Regal Care Trading Ltd

The Hollies Rest Home

Inspection report

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Ratings

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

Overall summary

We inspected The Hollies Rest Home on 27 and 28 July 2015 and the inspection was unannounced.

The Hollies is located in Southborough, Tunbridge Wells and provides accommodation and personal care for up to 31 older people. The home is set over three floors, with bedrooms across all three floors and communal areas situated on the lower ground floor. There is lift access between the lower ground floor and upper levels. At the time of our inspection there were 29 people living at the home. 28 people were living with dementia and many people had mobility difficulties and sensory impairments. Some people were living with mental health issues.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left at the beginning of July and interim management arrangements were in place to cover the service whilst recruitment to the post was in progress.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of this report.

People said they felt safe living in the home, however we found that not all risks had been identified or effectively managed. People were not protected from risks associated with unsafe and or unsuitable premises.

There were insufficient numbers of staff to provide adequate care and supervision to meet people's needs.

The provider did not always follow safe recruitment procedures to make sure staff were suitable to work with people because full employment histories were not always obtained or references checked effectively.

Staff received training and support to carry out their roles, but we have made a recommendation for improvement about this.

The provider had not ensured that, where people could not give their consent, the requirements of the Mental Capacity Act 2005 were consistently met.

People did not receive the support they needed to eat their meals. Staff did not take appropriate action to reduce the risk of dehydration and malnutrition for some people.

People received medical assistance from healthcare professionals including district nurses, GPs, and the local hospice. However, staff did not consistently follow guidance regarding people's health needs.

The premises and equipment did not meet the needs of people living with dementia and mobility difficulties.

People were not always treated with compassion and their preferences and right to confidentiality respected.

People's needs were not consistently met as assessment and review systems were not always effective. People's changing needs were not consistently responded to. We observed that the people who required the most care and support were not always given the support they needed to ensure they had meaningful occupation during the day.

People felt the home was well run and were confident they could raise concerns if they had any. However, there was no registered manager and the registered provider had not adequately monitored the service to ensure it was safe and effective. They had not identified or acted upon areas where improvement was required.

People's medicines were stored and administered safely in accordance with best practice guidance.

We did see and hear some individual examples of staff treating people with compassion and kindness.

People were supported to maintain their relationships with people that mattered to them. Visitors were welcomed and their involvement encouraged.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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?
The service was not safe.

Staff understood their safeguarding responsibilities.

People were at risk of harm because not all risks had been effectively managed.

There were not sufficient staffing levels to safeguard the health, safety and wellbeing of people.

Safe recruitment procedures were not always followed.

The registered provider ensured that medicines were stored and administered safely in accordance with best practice guidance.

Inadequate

Is the service effective?
The service was not effective.

Staff received training and support to carry out part of their roles. However the provider had not ensured that the training was appropriate to meet their learning needs or to make sure staff effectively met the needs of people living with dementia in relation to supporting people who were distressed.

People were not always asked to consent to their care and treatment. Where people were unable to consent the registered provider had not always acted within the law to make decisions on their behalf.

People were nutritionally at risk as did not receive the support they required.

People did not have their health needs fully met.

The provider had not ensured the premises was suitable for people living with dementia and mobility difficulties.

Inadequate

Is the service caring?
The service was not consistently caring

People told us they found the staff caring.

People were not always treated with compassion.

People's needs and preferences were not consistently respected.

Personal information was not stored confidentially.

Requires Improvement

Is the service responsive?
The service was not responsive.

People's needs were not consistently met as assessment and review was not always effective.

Inadequate

Summary of findings

People did not always receive personalised responsive care that met their needs.

Some people were at risk of becoming socially isolated with little activity to stimulate or interest them.

People knew how to make a complaint and were given opportunities to give their views. Relatives told us they were kept informed by the home.

Is the service well-led?

Inadequate 

The service was not well led.

The provider had not ensured that there were effective systems and leadership in place to monitor and improve the culture, quality and safety of the services provided.

There was an open culture. Staff felt supported and were confident that they could discuss concerns. People who used the service and their relatives felt the staff and management were approachable.

The Hollies Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 July 2015 and was unannounced.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the visit we looked at whether we had received any notifications. A notification is information about important events which the provider is required to send us by law. We also spoke with the Local Authority to gather information about the service.

We spoke with seven people and six people's relatives about their experiences of using the home. We also spoke with the deputy manager, an area manager, the director of operations, five care staff, a maintenance worker, two kitchen staff, the activities co-ordinator, two visitors, and three professionals including a District Nurse and a GP. We examined records which included people's individual care records, computerised charts, five staff files, staff rotas and staff training records. We sampled policies and procedures and examined the provider's quality monitoring systems. We looked around the premises and spent time observing the support provided to people within communal areas of the home.

Inadequate

Is the service safe?

Our findings

People told us they felt safe: "Yes, I feel safe - I'm free to wander" and that if they were worried about anything they would tell someone: "I'd speak to my family first"; "I'd talk to someone, the governor." People told us that they felt the building was in need of repair and refurbishment. A relative told us "It could do with doing up, it's a bit run down." And one visitor told us, "The staff they've got are very caring but they need a new building." One health professional said, "Staff work incredibly hard in the surrounding they've got."

Although people told us they felt safe, we found that the systems to protect people from harm were not consistently effective. For example, the provider had identified that there was a problem with the operation of the lift, which meant there was potential for people to get trapped. We saw that on the basement floor there was a sign above the cupboard that housed the lift's motor. It told staff what to do in the event of the lift failing. An audit undertaken in June 2015 by the director of quality stated, "All staff are trained in the manual adjustment of the lift as it breaks down often and staff and clients are trapped." We spoke to one senior who told us they had not received training to do this. Despite the issue being known to senior staff, no risk assessment was in place and the emergency plan specifically noted, "On no account should staff attempt to lower the lift unless they have attended and completed a recognised training session with the lift service company and are competent to carry out the procedure." Although the risk had been identified there was no evidence that the lift was due to be replaced or the problem rectified.

The Hollies is a large period building set over three floors and communal areas, such as the dining and lounge areas, were all positioned on the lower ground floor. The majority of people had bedrooms on the upper floors, however the stairs to the lower ground floor were steep and the floor covering was coming away. This meant that the stairs were not accessible to people living at The Hollies and so the only means of access to the communal areas was the lift. We used the lift and found that it made a loud noise and was very slow to move between floors which did not feel comfortable when using it. One professional told us, "I refused to go in the lift, as it was very small, very slow and the noise freaked me out." One person told us "The lift takes too long- very depressing, I was frightened, a dreadful noise." The noise and speed of the lift did not provide people with a comfortable and secure way to move between floors. People were placed at risk of being trapped in the lift if it stopped working.

There were a number of areas around the home that placed people at risk of injury, including, flooring in corridors, on stairs and in bathrooms and toilets which was not sealed properly and posed a potential hazard. Poorly sealed flooring increased the risk of the spread of infection in the home as it was difficult for staff to keep clean. Some flooring on stairs and in bathrooms posed a potential trip hazard. In some bathrooms and toilets, we saw that boxing intended to cover pipework was loose and coming away. This placed people at risk of injury from coming into contact with loose wood and exposed pipes. In the corridor that was designed as a sensory area, we saw that a radiator cover which was meant to protect people from the heat of the radiator, was loose and could be pulled away. One member of staff told us, "It (the home) needs to be refurbished, especially the floors." Some bedrooms also required repair. One person's sink had hazard tape around its porcelain base and another room had a water damaged wall which we were told was due to people having their hair washed at the sink. Décor throughout was in poor condition which made effective cleaning difficult. Although domestic staff were cleaning during our inspection, some floors were sticky under foot. On the first day of inspection, before breakfast, we found a hazard sign used to alert people to a wet floor, was laying on a dining table. This placed people at risk of infection as potentially contaminated equipment was placed in an area in which they ate their meals.

The provider had not taken appropriate action to identify and reduce risks to people's safety and welfare and to ensure the premises was effectively maintained. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We raised the maintenance issues with the area manager and on the second day we were shown that as a result of our inspection they had collated these into an environmental improvement plan. We were told the intention of this was to begin to rectify the areas that required maintenance or repair. We were unable to tell if this work would be carried out in a timely way but we will see any results during our next inspection.

Inadequate

Is the service safe?

When asked if there was enough staff one person told us, "No, there's never enough staff though they're pretty good at coming quickly." And another told us, "You've got to wait for them to come and collect you." One relative told us, "They haven't got the manpower there to look after everybody if there's a problem and a person needs more attention."

One member of staff explained, "We're each allocated a floor, we get them up, take them down for breakfast, then get the rest up." There were times when people were without staff to supervise, provide support and ensure their safety. One staff member told us, "Because we have such demanding residents on the middle floor, people mostly need two staff at once." Rotas showed that staffing levels remained consistent with four care staff and a senior in the mornings and three care staff and a senior in the afternoons. Night shifts started at 7.30pm when three staff were rota'd until the following morning. This meant that at times whilst staff attended to people's personal care needs there were insufficient numbers of staff deployed to provide adequate supervision to other people. We looked at people's care records and found that some people who were assessed as requiring repositioning whilst in bed, had not always receive the care they needed, which meant they had been put at risk of developing pressure sores.

During the day some people were receiving care in bed and others spent the day in communal rooms situated on the lower ground floor. Staff were busy and there were times when people were unsupervised and did not receive the support they needed. For example, some people living at The Hollies displayed behaviours that challenged and on both days of our inspection we saw that these people were left unsupervised in the small confined dining room during mealtimes. On both days we saw one person display behaviours that agitated others and that there were incidents of shouting. On both occasions we saw that staff were not in attendance to supervise and ensure that people were safe and that potentially difficult group dynamics were managed.

Rotas showed that there had been regular and long term use of agency staff as the management were trying to recruit to permanent posts. Staff told us this had an impact on care, one said, "New staff don't know what they are doing so it takes longer to get them [people] up, and then we don't get to do the other stuff such as paint their nails." One relative said, "It seems like a lot of people wandering around and not necessarily enough staff to attend to them all."

We found that staffing levels were not based on an analysis of people's support needs and had remained consistent despite people's needs changing. Although the new provider was aiming to introduce a dependency tool, this had yet to be implemented. One visitor told us, "Staff are busy the whole time, I never see them sit down."

There were insufficient numbers of suitably skilled and competent staff deployed to meet people's needs and ensure their safety. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the staff files did not contain all the information required to assure the provider that they were employing staff that were suitable to work with people. Of the five staff files we saw, only two showed that the appropriate checks had been made to ensure staff were suitable to work with people. Some were missing employment history and two staff recruited from oversees had exactly the same reference with identical wording. The provider had not identified this or followed it up with the referee. One staff member's reference inaccurately described them as a female when they were male. The provider had not made sure there were robust recruitment procedures in place to ensure staff employed were suitable to work with people and could safely and effectively meet their needs. The failure to carry out safe recruitment practices to ensure staff were suitable to work with people was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were managed safely. The provider had an effective medicines policy and staff understood how to safely order, store and administer medicines. People's Medication Administration Record (MAR) charts were completed satisfactorily to show that they had received the medicines they needed. We were told all senior staff involved in medication management were trained and updated yearly by an external provider. In addition, we saw records that showed there were internal competency 'spot checks' operated by the provider. We saw that staff administered medicines to people safely and following relevant guidance. All medicines were labelled with directions for use and contained both the expiry date and

Inadequate

Is the service safe?

the date of opening. Medicines were delivered and disposed of safely and appropriately. Medicines were stored safely and securely. Medicines requiring refrigeration were stored in a locked fridge and the temperature of the fridge monitored regularly to ensure it remained within the manufacturers recommended guidelines. Therefore making sure medicines remained fit for their use and safe for people to take.

We saw that the home displayed guidance for reporting abuse. All the staff members we spoke with had undertaken training in safeguarding people from abuse within the last year. All were all able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let my manager know if I suspected abuse was going on. Failing that, social services, the CQC or the police". Another staff member said, "The training was quite good. I know we have a responsibility to protect people and I take that very seriously."

Inadequate

Is the service effective?

Our findings

People who were able to speak with us told us, "They look after you well, I must be honest." and "They're well trained, occasionally you come up against one that isn't. "One person said that they thought the senior staff were not trained sufficiently and that "We need a matron to supervise the night staff as they're noisy running up and down the stairs."

People gave mixed feedback about the quality and variety of food provided. One person said, "The food's good" and another told us, "I've no complaints, I'm not a big eater." Others said, "People don't like it too hot", "It's alright" and "The food's very bland and too many sandwiches. It's soup every night and sandwiches with a different filling." One health professional described meal times as "Degrading." A number of people required physical assistance with eating and drinking and most required prompting and supervision to ensure they could eat their meal. Meals were served in five different areas of the building, including bedrooms, dining room and lounges, and as a result staff were unable to provide people with the support they needed. One staff member told us, "Because we are short of staff we are not able to support people properly at mealtimes." We observed people picking up their cooked meal with their fingers to eat it and one person who had eaten all their meal except the meat was left holding a lump of meat as it had not been cut up. People were not provided with appropriate finger foods and where staff were too busy to assist, people did not receive the support they needed. We observed three people sat together at a table with no drink awaiting their food. Staff served one person at the table and the other two individuals were left waiting for theirs.

People were given a choice of meals and staff came round with two plates of food to choose from. However this took time and where people were seated in different areas, staff were stretched which resulted in people being left unsupervised or unsupported for long periods of time. We saw that at times the dining room was left unsupervised and one person sat at a table alone, had slumped forward without staff noticing. Another person was sat at a distance from the table and at arm's length from their meal. Staff were not present to ensure people's eating experience was comfortable and people did not receive support when they needed it. When an inspector made staff aware of these individuals, staff responded and provided the support they needed.

We examined care plans that described the care and support people required. One person's care plan said staff were to "Ensure he is taking 1.5 litres of fluid everyday" and that the person's food and fluid intake should be monitored. We examined this person's computerised notes where staff recorded the care they had given. On five out of eight days this person had not received the fluids their care plan said they required. We saw that another person's fluid chart showed they had drunk very little for the past week. Although the GP had been called to see the person during our inspection, the person's fluid chart showed that they had been taking very little fluid for a number of days prior to the GP being called. We spoke to the management team about monitoring fluid and they told us they were aware this was an issue and were implementing a paper fluid chart for staff to record. On the second day of our inspection we were shown this was put in place.

We also examined the care plan and associated documentation for a person staff had told us was at risk of poor nutritional health. We noted the Malnutrition Universal Screening Tool (MUST) had been completed for this person. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It includes management guidelines which can be used to develop a care plan. We noted from recent assessments, that despite staff telling us this person was at risk of malnutrition, the person's 'MUST' score had remained at zero, indicating no risk had been identified. Where staff used their hand held devices to record what people ate, we saw that food charts had been regularly completed. However, this person's chart did not contain enough detailed information regarding the food they had eaten to judge whether their diet was adequate and their nutritional needs were being met.

Weight charts showed that some people identified as being at risk of malnutrition had not had their weight monitored consistently. We saw that another person had a recorded weight loss of 7kg in seven days but their records showed they had not been weighed since, which meant their weight was not being effectively monitored.

Inadequate

Is the service effective?

People did not have their nutrition and hydration needs met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We examined care records and saw that people were supported to access a range of health professionals including Speech and Language Therapists, GPs, District Nurses, The Hospice and Community Mental Health Teams. However care plans, risk assessments, charts and daily records did not always contain detailed information about people's care needs and we found staff had not always delivered the care that people had been assessed as requiring. For example, we noted that one person's mobility assessment stated that they had been bed or chair bound for several weeks. The care plan stated they required frequent positional changes during the day and two hourly turning at night to prevent the development of pressure sores. The records of repositioning for this person for the previous week showed that this had not been adhered to. On one day, only one positional change in 24 hours was recorded. On another, we noted that the person's positional change recorded was to the left side only on three consecutive occasions. This meant the person was at risk of developing pressure sores.

Another person was assessed as being at high risk of pressure sores and although their care records stated they should be repositioned two hourly, their records showed that they were not being repositioned consistently at night. On one day the previous week before the inspection, they had been repositioned at 22.05pm and then not again until 08.43 the following morning. This meant the person was at risk of pressure sores.

Another person at risk of pressure sores had a care plan that stated that they used a prescribed topical cream that "Must be applied religiously all over his body." However their topical medicines record stated that this was to be applied "As often as required." Records showed that this person had not had this medicine applied for ten days. The guidance was unclear for staff to follow, which meant it was not possible to ensure safe and effective care and treatment had been given. We spoke to the deputy manager about this who confirmed the guidance needed to be made more clear.

People did not receive safe care and treatment that effectively met their health needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises did not meet the needs of all the people using the service. Some of the bathroom and toilet facilities did not meet the needs of people with mobility challenges. Staff told us, "We are not short of bathrooms, but the one downstairs is not big enough." We saw that the middle floor's only bathroom was not easily accessible as it had a step. Whilst the middle floor had two toilets one of these was only accessible by step and was so small that the door was difficult to close when anyone went inside. The top floor had shower rooms where space was limited making safe transfers from a wheelchair difficult. Staff told us "It's a bit hard to get in some of the bathrooms- it's too small for them." We looked at people's care records including hygiene charts designed to show when people had bathed, showered or received a full body wash. However as records were incomplete and did not include many entries for people having had a bath, shower or full body wash, it was not possible to determine whether people had received the care they required in these facilities.

Communal areas were positioned on the lower ground floor level of the building. A health professional told us, "It's very bleak downstairs." One visitor told us, "When I first came, I went out and cried my eyes out because I didn't think anything of the building." They also said, "When you first come in, you think you are in a dungeon." The building's layout and the level of staffing made it difficult for people to return to their own room on other floors should they wish to during the day, as the only access to upper floors was by lift for which they required staff support to use. Therefore most people were escorted down to the communal areas and remained there until escorted back up to their rooms in the evening. One visitor told us, "It would be nice if we could sit in her room, but going up in the lift is too much hassle." One relative said they thought that their loved one would on occasion prefer to spend more time in their bedroom, but that this appeared to be discouraged by staff. They told us, "Maybe because it's a dementia home they don't like them in their bedrooms and prefer to see them all."

Although the lower ground floor provided a circular walk for people to use, the décor, layout and furnishing were not appropriate for people living with dementia. For example, the furniture provided did not meet people's needs and was not comfortable for them to use. Armchairs in the lounge had black bin liners on them to protect them from incontinence and spillages, which did not provide people with a comfortable and dignified place to sit. Staff and

visitors told us that some of the chairs were second-hand and had come from other places and did not always meet people's needs. One staff member told us, "The chairs aren't right, they are not comfortable." The dining room was small and space was limited because many people used wheelchairs and mobility aids. This meant that not everyone could eat in the dining room if they wished to. We saw a number of people eating in armchairs in the lounges. One staff member told us, "It's congested in some places. The lounge doesn't fit everyone's needs as they sit very close to each other." And another said, "There's too much clutter in the way." One relative told us, "It does seem a bit crowded…it seems too compressed, a lot of people on the ground floor, a lot of people sitting around in a confined space." Another said, "During the day residents are downstairs and it's a little bit crowded- not a lot of space."

The management team showed us plans for new furniture and a new layout for the communal areas, however the plans had not considered the needs of people with mobility challenges. The plans included some seating in rows that would be difficult for people with mobility aids to access. They also included the removal of dining tables from the lounge with the aim of making the current small dining room the only place for people to eat at tables. The size of the dining room did not allow everyone to be accommodated and therefore more people would be required to eat in armchairs elsewhere in the home. We talked this through with the area manager who acknowledged the issues raised by the inspector.

Mattress covers on some beds were ripped and some mattresses were stained. Some people had pillows that were very worn and no longer offered support. Beds were low which did not aid the mobility of people using them. We saw that a mattress was stored in the corridor and we were told this had been there some time as there was nowhere else to store it.

The homes layout, décor and facilities were not suitable for the diverse needs of people living at The Hollies. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff knew people well and were able to describe how people preferred to be supported and what care each person needed. One staff member told us, "When I came here I read through the care plans religiously as I didn't want to mess up." We looked at records and saw that staff undertook a three day induction. The provider had signed up to the care certificate (This is a nationally recognised standard for staff induction training), but was yet to implement this. One staff member told us, "We need a longer induction as some staff don't know what they are doing- it's three days and it should be at least a week."

We examined records and found that staff undertook a range of training, some were two hour sessions held by a trainer and others, such as Dementia and Challenging Behaviour were e-learning sessions. However not all staff understood how to meet the needs of people living with dementia who were distressed. For example, we saw that one person was distressed for a long period of time and although their care plan gave guidance as to how to comfort and distract them, staff did not appear to know what to do and told us, "It's part of their mental health" and, "We can't distract them now." Another staff member said, "We've had a lot of training, but I would like it more if we had it in person." We looked at staff files and could see that staff received supervision from a senior or manager, although we saw that some of these were group supervision and others gave very little detail and were in a tick box format.

We recommend that staff training, induction and supervision is reviewed in line with best practice guidance and the needs of people living at The Hollies.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted. It provides a process by which a person can be deprived of their liberty when they do not have capacity to make certain decisions and there is no other way to look after the person safely. We spoke with the deputy manager who told us that a number of DoLS applications had been submitted but they were awaiting the local authority's authorisation. We saw that best interest meetings were held and the home had requested that one person was supported by an Independent Mental Capacity Advocate in their decision making process. We spoke to staff and found they were not consistent in their understanding of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards (DoLS). Some staff were confident in their understanding and others were unable to describe the principles of the Mental Capacity Act 2005 or DoLS even though they had completed training. We found

Inadequate

Is the service effective?

that one person was regularly receiving their medicines hidden in their food without their knowledge. We examined the person's medicines records, care plan and mental capacity assessment for this person and found that this had not been discussed with the person and they had not given their consent to receive the medicine. There was no evidence to show that a decision to administer the medicine without the person's consent had been made in their best interests.

We recommend that people's mental capacity assessments are reviewed to ensure that staff act within the law when making decisions on behalf of people and the requirements of the Mental Capacity Act 2005 are consistently met.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care they received, "Yes I like it here" and "They're alright…very friendly, they look after me." Another person told us, "They're very nice, all of them, not met a bad one". Relatives told us, "My perception is that they seem to like them and there is a general warmth." And, "If nothing else they (staff) are very kind, friendly and loving."

However one health professional said of staff, "I think that they are task orientated." And one relative told us, "They seem to know what they are doing but I get the impression they are rushing around doing that, rather than spending time with residents." We saw that staff delivered care in a courteous, but sometimes hurried manner. This meant at times care was not as sensitive as it could be and explanations of care were not consistently given and therefore people's dignity was not always respected. For example, we observed a person being assisted in a hoist. The staff member assisting offered very little interaction or explanation of care as they attempted to straighten this person's clothing before moving on to the next task.

During lunchtime a person was crying at a table in the dining room. Staff that came in to the room did not offer any comfort or assistance to the person. Later we saw the person sat in an armchair and crying quietly with their face tucked in their hand. Although three staff were at times nearby, they did not offer any comfort or support to the person. After 10 minutes the person was still crying and we approached a member of staff to assist. They fetched a tissue and wiped the person's chin. Twenty minutes later this person was still crying and unattended to by staff. We approached the deputy manager who assisted and offered some comfort and reassurance to the person. A further twenty five minutes later the person continued to cry whilst Bingo was going on around them. Shortly afterwards the person fell asleep. We looked at the person's care plan which stated that during such times staff should "Give her constant reassurance and understanding and be patient when extremely anxious." The plan said that staff should divert this person's attention and that "This is usually very easy and only takes for (x) to be chatted to and her attention diverted." Although the care plan gave staff guidance for comforting this person, staff did not follow this and treat the person with respect and compassion.

We saw that people's care records included some people's preference for male or female staff. One staff member told us, "I was told that (x) doesn't like male carers and so I always make sure that is the case." We found that in one person's care records it stated that they could become challenging being given personal care or when toileted and that this could be "Due to embarrassment." Their care plan noted; "It is proven that (x) will respond better to a gentleman carer than a female and so please accommodate this where possible." We looked at care records for this person and saw that this had not been adhered to. Their care notes showed that even when male staff were on duty this person had received personal care from female staff. Although their care plan made clear their needs regarding intimate and personal care this had not always been respected.

One bedroom located on the lower ground floor was shared by two people. The bedroom was used by the hairdresser every Monday and Wednesday to wash and blow-dry other people's hair. When we asked the hairdresser what they would do if the two people wanted to return to their room, they said "We would struggle" and "There's an armchair." A visiting health professional told us that they were guided by staff to use this bedroom when people required a medical examination; "Wherever they (people) are, they are brought to (X)'s bedroom and we are doing examinations on someone else's bed." This arrangement did not respect the privacy of the people who were accommodated in this bedroom.

Private information kept about people was not always stored securely. Personal records relating to people were kept in a filing cabinet in a small room near the communal areas of the home. During our inspections we saw this remained unlocked and we observed it was accessible to visiting adults and children. This meant people could not be assured that their personal information would be kept confidential.

People were not consistently treated with respect and compassion and their confidentiality respected. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People were offered choices such as a choice of drinks, a choice of meal, where to sit at lunchtime and whether they'd like their hair done and staff respected their decisions. People said they could go to bed when they chose and one person told us they chose to sit in the

Requires Improvement

Is the service caring?

conservatory because it was quiet. One relative told us, "The staff are brilliant they couldn't be more helpful." and one visitor told us, "I find they are very caring." One staff member told us "The best thing is the relationship between the residents and some of the staff.…. We are always mucking around with each other." We observed there were times when there was laughter, warmth and friendly banter shared between people and staff.

We also asked staff how they promoted people's independence. One staff member said, "I don't interfere if I think someone can do something for themselves". Another staff member told us, "I like to get people to make their own decisions if they can. For example, if someone doesn't want to do something, like join in an activity, then it's up to them."

People were given information about their care and treatment. For example, the previous month a GP held a session with a person to ensure they understood their end of life options. A staff member told us, "They talked to (X) for one and a half hours explaining to her the options.…. and she was very happy at the end of it."

We saw that information on how to complain was made available in every person's bedroom. On the lower ground floor corridor there were notice boards that displayed everyday activities in pictures, as well as events such as forthcoming sing-a-longs and trips out. A list of dates of monthly residents meetings were also displayed as were the results of service users' and relatives' satisfaction questionnaires. There was also a dignity in care display that showed photographs of two staff and shared some background information about each of them.

Inadequate

Is the service responsive?

Our findings

People that were able to speak with us said the staff responded to their needs and provided the care they needed. “By and large, they’re good.” And, “Yes they’re very good, very kind and caring, I don’t mind male or female” and “They help if necessary”.

However one health professional told us they were concerned regarding the homes ability to respond to the needs of people who were unwell in bed. “I don’t think the layout is acceptable, people aren’t going to be heard if calling out. The person who has highest needs is furthest away.” Another health professional told us, “There have been times when we have thought people need nursing care not residential.” One relative told us that the previous registered manager had undertaken an assessment by visiting the residential care home their loved one used to live in. They said, “They didn’t really ask for a lot of information from us as far as (X) as a person, they didn’t really ask us anything.”

Before people moved to the home an assessment of their needs was undertaken. This included information regarding a person’s personal care needs, physical and mental wellbeing, mobility and family. Prior to our inspection we had received information of concern regarding the homes ability to respond to people’s deteriorating health. The Local Authority had undertaken a full investigation into the care received by one person and found that the home had failed to ensure that this person’s needs were met. The investigation identified that the person’s assessment had taken place a number of weeks prior to them moving to The Hollies, during which time their needs had changed. Although the home had sought medical intervention this person’s health continued to deteriorate quickly. The investigation concluded that the provider and staff at The Hollies had failed to respond effectively and had failed to reassess and review the person’s changing needs. As a result, the Local Authority concluded that the person had not been protected from unnecessary suffering before dying. The provider had not ensured that people received appropriate assessment and reassessment in order to ensure their needs could be met.

On the first day of our inspection we asked a staff member about one person who was unwell in bed and they told us, “Two weeks ago they were up and about” and that they had recently become “Bedridden and were just being made comfortable.” We asked staff if this person had family and were told “Not that I’m aware of.” We looked at the care records for this person and found that they had only been checked once in a six hour period the morning of our inspection. We looked at this persons care plan which said that they used incontinence aids and that these were to be checked; “At least every hour, to ensure she is comfortable at all times”, their care records showed that this was not taking place. On many days there were gaps of over six hours between checks and care delivered. The home had a call bell risk assessment which stated that residents in rooms who cannot use call bells should be checked hourly. Records showed this was not adhered to. People did not consistently receive responsive care that ensured their safety and well-being.

The home employed an activity co-ordinator who spent part of their day undertaking administrative tasks and the rest of the day with people undertaking activities. People had mixed views regarding the activities at The Hollies. One person told us, “I wander around” and another said, “I’m never bored, I sleep. You get too many interruptions at night.” One person told us, “I love Sunday afternoons, we have sing songs, most people love the old fashioned songs.” Another told us, “Boring, very boring- I will say that about this place, it’s always the same thing.”

We observed that most people spent their day in the communal areas located on the lower ground floor. A noticeboard displayed daily activities such as hairdresser and bingo on a Monday, a quiz on a Tuesday and armchair exercises, karaoke and bowling other days. The activity co-ordinator spent the mornings undertaking other duties and so generally people were not provided with activities in the mornings. The activity co-ordinator told us that more individual activities took place on mornings and we observed people watching the television, looking at newspapers, one person knitting and several people nursing dolls. We also saw a number of people with no occupation. One staff member told us, “Quite a lot of people can’t occupy themselves and there aren’t enough carers to do stuff with them.” Another told us, “Not everyone joins in…you need a variety.” People who were restless were able to walk around the corridor although space was limited. The home was trialling a circa machine, which is an easy to use computer programme system, designed to encourage communication between people living with dementia and their care givers. However we

Inadequate

Is the service responsive?

were told only one person used this and did so independently without staff sitting with them and aiding conversation. This meant that the equipment was not being used appropriately to help people engage with staff.

On both days of our inspection we observed group activities. We saw that people enjoyed singing and it was an activity that many people joined in, clapping and swaying with some people able to get up to dance with the activity co-ordinator. On the second day of our inspection we observed a quiz, where eighteen people were sitting in the main lounge and asked questions such as "Who is Sherlock Holmes' house keeper?" This activity did not appear to be inclusive or accessible to many people living at The Hollies and as a result many were disengaged and sat without joining in. One relative told us, "Staff are very friendly but the residents are left to their own devices for long periods of time."

Some people's care records showed that there were long periods of time without meaningful occupation. For example, one person had only undertaken activities on seven out of the previous twenty six days despite their activities plan of care stating they enjoyed massage, karaoke, entertainers, foot soaks and watching the television. Another person's records showed that they had also not undertaken any meaningful occupation in thirteen out of the previous twenty six days. Their activities care plan stated they enjoyed a wide range of activities.

We saw that there were some day trips planned and asked how people with more complex needs were supported. The activities co-ordinator explained that there were a number of people who were not supported to go out. They explained that a minibus was hired and space was limited as some people required the use of a hoist for personal care they could not go. They were unaware of the changing place toilets throughout Kent where hoisting facilities were included in public buildings. They told us one person had not been out of the home since July 2014. The activities co-ordinator explained that they would not take this person out as it would be uncomfortable for them in a wheelchair. Their activity care plan had not assessed or recorded this. Another person's plan said they would like to go out for dinner and a walk but we were told they had not been out since September 2014. The activities co-ordinator told us that two other people were "Not allowed to go out" because of their families' wishes. However their activities care plan did not reflect this.

People did not always receive personalised responsive care that met their needs. Some people were at risk of becoming socially isolated with little activity to stimulate or interest them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The management were made aware of these concerns and told us they were implementing a number of initiatives that would address them. We will assess whether these have improved the personalised support people receive and their quality of life when we next inspect.

People told us they were supported to maintain links with their family and friends and visitors told us they felt welcome. One relative told us "You can come anytime you like and they are welcoming." Another relative told us "They treat me well and are always receptive to us; they don't restrict us from coming." Another relative told us the home was good at keeping them informed, "They do ring me if there is something they are concerned about."

We saw that guidance on how to complain was displayed throughout the home. This information set out contact details for the provider, timescales for responding to complaints and details of the local government ombudsman should people feel dissatisfied with the way their complaint had been handled. Although no complaints had been received relatives told us they would raise a complaint if they needed to, "I have not raised any direct concerns but I have their number." And a visitor told us, "I can assure you if I ever found something wrong, I would be the first to complain."

Inadequate

Is the service well-led?

Our findings

Relatives and visitors told us they thought the management were approachable. “Every time I’ve been down there- I’ve had a good relationship with the management.” And, “The deputy manager was very helpful, very approachable.”

One professional told us, “My overriding impression was that it was open and relaxed and there was no restriction to my movement. I was welcome at any time.” We asked staff about the day-to-day running of the home and how the management led the service. The staff we spoke with told us the management team were fair. One staff member said, “If I had a problem I would feel comfortable talking to the deputy manager or a senior.” Another staff member told us, “If I have a problem I go to the manager and they will sort it out if they can”. We asked staff whether their suggestions for improving the service had or would be acted upon. One staff member told us, “I suppose it depends what it was. If it was something small, like changing when we serve meals then probably yes. But if it was a bigger issue, like staffing levels or new equipment, then I’m not too sure”. Another staff member said, “We don’t have much say about things like that. I don’t mind really. It’s the manager’s job.”

The home was without a registered manager as the previous manager had left several weeks before and arrangements for ensuring the home was managed effectively were unclear. On arrival we were told the deputy manager was leading the service whilst recruitment was underway. We spoke to the deputy manager and they explained that they had been asked to act up into the role by the provider. A short while into our inspection an area manager who the deputy had never met before, arrived to offer their support. Later we were told by the Director of Operations that the area manager would be at the home each day and would be taking managerial responsibility whilst the provider tried to recruit.

We looked at the home’s Statement of Purpose that set out the aims and objectives as well philosophy of care. The objectives included providing a safe and enjoyable environment, providing emotional support and providing good physical care as well as, “To provide high standards of care, stimulation and understanding for service users who suffer from confusion, dementia or Alzheimer’s.” However our inspection identified a number of issues that showed that these objectives were not being met. We walked around the home with the area manager to show them areas requiring maintenance that represented a safety risk. We showed them issues such as limited access to a middle floor bathroom and toilet, and highlighted the risk associated with the unreliable lift. We asked the management to observe a group activity so that they were able to judge whether it was effective in stimulating the majority of people living at The Hollies. The management acknowledged that there were both environmental and practice concerns that needed improving.

The registered provider did not have in place effective systems for monitoring the quality of care provided. For example, they had not identified that two people’s right to privacy was not being respected as others regularly used their bedroom to receive care. The provider had not identified that staff did not always have the time or understanding to effectively meet the needs of people living with dementia in a sensitive way.

The provider‘s lead representative for quality assurance had undertaken an audit of the home in June 2015, but had failed to identify some of the issues raised during our inspection. For example the audit stated, “There was good evidence of activities and an activities board, Facebook page and social media being used to advance the home.” However we found that care notes and observation showed that where some people had more complex needs, opportunities and choices were limited. The audit identified some, but not all maintenance issues within the premises. The audit stated “The lift between floors is old and not functioning correctly.” It had clearly identified that there was a risk associated with the lift, but although this was identified as ‘More prevalent in summer’ no action had been taken.

The audit had not identified issues regarding staffing levels and recruitment. The audit noted “During the day staff ratio is 1:6 in the morning and 1:10 at night.” It failed to identify whether this was sufficient given people’s needs and the layout of the building. The audit said that staff files are complete, however we found issues regarding the effectiveness of checks made, including duplicate references and gaps in employment history. The audit also failed to identify gaps in care delivery, such as repositioning people and adequate fluid intake, and the recording of care delivered.

The home’s Statement of Purpose stated “During the course of their stay, all service users’ needs are reviewed

Inadequate

Is the service well-led?

monthly and should there be any drastic changes, a review of the appropriateness of the home or their care will be discussed with all relevant Heath Professionals, families and Service User." However we found that this had not been adhered to. We looked at the care plan and associated documentation for a person staff had told us had mobility difficulties, poor nutrition and from time to time exhibited behaviours that challenged. We noted from the care plan only one mobility assessment had taken place since 29 April 2015. There had been no falls risk assessment since 29 April 2015. We also noted there had been no update of the person's eating and drinking care plan since 30 May 2015 and no assessment using 'MUST' since 4 May 2015. We looked at the person's challenging behaviour and activities care plans and these had not been reviewed since 30 May 2015.

We looked at people's care records including hygiene charts designed to record when people had bathed, showered or received a full body wash. Whilst these records included when people had shaved or had their hair brushed, they did not include many entries for people having had a bath, shower or full body wash. When we asked the deputy manager to show us when people had last bathed they acknowledged that records were incomplete. Nineteen out of twenty nine people had no record of having had a bath, shower or wash in their hygiene chart for the month of June. Twenty out of twenty nine people had no record of having bathed showered or had a full body wash in the twenty seven previous days of July. Consequently, it was not possible to determine whether people had received the care they required.

People who used services were not protected against the risk of unsafe or inappropriate care because the registered provider did not have consistently effective monitoring systems in place and records were not always accurate or up to date. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some monitoring systems that were used effectively to promote quality and safety. For example the previous registered manager analysed accidents and incidents, looking at patterns relating to the people involved and the places and times they occurred. Actions were recorded and there were clear timelines in place.

We saw that the previous manager kept an action plan that included issues raised from staff meetings, residents meetings and audits. Some issues had been addressed and others were on-going. For example, questionnaires had been sent out in April and where issues such as the presentation of the food had been raised, the manager had taken action.

Residents and family meetings were planned for the months ahead and we saw that these were scheduled for both evenings and the daytime, in order to promote attendance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive person centred care and support in a way that met their changing needs.** **People were at risk of becoming socially isolated with few person centred planned activities to meet their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not consistently treated with respect and compassion.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People did not receive the support required to ensure their nutrition and hydration needs were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not ensured the home was maintained and equipped to an appropriate standard that met people's diverse needs.**

Regulated activity	Regulation

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 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risk of unsafe or inappropriate care because the registered provider did not have effective systems in place for monitoring the quality and safety of the service and identifying when there were issues.
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The Providers recruitment procedures were not sufficiently robust.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not were not protected against the risk of unsafe or inappropriate care or treatment as the provider had not taken appropriate action to mitigate risks and to ensure the home was effectively maintained. People were not consistently supported with their health needs.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 26 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider failed to ensure that there were sufficient numbers of staff deployed to safeguard the health, safety and welfare of people.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 18 November 2015.