them regularly.
- There had been one complaint since the last inspection, which had been dealt with in accordance with the provider's policy and procedure.
- People and their relatives were given the opportunity to give their feedback on the service during care reviews, meetings and surveys.

End of life care and support

- No people were receiving end of life care at the time of inspection.
- People's end of life wishes were sensitively considered and their plans explained what was important to them, things they wanted to avoid, and where they wanted to be cared for.
- The compliance manager was in the process reviewing and updating end of life care plans to make them more person centred.
- Some relatives told staff they did not wish to discuss their family members end of life wishes, which staff respected.
- Staff consistently told us they were supported by the registered person with empathy and understanding when people had passed away.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has changed to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last two inspections in 2021 and 2022 the registered person continued to fail to fulfil the legal requirements of their role; to maintain secure, accurate, complete and contemporaneous records of people's care and treatment; to ensure compliance with regulations, to assess, monitor and improve the service to ensure that quality and safety were not compromised and to mitigate risks to people. This was a continued breach of Regulation 17(1)(2)(a)(b)(c)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in continued breach of regulation 17.

- The delivery of high-quality care is not assured by the registered person's leadership, governance or culture. This had led to significant widespread shortfalls in the way the service is led resulting in multiple, continued breaches of regulation.
- On 4 July 2022 we served a warning notice on the registered person notifying them they were failing to comply with Regulation 17 (1) (2) (a)(b)(c)(d), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The warning notice required the registered person to become compliant with Regulation 17, section (1) (2) (a)(b)(c)(d), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 30 September 2022.
- At this inspection we found the registered person had failed to make the required improvements identified in the warning notice to make the service compliant with the regulation 17.
- Governance and performance management was not reliable and effective. Quality assurance processes had not effectively identified emerging risks to people and ensured they were managed safely.
- The provider's processes had failed to identify breaches of regulation found during this inspection.
- At this inspection we found the service was in continued breach of regulation 18 (staffing) and regulation 12 (safe care and treatment)
- At this inspection we found two new breaches of regulation 11 (consent to care) and regulation 18 Care Quality Commission (Registration) Regulations 2009(notification of other incidents-detailed below).

- At the last inspection the registered person had not always maintained securely, confidential records of the care and treatment provided to people. On several occasions during the last inspection we found that doors with keycodes leading to outbuildings were unlocked, allowing people access to the grounds outside. The insecure outbuildings contained numerous confidential care records archived over many years. At the start of this inspection we checked the door with a keycode leading to the outbuildings and grounds, which was insecure. We checked the outbuildings and found them insecure. Whilst the vast majority of confidential material had been removed to appropriate storage or destroyed, there were still some personal confidential records found in the insecure outbuildings.

- Professionals did not doubt the registered person's dedication to the people living at Holly Grange Residential Home. However, they frequently raised concerns about their competence and capability to manage the home effectively. One professional told us, "They [registered person] just don't seem to get it. No matter how much support they are given the same old mistakes are repeated." This sentiment was corroborated by the provider's inspection history.

- At the last inspection the registered person agreed they needed to develop and update their skills and knowledge in relation to their role and responsibilities as a registered person. At this inspection the registered person could not demonstrate they had undertaken such learning and development.

The registered person had failed to fulfil the legal requirements of their role; to maintain securely accurate, complete and contemporaneous records of people's care and treatment; to ensure compliance with regulations, to assess, monitor and improve the service to ensure that quality and safety were not compromised and to mitigate risks to people. This was a continued breach of Regulation 17(1)(2)(a)(b)(c)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Providers must notify CQC without delay of all incidents that affect the health, safety and welfare of people who use services. The registered person did not fulfil their regulatory responsibilities in relation to these incidents and had failed to notify the CQC without significant delays, of nine different incidents involving injuries to and the potential abuse of people. This meant that we did not have oversight and assurance that these incidents were investigated to identify necessary learning to prevent a recurrence.

The registered person had failed to notify CQC of these incidents without delay. This was a breach of regulation 18 Care Quality Commission (Registration) Regulations 2009

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider's policy identified the actions the registered manager and staff must take in situations where the duty of candour applied.

- The compliance manager had developed a quality assurance tool and safeguarding tracker, which monitored the provider's compliance with the duty of candour.

- Accident and incident records demonstrated the provider was complying with their legal responsibilities under the duty of candour.

- Relatives told us staff contacted them immediately if something had happened. For example, one relative told us, "They [staff] always call us if something happens, like when they [person] have an infection or they're [person] not well." Another relative told us, "They [registered person] let us know when anything has happened and are always apologetic."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People, relatives and professionals described the registered person to be committed to the people living

in their home.

- Staff were passionate about what they did and consistently placed people at the heart of the service, and clearly demonstrated the caring values and ethos of the provider. One staff member told us, "I've been here for 36 years and wouldn't work anywhere else because of the residents [people]." Other staff members told us, "I love working here. Just seeing them [people] smile and knowing you are making them happy" and "The residents [people] are all I care about."
- Staff felt respected, supported and valued by the compliance manager. Staff told us they were able to raise concerns with the deputy manager, whom they respected and trusted. However, staff were concerned that the registered person did not always listen to their concerns. For example, concerns raised regarding staffing levels. One staff member told us, "Not much has changed since you were here last time."
- People and relatives consistently told us the registered person was highly visible in the service, readily approachable and took a genuine interest in what people and their family had to say.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their families told us they felt fully engaged with the staff and the registered person. They consistently reflected that this was due to the warm and friendly approach of the staff team. One relative said, "Everyone is so friendly and welcoming, there really is a family atmosphere here and it is like a home. The carers [staff] let us know what's happening and make you feel part of the family."
- Staff told us they were often task driven and would like to spend more time with people and talk with them, to nurture and build relationships with them.
- The compliance manager was determined to promote a positive, caring, transparent and inclusive culture within the service, which motivated staff to continue providing better care and support to people.

Continuous learning and improving care

- At our last inspection reporting of incidents, risks, issues and concerns was unreliable or inconsistent, and was discouraged. People, their families and staff had not always been told about incidents, or how the service has responded to them.
- At this inspection we found significant improvement driven by the compliance manager in relation to the reporting, recording and review of all accidents and incidents.
- Where concerns had been raised or accidents and incidents had occurred, the management team had completed investigations and spoken directly to people and relatives to explain the circumstances and action they had taken to prevent a recurrence.
- However, during the compliance managers' recent period of unforeseen absence, there was a marked deterioration in the standard of the provider's response to such incidents. The compliance manager had re-established continued improvements in this regard since their return.
- The compliance manager had introduced a quality assurance monitoring tool and safeguarding tracking tool which had improved the management oversight in relation to the quality and safety of the care provision. It was too early at this inspection to determine whether the improvements driven through the implementation of these systems had become embedded and were sustainable in the absence of the compliance manager.

Working in partnership with others

- We received mixed feedback from people, relatives, staff and health and social care professionals regarding their engagement and involvement in the development of the service.
- People, relatives and two healthcare professionals told us the registered person had enabled and encouraged open communication.
- Commissioners of people's care continued to raise concerns regarding the registered person's

engagement with local authority safeguarding and quality assurance reporting processes.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to submit CQC notifications about incidents without delay. Care Quality Commission (Registration) Regulations 2009: Regulation 18

The enforcement action we took:

NOD to vary registration to remove Holly Grange Residential Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure people's care and treatment was always provided with the consent of the relevant person. Regulation 11 (1)(2)(3)(4)

The enforcement action we took:

NOD to vary registration to remove Holly Grange Residential Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not consistently provided safe care, by planning and delivering care to mitigate identified risks and to meet people's changing needs. Regulation 12 (1)(2)(a)(b)(c)(e)

The enforcement action we took:

NOD to vary registration to remove Holly Grange Residential Home

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

The registered person had failed to comply with a warning notice by 30 September 2022. The registered person had failed to fulfil the legal requirements of their role; to maintain securely accurate, complete and contemporaneous records of people's care and treatment; to ensure compliance with regulations, to assess, monitor and improve the service to ensure that quality and safety were not compromised and to mitigate risks to people.

Regulation 17(1)(2)(a)(b)(c)(d)

The enforcement action we took:

NOD to vary registration to remove Holly Grange Residential Home

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered person had failed to consistently ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to support people to stay safe and meet their needs

Regulation 18 (1)

The enforcement action we took:

NOD to vary registration to remove Holly Grange Residential Home