The White Horse Care Trust

Holly Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Holly Lodge provides accommodation with nursing and personal care for people with a learning disability and/or associated health needs. Holly Lodge accommodates people in three separate units each with its own facilities. They are joined into one building by a large activity room, which all three units shared. The service is all on the ground floor with private gardens. At the time of our inspection there were 15 people living at the service.

The service has not been fully developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

The service was larger than current best practice guidance or within principles for the number of people living in one property. It was bigger than most domestic style properties as 18 people were accommodated. The size and location of the service having a negative impact on people was not mitigated by the building design. The service was located away from other properties set in its own grounds. This meant the service was geographically isolated from the village of Pewsey. The signage identified Holly Lodge as a care home although staff were discouraged from wearing uniform that suggested they were care staff when accompanying people.

People's experience of using this service and what we found
The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. People did not consistently receive person-centred care. Some interactions observed demonstrated use of inappropriate language and a lack of awareness of people's privacy and dignity. We were not confident people were given choice in all aspects of their life, for example, we observed staff giving people meals without offering them choice.

People's medicines were not always managed safely and not all staff had their competence to administer medicines checked. Risks were not always managed safely as systems were not in place to make sure all risks were identified, assessed and management plans put in place. For example, risks of using bed rails had not been assessed with safe management plans in place. Staff took immediate action to make sure bed rails were safe during our inspection. There were sufficient numbers of staff on duty. The service was clean and smelt fresh.

Staff had not always had the training they needed to care for people effectively. There were issues with staff accessing training which the management team were aware of.

People were not always supported to have maximum choice and control of their lives and staff did not

support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice. The service could not demonstrate that when decisions were being made for people they were the least restrictive option.
People had access to healthcare when needed and staff worked together and with other professionals. People had support to eat and drink and mealtimes seen were unhurried and a social occasion. However, choices of meals were not provided on both days of the inspection.

People did not always have an up to date care plan and monitoring information for staff to follow. The service was in the process of transferring records to an electronic system which meant there were many plans that needed updating. Monitoring records were not completed accurately and in full to record care and support provided. Some guidance provided was detailed and had been updated. People had the opportunity to record their end of life wishes and plan for the care they wanted.

We were not notified of all reportable incidents. Quality monitoring was not effective in identifying all the improvement needed. Action plans were not in place where improvement had been identified. This meant we were not able to see if actions needed had been carried out. Complaints were managed, however the complaints policy had incorrect information. The provider told us they would update this policy.

Despite the shortfalls we had found at this service people and their relatives told us they were happy with the care provided. The service had a registered manager who was established and experienced. One relative told us the registered manager was, "approachable, natural, professional, available and hands on". Some people had experienced good outcomes and made improvements in areas such as wellbeing. People and their relatives told us staff were caring and knew people well. We observed some positive interactions that showed staff had a caring approach and knew how to adapt their approach for individuals.

We have found three breaches of Regulations.

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

The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/ or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

As part of thematic review, we carried out a survey with the registered manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people.

The service used some restrictive intervention practices as a last resort, in line with positive behaviour support principles.

Rating at last inspection –
The last rating for this service was Good (report published 26 April 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details can be found in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Holly Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and three relatives about their experience of the care

provided. We spent time observing care and support as some people were not able to discuss their experiences with us. We spoke with six members of staff, the registered manager and the deputy manager. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and provider policies. We contacted eight healthcare professionals for their feedback about the service. We also contacted Healthwatch Wiltshire. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We spoke with the nominated individual on the telephone. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also contacted six relatives of people who live at the service for their feedback about the care and support provided.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management

● People were not protected from unsafe medicines systems. People who were prescribed topical lotions and/or creams were at risk of not having creams applied when and where they needed them. There was little or no guidance for care staff to know what cream to apply and where on the person's body it was needed.

● Staff were not always recording information about what creams they had applied. Where the staff were recording on people's medicines administration records (MAR) we found there were gaps in the recording. This meant the service could not be sure people had been supported to have their medicines as prescribed.

● Where creams and lotions were in use we found staff had not dated the container when they were opened. National Institute for health and Care Excellence (NICE) guidelines state that creams should be stored securely and have the date recorded when they were opened. This enables staff to monitor creams for expiry dates.

● All staff had not received training to administer medicines competently. Whilst nursing staff were responsible for the management of medicines the application of creams and lotions was carried out by the care workers. Care workers had not been assessed as competent or provided with training on how to apply creams safely. The deputy manager told us the service used to assess all staff competence annually, but this had ceased.

● Staff were not always recording the temperatures of the rooms where medicines were stored. The providers policy stated staff would record temperatures daily to make sure medicines were stored below 25 degrees. Records of temperatures in one medicine room had gaps in the recording for the month of September and for four days in October.

● Risks were not always assessed and identified so that measures could be put in place to keep people safe. The service had not assessed the risks of using paraffin-based emollients. Whilst safe to use, paraffin-based emollients can be a fire hazard if they come into contact with an ignition source. We raised this with the registered manager who told us they would address this.

● Where people had bed rails in place the service had generic risk assessments in place which did not assess the person's individual needs. Staff had not measured the bed rail positioning to make sure gaps were in line with Medicines and Healthcare products Regulatory Agency (MHRA) guidelines. We saw in one person's records there had been an incident where they had been trapped by their bed rails. The service had not taken action to make sure this person was using their bed rails safely. We raised this during our inspection and staff took immediate action to make sure the bed rails were safe.

● People's individual risks had not always been managed safely. People had been assessed for their risk of developing pressure ulcers. The assessments for one person developing pressure ulceration was not correctly analysed which meant this person care and treatment may not safely meet their level of need. We

saw another person had two different forms in their records to assess their risks of developing pressure ulcers. One stated the person was at low risk and the other stated the person was at medium risk. We raised this with the registered manager who took action to address this shortfall.
● Where people had been assessed as being at risk of developing pressure ulcers there was some guidance in place manage the risk. This was not detailed enough to give staff guidance on how to support people. For example, one person had guidance that stated staff needed to do position changes throughout the day. The guidance did not say how often this person needed to be re-positioned. Records of this person's re-positioning demonstrated inconsistency with the frequency of being helped to move.
● When people lost specific amounts of weight the providers risk assessment stated people needed to be weighed every two weeks. We found one person had lost 5kg in a two-month period. Records showed they were weighed monthly instead of weekly as stated in the policy. We raised this with the registered manager during our inspection.

Failing to take the required action to provide safe care and treatment is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● We observed nurses administering medicines and saw their practice was safe. They knew people well and engaged with them about their medicines. 'As required' (PRN) protocols were in place for medicines that were prescribed PRN. These gave good detail for when to administer this type of medicine.
● People's MAR had a photo of them and all the details needed to support administration of medicines.
● Where people experienced distress there was behaviour support plans in place to guide staff on action to take. This included detail on supporting people's emotional wellbeing.

Systems and processes to safeguard people from the risk of abuse
● People were safeguarded from abuse. People told us they felt safe at the service and relatives were confident their family member was safe. Comments included, "I have no problems at all with Holly Lodge, it's the safest [relative] has been for many years, [relative] is well looked after", "I feel [relative] is safe. The building is secure, and purpose built with high regard for safety" and "Yes [relative] is safe, I have no concerns."
● Staff we spoke with all understood their role in safeguarding people from the risk of abuse. They were able to tell us the different types of abuse and the signs they were looking out for.
● Staff all knew to report concerns to the management team and they were all confident action would be taken. There was information displayed at the service to guide staff on how to report concerns to external agencies.
● The registered manager worked with the local authority safeguarding team to investigate concerns raised. We observed one person had made an allegation of abuse against a member of staff. The registered manager whilst looking into their allegation took six days to notify the local authority. The registered manager told us multiple attempts had been made. An external healthcare representative gave advice regarding the concern and confirmed there were difficulties contacting the safeguarding team.We discussed this with the nominated individual who told us this delay was not their standard safeguarding procedure. They told us they would look into this. The registered manager completed a notification to inform us of this safeguarding incident.

Staffing and recruitment
● People were supported by sufficient numbers of staff. All shifts were led by nursing staff who were on hand to respond to nursing and health needs. We observed during our inspection there were sufficient numbers of staff to respond to people when needed. Relatives told us they thought the service had enough staff on duty.

● Staff told us there were enough staff on most days, but numbers could reduce at weekends. We discussed this with the registered manager who told us they had implemented systems to try and address this shortfall. Where numbers of staff dropped at a weekend, the service aimed to use agency staff. The registered manager told us they tried to use the same agency staff where possible to provide people with consistent care.

Preventing and controlling infection

● The premises had been inspected in January 2019 by the local authority environmental officer and had been awarded a '5' rating. This meant the service had good or very good hygiene standards.

● The service was clean and smelt fresh. Staff were observed to be following set cleaning schedules to ensure all areas of the service had a thorough clean. Personal protective equipment was supplied, and staff were observed wearing it when appropriate.

● We observed two chairs that were ripped, or the faux leather was peeling off. This meant these items could not be cleaned thoroughly. We raised this with the registered manager who told us they were aware of these items and would look at repairing them or replacing them.

Learning lessons when things go wrong

● Accidents and incidents had been reviewed by the management. Staff were able to reflect on incidents and any improvement needed was discussed.

● The provider planned to introduce an online recording and monitoring system so that they would have better oversight of all accidents and incidents.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life. At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were not always supported by staff that were appropriately trained to carry out their roles. Records kept at the service demonstrated there were gaps in training attended. For example, of the 65 staff employed only 40 had completed Mental Capacity Act training. Some staff had completed the training in 2012 and had received no update. Only four of the care staff had a record of completing pressure area care training. Staff who started at the service in 2018 had not all received first aid or food hygiene training.
- The staff were not supported to attend training set by the provider as mandatory. Training was available face to face or by e-learning. The registered manager had significant issues with supporting staff to complete training by e-learning. There was only one laptop for staff to use and connecting to the online learning was problematic. In addition, releasing staff from their shifts to complete training had proved difficult.
- Not all staff were given the opportunity to have supervision. This is a process where staff have one to one meetings with their line manager and discuss concerns or identify training needs. Records demonstrated five staff had not had a supervision in 2019. We discussed this with the registered manager who told us this was an area they were working to improve.
- We discussed this with the registered and deputy managers who both recognised there were issues with training for staff. They were working with the provider's learning and development manager to address the shortfalls. Following our inspection, we were sent details of staff who were booked on specific training over the coming months.
- Despite the shortfalls in training and supervision opportunity the staff we spoke with told us they felt confident in their roles and supported. We did not observe any impact to people living at Holly Lodge as a direct result of the issues with training.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a

person of their liberty had the appropriate legal authority and were being met.
● People's mental capacity was assessed to make specific decisions and best interest meetings were held where people had been assessed as lacking capacity. Records did not always detail who was involved and what decisions were taken in the best interest process. This meant the service was not able to demonstrate the least restrictive option was the outcome of discussion. We discussed this with the registered manager who told us the provider had introduced new MCA documents which would improve this process.
● The service had applied to the local authority for DoLS authorisations, one had been approved. The service was meeting the conditions of this authorisation. The registered manager kept the local authority updated on the pending applications.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed prior to any service being offered. Staff used nationally recognised assessment tools such as the Malnutrition Universal Screening Tool (MUST) and the National Early Warning Score (NEWS) for ongoing assessments. One healthcare professional told us, "When I arrive the staff will have taken a recent set of observations and completed NEWS scores, so they can identify any deterioration and escalate as indicated."

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they liked the food. Comments from people and relatives included, "I like all the food", "The food is alright, good" and "The food is very nice, I can come every day." People's needs for assistance to help them to eat were recorded in their care plan. Where people needed adapted cutlery and crockery there were pictures provided of what they preferred to use.
● Mealtimes observed were not rushed so people had the time they needed to eat their meals. If people had visitors at mealtimes, they were invited to join people to eat with them.
● Mealtimes were a social occasion with staff sitting down to eat with people and help them by verbal encouragement or assistance. On day one of the inspection we observed everyone was not offered a choice of meal. On day two we observed people were offered a choice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to move between services with support from staff who knew them. For example, one person who had moved to the service in recent months had been supported by staff from their previous home. Staff from Holly Lodge had gone to their previous home to see them. This meant some members of staff were familiar to the person when they moved in.
● Staff had a handover at the start of their shift. This enabled the staff to update each other with any changes to people's needs or events that had happened during shifts.
● People had access to healthcare professionals when needed. The staff worked with local healthcare providers to meet people's health needs. Professionals such as speech and language therapists and occupational therapists were involved in people's care and written detailed guidance for staff to follow. One relative told us, "When [relative] has needed medical attention it has been provided promptly, with hospital admissions when relevant. Referrals to support staff seem good."
● People had a health action plan which recorded their health needs and how these were to be met. There was good guidance for staff to know how to support health conditions such as diabetes and epilepsy. For example, people had epilepsy protocols in place to guide staff on how to support people experiencing a seizure. These were detailed and had been written by healthcare professionals.
● People had hospital passports to document their needs for emergency staff to be aware of if they should go into hospital.
● Relatives we spoke with told us how their family member had improved since living at Holly Lodge. One

relative told us their family member had experienced less falls, another told us about reliance on medicines being reviewed with positive outcomes.

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

● People were living in a home that had been purpose built. The home was built before the Registering the Right Support guidance was published. There were three separate units all joined by one large activity room. Each unit had its own facilities and access to the garden.

● The corridors were wide, and all areas were accessible for people who used wheelchairs. Communal areas were in good repair.

● People had their own rooms which had en-suite bathrooms, some with showers. There were communal bathrooms available with shower facilities and bath facilities with hoist access.

● There was level access to the gardens which were available right around the building. Each lounge area had doors which opened onto the garden area for people to use if they wished.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● At our last inspection in April 2017 whilst the service was rated as Good there were interactions observed that were not positive. We fed them back to the registered manager who told us they would address this with staff. At this inspection we saw some further examples of where people were not treated with dignity and respect.

● People's rights were not fully respected by the staff. On the first day of our inspection we observed a member of staff was supporting a person to eat their meal. They were not familiar with the person and asked other staff for guidance. This conversation took place in a dining room with other people present. Staff discussed this person's needs with regards to eating and drinking. One member of staff was heard to say, "I am fine with feeding [person]." Another person was given their meal without being offered a choice. They told the member of staff they didn't like part of the meal. The member of staff told the person they didn't need to eat what they didn't like, and they would see if there was something else. They didn't return to the person with any alternative. One member of staff asked a person if they were ok. The person said "no". The member of staff did not enquire what was wrong or if there was anything they could do to help. We discussed this with the registered manager who explained that some staff had moved around recently so might not know people as well as others. They told us they liked to move staff periodically to work on all units, so they got to know everyone living at the home. One member of staff told us this made them feel "lost".

● People were not always offered choice in all aspects of their care. On day one of our inspection people were not offered a choice of meals, by the second day options of meals were offered. The registered manager told us everyone had a choice of two meals every day. If they did not like those choices, there was alternatives available. This is not what we observed on day one of our inspection.

● People had a 'choice' form in their records. This was a form staff used to record the choices people had during the day. We saw for some people this was limited to whether they wanted jam on their toast and what clothes they wanted to wear. We were concerned people were not having any other choices. We discussed our concerns with the nominated individual who told us they would look into why this service had a form in use to record choices. This was not a provider document in any other homes they managed. They would expect choices to be offered for everything and be part of daily practice.

● There was only de-caffeinated coffee being served at the service. We asked the registered manager why this was and was told that had always been in place at the service. We were told there was regular coffee available but people were not routinely offered a choice. People should be able to have a choice of what type of drink they would like.

● Routines at the service were not always person-centred. We were not able to see that people's preferred daily routines were always followed by staff. Daily activities were dependent on the staff that were available. Staff told us at weekends this could be an issue so activities did not always happen. One member of staff told us, "It would be nice to go out more." One person was advised to complete daily exercises by their physiotherapist. Records demonstrated that during September they had been supported to do their exercises for five days. During October it was recorded that on two days they had carried out their exercises.
● Some fluid records had times printed on them for when people were to be offered drinks. We asked staff if they followed the times recorded on the charts, they told us they did. This type of record does not encourage staff to work in a person-centred way.
● People had been able to personalise their rooms with decorations and photographs. We saw however, several pieces of equipment in people's en-suite bathrooms which would make it difficult to use them. For example, for one person had a wheelchair in their en-suite which blocked access. We also noted some people had suitcases in their bathrooms which was not an appropriate storage facility.

Failing to provide care in a person-centred way is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● People had reviews of their care with staff, relatives and healthcare professionals. During our inspection we observed one person had a review of their care which they were involved in. One relative told us, "They [staff] do make an effort to involve us in [relative]'s care. Communication generally seems very good and we have no worries with the care." Another relative told us they had not had as much opportunity to be involved in care reviews. They told us they had not been given enough notice to attend.
● The staff team had received many compliments about care provided from relatives and professionals. Overall relatives told us they would recommend Holly Lodge to others.
● We did observe some examples of staffing maintaining people's privacy and dignity. We observed staff taking steps to place screens by one person's door. Staff told us this was because the person wanted to walk to the bathroom in their night clothes. As there was an external workman in the building screens were put up to provide privacy.
● Relatives were able to visit the service without restrictions. During our inspection we observed some relatives visiting people. They were offered refreshments and made to feel welcome. One relative told us, "I can visit whenever I like, staff are always friendly and welcoming."

Ensuring people are well treated and supported; respecting equality and diversity
● People, their relatives and healthcare professionals told us staff were kind and caring. One relative told us, "Our impression has always been that the staff have been very caring." We observed some positive interactions where people were supported by staff who clearly knew them well. People were observed to look comfortable around staff and reaching out for help when needed. One relative told us when they visited they observed interactions with the staff and looked for any signs their relative was not comfortable. They had not seen anything of concern. One relative told us staff were, "Caring, absolutely. Friendly, kind, happy, honest. The team speak to [relative], not through [relative]."
● Information was recorded about people's backgrounds and their likes and dislikes. People had a one-page summary for staff to see at a glance key information such as, 'What people know and like about me'.
● Staff were observed to try different methods to communicate with people. Staff took time to try to communicate by sitting down with people and using touch, gestures and pictures. One person had developed their own sign language which staff used to help communication.
● Staff at the service all talked about how they supported each other and worked as a team. Comments from staff included, "Support staff are fantastic" and "I have felt welcome here."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

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

● People's care and support was not being monitored effectively to ensure it met their needs. At Holly Lodge people had their food and fluid monitored. Staff were not recording meaningful entries to enable staff to monitor food intake. For example, staff recorded that people had eaten 'all' their meal. There was no indication of how much food this was. Where people did not eat their meal, there was no action recorded of what staff had done about this.

● Fluid monitoring was not consistently recorded. Some people had targets recorded of how much they should drink in 24 hours. Some people did not have any targets recorded. This meant staff had no guidelines to know if people were drinking enough fluids. Totals of fluids had not been added up, so staff were not monitoring people's intake. Some people's fluid charts recorded they had not consumed any fluids after 5pm. For one person we saw they had not had fluids after 5pm on one day and none till 10.45am the next day. This was a gap of over 17 hours with no fluids recorded. We asked the registered manager about this who told us people would have been offered and given drinks, but staff had not recorded this action. They believed this to be a recording issue not a staff practice concern. They also said one person was on restricted fluids due to a health need. This information was not available in the person's care plan. We could not be sure the person's care had been planned to meet their needs.

● Some care plans were out of date and contained conflicting information. We saw one care plan had not been updated since September 2018. One person had a 'as required' PRN protocol in place for a medicine they were no longer prescribed. This would be confusing for any agency staff. The registered manager informed us the service was in the process of moving to electronic recording systems. All care plans would be held online and updated during the transfer. The provider hoped to have this all completed by the end of November 2019. The registered manager told us some care plans had not been updated as they were putting efforts into making the transfer as quickly as possible.

● Whilst the service was transferring records to electronic format we saw there was a contingency plan in place, but it was not effective. This was a concern as the service used agency staff who would need up to date guidance. Some people's needs were complex with multiple health conditions, guidance on how to support the person in all areas was needed.

Whilst we found no evidence people had been harmed, the provider had failed to maintain accurate and complete records for people. This placed people at risk of harm which is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had detailed morning and evening personal care routines. This gave staff guidance step by step on how people wanted to be woken in the morning and helped to bed. Daily notes were kept which recorded care and support provided.

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

● People were able to take part in group activities such as art and craft and musical events. The service employed an activity worker who planned and co-ordinated activity provision for people. They told us they liked to theme activities and add in to plans seasonal events. For example, there was going to be a Halloween disco later in October. People told us some of the activities they liked to do. Comments included, "I like to play bingo", "I like cooking cakes" and "I like to do colouring." One person told us they liked to keep their room tidy, another told us they had been out for breakfast as a treat.

● We observed an activity taking place for some people and saw staff engaged with people and supported them to take part. Staff had supported people to go on holiday and to local towns for events such as the theatre and to watch motor sport.

● The service had two vehicles that were used to support people to access their local community. Some staff walked with people into the local village. As there were only two vehicles this could limit the number of times people could go out. Many people used wheelchairs and needed wheelchair supporting vehicles. During our inspection some people went out for a drink in the local village which we were told they liked to do.

● People had a 'sensory room' they could use which had different colour lights and music. For people who preferred a sensory experience this was available to them at any time.

Improving care quality in response to complaints or concerns

● The service had a complaints policy which was available to people. We saw the policy informed people to refer their complaint to CQC if they were not satisfied with the provider investigation. This is incorrect information as CQC do not investigate individual complaints. The nominated individual told us this policy was going to be reviewed shortly and would be changed to give people the right information.

● The policy had been produced in a pictorial and easy read format to help people understand the process. One person told us if they needed to complain they would, "Tell my key worker, I always talk to her."

● Complaints had been recorded and investigated by the registered manager and the provider. Records were kept with any follow up action. We checked if the service had followed up on actions they told us they were going to take in response to one complaint, and found they had.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were recorded in their care plans and details for staff to know how to communicate with people. Staff used different formats to communicate with people including using pictorial information.

End of life care and support

● During our inspection there was nobody assessed as being at the end of their life. Staff had provided this type of care in the past and worked with local healthcare professionals to make sure people were comfortable.

● People had information recorded in their care plans about what they wanted at the end of their life and where they wanted to be cared for. We noted that one person had their will in their care plan. We asked the registered manager to store this document in a more appropriate place.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● Quality monitoring systems were in place with a number of audits being completed by staff. Some medicines audits had identified the issues we had found but not all. There was no evidence of action taken where improvements were identified. The management team did not generate action plans when improvement had been identified to monitor the actions completed or ongoing. For example, a health and safety check had identified one person's bed had been overdue for a service. This had been reported in July 2019. There was no action recorded to confirm the required servicing had taken place. The deputy manager told us staff reported concerns to her and she took the necessary action. She told us the required action for the bed would have been carried out but recognised she did not have time to go back and record action taken.

● Some staff had used sticky notes in care plans to highlight what needed updating. This was a concern as sticky notes can get lost. We saw a sticky note in one person's file about them being trapped in a bed rail. The note recommended the person's care plan be updated. There was no date of recording or indication of who had recorded this note. We were unable to determine if the required action had been taken so we asked the registered manager to address this. This is not a robust system of identifying improvement or ensuring people were protected from potential harm. The registered manager and nominated individual told us they were planning to introduce an online system which would capture audits, required improvement and actions needed. It would also record when actions were closed which would give the service and provider a better oversight of service development.

Whilst we found no evidence people had been harmed, the provider had failed to assess, monitor and improve the quality and safety of the service. They had also failed to assess, monitor and mitigate the risks to people at Holly Lodge. This placed people at risk of harm which is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection we identified two historic safeguarding incidents that had not been notified to us. The incidents had been dealt with appropriately with the local authority safeguarding team, but we had not been informed. Services are required by law to notify CQC of specific incidents or events that affect the service. The registered manager completed notifications for these incidents immediately.

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

● Holly Lodge had a registered manager in post who was an experienced nurse. Staff were complimentary about the management at the service, they felt able to approach management and felt supported. Comments from staff included, "Couldn't wish for better managers" and "Managers are quietly motivating, they have been good to me." One relative told us, "[Registered manager] is so approachable, natural, professional, available and hands on."
● The registered manager was supported by the provider with regular visits from the nominated individual and trustees. They were also able to meet with other managers in the organisation and share best practice and concerns.
● The management at the service were open and transparent with the inspector. They told us they had struggled with working as a nurse in the service at times and carrying out their management work. They also told us transferring to electronic recording was a challenge for them, but they were positive about the benefits the new system would introduce.
● Staff we spoke with enjoyed their jobs and liked working at Holly Lodge. Comments included, "This is a good place to work", "I enjoy seeing people they get to see friends when they are with me" and "Morale is very good, there is good teamwork."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and registered manager understood their legal responsibility to be open and transparent with people and their relatives when any incident or accident occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff were able to attend team meetings and there were "house meetings" for people to attend and share their views.
● The provider used surveys to gather views from people and relatives. Surveys had been sent out prior to our inspection so results had not all been gathered. The registered manager told us the provider would collate the results and share them.
● The provider rewarded staff with a 'thumbs up' reward. The deputy manager told us this was a reward to say thank you to staff who had stepped up and helped out. For example, a previous winner had helped with some cooking when the service needed help. Staff received a certificate and a trophy. The registered manager told us they also thanked staff regularly and bought cakes and sweets as a token of their appreciation.

Working in partnership with others
● Staff worked in partnership with a range of health and social care professionals. People's records demonstrated that various professionals were involved in supporting people. One healthcare professional told us, "I have a great deal of confidence in [staff] assessment of situations – usually if Holly Lodge ask for a visit we know the resident is poorly."
● The service had worked with the medicines optimisation in care homes team (MOCH) to improve medicines management. One visit had been completed and the MOCH team were booked for later in October to return.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people consistently received person-centred care. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always have all of their medicines managed safely. Risks had not always been identified and assessed with management plans in place to keep people safe. Regulation 12 (1) (2) (a) (b) (e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems were not effective. The provider failed to assess, monitor and mitigate risks to people and maintain accurate and complete records in respect of each person. Regulation 17 (1) (2) (a) (b) (c)