

Hollybank House (Derby) Ltd

Hollybank House

Inspection report

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Tel: 01773831791

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This unannounced inspection took place on 24 and 25 May 2016. The service was last inspected on 11 April 2014 when all standards were met and no concerns identified.

Hollybank House is registered to provide accommodation for up to 45 older people. At the time of our inspection, 37 people were living there. The service is also registered to care for people who need nursing or personal care.

The service had 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.

People's dietary needs were not consistently understood. Staff were not always aware of people's specific dietary requirements. Care records did not always contain specific guidance for staff on how to meet people's nutritional needs. Where risks had been identified, these were appropriately monitored and referrals made to relevant professionals where necessary.

Where people lacked capacity to make certain decisions, the provider did not always follow the principles of the MCA to ensure best interest decisions were made lawfully. People were supported to make their own decisions about their care where they had capacity to do so.

People's needs were assessed but care plans did not consistently provide staff with guidance on how to meet people's individual needs. Risk assessments and care plans were regularly reviewed and updated to reflect people's changing needs.

Staff training was not consistently undertaken where the provider had identified the need for refresher training. Staff received one-to-one support from their manager, and formal personal development plans, such as annual appraisals, were in place.

People had varying levels of support to maintain hobbies and interests. People who were able to engage in group activities took part in the opportunities offered at the service. Relatives felt that people who were less able were less likely to have activities offered that were meaningful to them.

The provider had systems in place to monitor and review the quality of care at the service. However, these did not always identify risks or areas where action needed to be taken.

Medicines were managed safely and in accordance with current regulations and guidance. Staff received appropriate training to help ensure safe practice. There were systems in place to ensure that medicines were stored, administered, recorded and audited regularly.

Safe recruitment procedures were followed and the provider made appropriate pre-employment checks to ensure staff were safe to work in the care sector. There were policies and procedures in place to keep people safe from the risk of abuse. Staff understood and felt confident to raise concerns about people's care.

People received care and support from staff who were kind, caring and confident to meet their individual needs. People were supported to access health and social care services when required.

There was a formal complaints process in place. People and their relatives were encouraged to express their views about their care, and the provider was responsive to these.

People were not always kept safe from the risk of avoidable harm. Risk assessments did not consistently identify the level of risk, or identify what actions staff should take. People were able to access areas of the home that presented a risk to their health and safety. This was a breach 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 the report.

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 consistently safe.

Risk assessments did not always identify level of risk or action staff should take. Areas of the building where people had access presented a number of hazards. Medicines were managed safely.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

The provider did not ensure that staff received refresher training in the timescale they felt necessary. The provider did not ensure that care was consistently compliant with the Mental Capacity Act 2005. The home environment was not always adapted to meet people's needs.

Requires Improvement ●

Is the service caring?

The service was caring.

People felt supported by staff who were kind and caring. Staff took time to communicate with people to reassure them that their needs would be met in the way people wished.

Good ●

Is the service responsive?

The service was not consistently responsive.

People had varying levels of support to engage in activities and hobbies. The provider did not have a consistently proactive way of seeking people and their relatives' views about the service. People were involved in planning their care, and there was a clear system for managing complaints.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Systems for monitoring the quality of the service did not always identify areas of concern. Staff felt supported, confident and understood their roles and responsibilities. The provider had developed a range of policies to support the running of the

Requires Improvement ●

service.

Hollybank House

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 24 and 25 May 2016 and was unannounced. The inspection visit was conducted by one inspector, a specialist nurse advisor, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience has experience of caring for someone living with dementia.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We spoke with the local authority and health commissioning teams, and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. No concerns were raised by them about the care and support people received. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

During the inspection we spoke with 11 people who used the service. We spoke with five relatives and four friends who were visiting people living at the service. We spoke with four care staff, one nurse, the activities coordinator, the deputy manager, and the registered manager. We also received the views of one healthcare professional. We looked at a range of records related to how the service was managed. These included six people's care and medicine administration records, three staff recruitment and training files, and the provider's quality auditing system.

Not all of the people living at the service were able to fully express their views about their care. We used the

Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

People were not consistently kept safe from the risk of avoidable harm. We identified a number of hazards that presented a potential risk to people's safety. There were not always adequate protective measures in place to reduce the risk of avoidable harm.

Risk assessments were carried out in relation to nursing and personal care activities, and were reviewed every month. However these did not consistently identify the level of risk or clearly identify what actions staff should take to minimise the likelihood of harm. One person, who had a history of falls, had a completed risk assessment in relation to this. However neither the risk assessment nor the care plan identified what specific preventative measures were in place to reduce the likelihood of the person falling. Another person had a risk assessment and care plan relating to the need to keep their environment safe, but there was no specific guidance in either document for staff on how to achieve this. We found that some preventative measures were in place to reduce harm, and staff were knowledgeable about these. However, risk assessments did not clearly identify the measures that had been put in place and how decisions had been made to ensure they were proportionate to reduce the risk of harm to people. This demonstrated the provider did not take adequate steps to identify risks or actions required to minimise avoidable harm.

One person, who was being nursed in bed liked to have their bedroom door left open. This was a fire door, which was being wedged open. The bedroom doors did not have a mechanism fitted which would enable them to automatically close in the event of the fire detection system being activated. This put the person at risk in the event of a fire where they would not be protected by a working fire door. We spoke with the registered manager about this as a potential risk. They assured us they would investigate and take action where necessary.

Risks associated with the service environment were not mitigated. The staff kitchen was unlocked throughout the two days of the inspection visit. The laundry room was not routinely locked, and was accessible to everyone in the service. Equipment, tools and cleaning chemicals were not stored securely. Some of the people living at the service had diagnoses of dementia, and there was a risk that they would be unable to recognise these potential hazards. Staff confirmed that people had access to these areas and we saw this was the case. Environmental risk assessments did not identify these areas as risks, or identify what action should be taken. We spoke with the registered manager about this; however timely action was not taken. This placed people at risk of unsupervised access to areas containing a number of hazards, and meant people were at risk of avoidable harm.

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

Accidents and incidents were recorded, and the registered manager monitored and reviewed the outcome of any actions needed. For example, one person had a review of their medication and an alarm mat placed by their bed to alert staff to movement. These measures were put in place following several falls, and the person experienced fewer falls as a result of the action taken.

People told us they felt safe living at the service. One person said, "There is always someone around." A relative said, "I feel happy to go on holiday which I haven't done in two years because of my confidence in staff." People, relatives and staff felt confident to raise concerns about care, and knew who to share their concerns with. Staff also knew and felt confident to report concerns to the local authority or the Care Quality Commission (CQC) if they felt this was necessary. Two staff said they felt confident to recognise signs of abuse and gave examples of what they would look for and what action they would take. Staff felt supported to speak up and thought any concerns would be treated seriously. Contact details were displayed around the home for everyone to use if they had concerns about people's safety or the risk of abuse.

There were enough staff to keep people safe and meet their needs. People and relatives had mixed views about whether there were enough staff available. One person said, "There are always staff around to help" and another said, "It depends how busy they are [when asked about waiting for staff]." One relative said, "There is always someone around," but three other relatives felt there were not enough staff available.

Staff said that there were generally enough of them to be able to meet people's needs, but several staff identified a potential need for extra staffing in the mornings. Due to the increased needs of people at this time, staff felt having one extra colleague on shift would benefit people. Staff said they prioritised people's requests for support. Staff told us, and we saw there was always at least one staff member present in the lounge area of the service to ensure that people who needed assistance received it. The registered manager and deputy manager told us a dependency tool was used to help calculate staffing levels needed based on people's level of dependency and the amount of support they required. The staffing rotas reflected the staffing numbers determined by the dependency tool and people's individual health needs. We saw that the registered manager had ensured extra staff on shifts where there was an identified need for this. For example, to provide people with support to attend hospital appointments. This showed there were sufficient staff to meet people's needs at the service.

The provider undertook pre-employment checks to ensure prospective staff were suitable to care for people. This included checking references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is suitable to work with vulnerable people. All staff had an induction and probationary period to give the provider an opportunity to check they had the skills and values needed for the role.

People were supported to remain safe in the event of an emergency. Staff understood what their role and responsibilities were if there was an emergency or unforeseen event. The provider had up to date personal emergency evacuation plans for everyone who lived at the location. These contained important information about how people needed to be supported in the event of an emergency, for example, fire evacuation. The provider had a contingency plan in place to ensure people continued to receive support in the event of the building becoming unusable, for example, if there was a fire or disruption to utilities.

Staff told us, and records showed that safety checks were carried out on equipment in accordance with the manufacturer's instructions. For example, we saw staff visually inspect a sling for hoist equipment before using it, and records showed that these were also checked regularly in accordance with best practice guidance and legislative requirements.

People's medicines were managed safely. Staff had received training in the safe management of medicines and demonstrated that they understood how to do this. Staff told us and records showed that they knew what action to take if they identified a medicines error. The provider had up to date guidance for staff which was accessible for staff who dealt with medicines. We saw all medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation. Staff took time to

explain to people what their medicines were for, and checked that people were happy to take their medicines.

Is the service effective?

Our findings

The provider did not always ensure that staff had received refresher training in areas they felt essential. We saw that three staff had not undertaken training in falls prevention since 2012. Eleven staff had not undertaken first aid training within the last three years. The provider's policy on refresher training said staff should redo training in key areas of care every three years. Records showed that most staff received ongoing training in skills the provider felt necessary to maintain a good standard of care. This included first aid, moving and handling people safely, tissue viability, nutrition and dementia care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that two people's relatives had signed consent forms on their behalf, and staff confirmed that they did not know if the relatives had the legal authority to do so. Therefore, where people lacked capacity to make certain decisions, the provider did not always follow the principles of the MCA to ensure best interest decisions were made lawfully. People were assessed in relation to their capacity to make decisions about their care. Where they were able to make their own decisions, their care plans recorded this. Staff had good understanding of the principles of the MCA, including how to support people to make their own decisions. For example, one staff member described how they would try to explain clearly and simply what choices were available, and said they would ensure they had good eye contact with the person to make sure they had their attention, and we saw staff doing this during our inspection visit. The provider was not consistently working in accordance with the MCA, and people were at risk of not having their rights upheld in this respect.

The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The provider had assessed people as being at risk of being deprived of their liberty and had made applications to the relevant Supervisory Bodies appropriately. This meant restrictions in people's care was lawful.

The home was decorated in a way that could be confusing for people with dementia or cognitive impairments. For example, most bedrooms and communal areas were painted cream, with little colour differentiation in key areas. There were few adaptations made to aid orientation for people with a visual impairment or dementia. We spoke with the registered manager about looking at guidance on best practice to promote an environment that was more appropriate for different health conditions, which they said they would look at. This demonstrated the environment was not always tailored to meet people's individual needs and preferences.

People's dietary needs were not consistently understood or met. One person's care records identified that they needed a fluid intake of two litres per day. Whilst staff were recording the person's fluid intake, there was no guidance for staff on what action to take if the person's fluid intake was poor. The same person was identified as having a poor appetite, but there was no guidance for staff on how the person should be supported to ensure they had sufficient food. A second person was on a low-fat diet, and this was detailed in their care records. Staff, including kitchen staff, were not aware that this was the case, and the person was not being given food in accordance with their care plan. This placed people at risk of not having their dietary needs met.

People told us they were offered one option for lunch, and the menu board displayed one main meal option. Staff told us, and we saw people would be offered alternative meal options if they did not like what was on the menu. People sitting together were not always served at the same time. Some people were left sitting for over 30 minutes before food was served. We saw that not everyone who needed encouragement and support got this. There was little interaction between people and staff apart from practical support to cut up food or to eat.

All staff had a probationary period before being employed permanently and undertook an induction period of training the provider felt essential to meet people's health and social care needs. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of standards linked to values and behaviours that social care and health workers apply in their daily working life. During the induction period, staff worked alongside (shadowed) experienced colleagues so they could learn people's individual needs and preferences. One staff member said, "I shadowed [staff] for two or three weeks; this helped me to get to know what people liked and needed."

There were regular staff meetings which enabled staff to discuss information relating to care. Staff told us, and records showed they had individual meetings with their supervisor throughout the year to discuss their performance and training. They told us this was an opportunity to get feedback on their performance and raise any concerns or issues. One staff member said, "The training [in dementia awareness] really helped me put myself in people's shoes and have a better understanding of how dementia affects them." Another staff member said, "I can talk about training I need, or put forward ideas I have for people's care."

We observed a staff handover, where staff met to share information about people's care needs. Staff told us, and records confirmed that this happened at the start of every shift. The key points of the discussion were recorded so staff had up to date knowledge of people's daily care needs.

People felt that staff would support them to maintain their health and enable them to access healthcare services when required. One person said staff would ensure they had the health appointments they needed, stating, "They will write and book my appointments." Staff were knowledgeable about people's needs in relation to external healthcare services, and records showed that people were supported to receive healthcare when this was needed.

Is the service caring?

Our findings

People were supported by staff who demonstrated kindness and a positive caring attitude. People said that staff were caring, and praised the quality of care. One person said, "Staff are kind to me." Relatives also felt that staff provided care in a kind, caring and inclusive manner. For example, one relative said, "They're absolutely amazing [in reference to the staff]," and another commented, "I cannot fault them: they're like a big family."

Staff interacted with people in a caring and respectful way. They ensured people were comfortable and took time to explain what was happening around them in a patient and reassuring manner. Staff spent time with people who appeared anxious or agitated. Staff explained to us they needed to take time to try to establish what people wanted to do and actively listen to what they were saying, or what their body language was communicating. For example, we saw staff speak calmly and with patience to a person who was anxious about being supported to change seats using a hoist. This had a positive effect on the person and their anxiety reduced.

Staff we spoke with were knowledgeable about people's personal preferences, lifestyle choices, life histories and relationships. This meant they were able to engage people in meaningful conversations and we saw frequent friendly conversations between people and staff.

People were involved in their day to day care. They had choices about when they got up and went to bed, what they wanted to wear, and what they wanted to do. For example, we saw people being offered an alternative activity if the main planned activity that was taking place was not to their liking.

Some people needed time to express themselves clearly, and we saw staff gave them time and encouragement to communicate their views and wishes. Staff were knowledgeable about people's different communication styles, and supported them to communicate in ways which worked for them. For example, staff supported communication with one person about care choices using cards with pictures and a clear written description.

The home had achieved the local authority's Dignity Award campaign. Derbyshire County Council states, "A key test is if you're treating people with the same dignity and respect as you would want for yourself or your family." We saw throughout our inspection visit that staff supported people in a warm, friendly, and patient manner.

We saw staff respected people's privacy. Staff knocked on people's doors and announced themselves before entering. They spoke with people in kind and respectful ways, and asked their permission before performing care tasks.

People were supported with their medicines and care needs in a dignified way. Staff understood how to support people with dignity and maintain their privacy. For example, staff asked people about personal care in a discreet manner, and when people were supported to the toilet, staff did this in a way that maintained

people's privacy and dignity.

Staff knew how to refer people to advocacy services for support, although at the time of our inspection visit, we were not aware of anyone currently using an advocacy service. Information was available around the home about local advocacy services that could support people in speaking up about their care. This meant that people could be supported by independent advocates to participate in planning and reviewing their care, or in raising concerns.

Is the service responsive?

Our findings

People experienced varying levels of support to maintain interests and hobbies. People we spoke with told us about their previous hobbies and interests. However, people had mixed views about being supported to maintain their interests. One person said, "I used to enjoy walks. I can't do it now because I can't see well and I have to walk with a frame." Two people said they had physical health problems which prevented them from participating in activities at the service. Relatives did not always feel that people were offered activities that were meaningful to them. Staff told us, and we saw that the activity coordinator spent time with people daily to assess how they were feeling and establishing what activities they might wish to take part in. Staff told us, and we saw that people who were more independent were more likely to be actively engaged in activities. People with more complex needs, for example, with severe dementia, did not have so many activities tailored to their individual needs and preferences. Staff also told us that they tried to spend time with people to support them in any activities they wished to do, but this was not always possible as they needed to ensure people received personal and nursing care. We saw that the activity coordinator had a flexible timetable of activities, but noted that daily activities information was mainly aimed at people who were more physically active. This meant people who would benefit from one-to-one activities that did not require a higher level of physical ability, did not always have opportunities that met their needs.

The service provided questionnaires for relatives on an ad-hoc basis, inviting them to share their views on the quality of the service. These were available near the front door and there was a folder for relatives to place completed forms. We spoke with the registered manager, who confirmed that there was no regular proactive method of seeking people's and relative's views on the quality of the service. This meant the provider was relying on relatives and visitors noticing the questionnaires and completing them. Questionnaires were reviewed every six months to look at themes for service improvement, but the provider did not have a method of providing feedback to people and relatives to demonstrate where improvements had been made. The registered manager said that they would be talking with the provider to look at alternative ways of seeking feedback.

People could not recall being involved in reviews or decisions about their care, however everyone we spoke with was happy with this and did not want any more information on their care plans. One person told us, "Staff know how I like things, and I tell them what I want if I need to." Relatives were involved in people's care planning where people consented to this, or where this was in people's best interests. One relative said, "I am kept informed. They always share anything going on." Another relative said, "They always contact us." Records we looked at supported this. The provider also held regular meetings for people and their relatives to discuss the quality of the service, forthcoming events and improvements to care. Records showed where issues had been raised and how the provider had responded. For example, people had asked about the building environment, and a programme of refurbishment was now taking place. However, the meetings were about general issues in relation to the service, and did not address individual issues about people's individual care needs.

The provider supported a relative to produce a regular newsletter for people, relatives and staff. The relative said, "I produce a bi-monthly newsletter. Staff write about their life and share something about themselves."

The newsletter contained information about group activities and events that were planned so that people and their families were aware of what would be happening.

The provider had a clear policy on complaints management and information about this was displayed in the home. No formal complaints had been received since the service's last inspection, and the registered manager confirmed that issues raised were dealt with as quickly as possible to prevent them from escalating to a formal complaint.

Is the service well-led?

Our findings

The provider had systems to monitor and review all aspects of managing the home. This included essential monitoring, maintenance and upgrading of the facilities, and regular monitoring of the quality of care. However, safety audits did not always identify areas of risk or ensure that action was taken to reduce the risk of harm. We identified areas of the building such as the staff kitchen and laundry area which were routinely left unlocked. These areas contained equipment and environmental hazards that presented risks to people. For example, an upstairs shower room contained a sunken shower tray that presented a trip hazard. Staff assured us that they did not use this room, but the room was not locked and was accessible to people throughout our inspection visit. We spoke with the registered manager, who was clear that they intended to take action to address these issues.

We saw action had been taken to improve the service in some areas. For example, a safety audit identified that wardrobes needed to be fixed to walls to avoid the risk of people accidentally pulling them over and causing harm. The provider was in the process of ensuring that all wardrobes were securely fixed to walls. The provider ensured that external checks on the safety of the service were undertaken. For example, the local council had recently carried out an environmental health inspection and had found no areas of concern.

The service had a clear set of values which were central to developments and improvements. These values included respecting people's human rights, privacy, dignity, independence and choice. Relatives we spoke with spoke positively about staff who they felt demonstrated these values in their work. Staff told us they felt supported by the provider, the registered manager, and by their colleagues. They understood their roles and responsibilities, and felt supported and listened to if they raised concerns or had suggestions to improve care. Staff had regular supervision and staff meetings with the registered manager where they felt able to discuss concerns about the service and make suggestions. One staff member said, "[Registered manager] is really supportive." Another member of staff said the registered manager was, "Very good and responsive to people and staff needing help."

We saw that the registered manager had an 'open door' policy and throughout our inspection, people, relatives, and staff came to speak with them frequently. The registered manager took part in providing nursing and personal care for people regularly, and demonstrated good knowledge of people's individual needs and preferences.

The registered manager understood their role and responsibilities in ensuring that the service provided care that met the regulatory standards. They consistently notified CQC of any significant events that affected people or the service. They also felt supported by the provider to manage the service.

We saw organisational policies and procedures which set out what was expected of staff when supporting people. Staff had access to these, and were knowledgeable about key policies. We looked at a sample of policies and saw that most of these were up to date and reflected professional guidance and standards. The provider's whistleblowing policy supported staff to question practice and assured protection for individual

members of staff should they need to raise concerns regarding the practice of others. Staff confirmed if they had any concerns they would report them and felt confident the manager would take appropriate action. This demonstrated an open and inclusive culture within the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not consistently document risks to the health and safety of service users receiving care or treatment. Actions were not consistently taken to mitigate risks. 12 (2) (a) and (b)