

Shawlmist Limited

The Hollies

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 

Summary of findings

Overall summary

About the service

The Hollies is a residential care home providing personal care to up to 27 people. At the time of our inspection there were 21 older people using the service, some of whom were living with dementia.

The Hollies care home had three floors. The ground floor was made up of the kitchen, dining room, living room, shower room and people's individual bedrooms. The second and third floor had bedrooms.

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

People were not safe because risks were not identified and managed in an effective and timely manner. This included issues in relation to the environment that presented a risk of people tripping and high-risk shortfalls in fire safety planning and equipment. Medicines were not managed safely and guidance to people at risk of choking was not always followed. People were not protected from the risk of infection because the standard of cleanliness and repair to the premises was inadequate.

There were not enough skilled and knowledgeable staff to care for people. Staff practice in relation to following guidance from health professionals, moving and handling people, recognising and acting on concerns about avoidable harm was poor. Some people told us they did not feel safe at the service due to physical aggression from other people using the service. Guidance was insufficient on how staff should support and maintain the safety and wellbeing of all parties concerned.

Care was task led and people's choices were limited. For example, there was a set rota for showering and each person had a set day for a weekly shower. This was, in part, due to the lack of bathing facilities on the premises. There was only one shower to meet the needs of all the people living at the service. The registered manager confirmed that two additional bathrooms were not, and had never been, in use.

Staff were kind but did not have time to chat to people. People told us they were bored and did not have enough to do. We saw that some people sat all day with no stimulation or interaction from staff beyond tasks such as offering a cup of tea or personal care. Although some activities were provided on three mornings each week, these had not been developed in line with people's interests. People told us they never went out other than into the garden during the summer.

People were not 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 provider and the registered manager did not have sufficient oversight of the service and had not identified the concerns we found during the inspection. Despite some issues being identified at previous inspections, and by other professionals including the fire service, they had failed to take timely action to make improvements to ensure people received care that was safe, person-centred and of a high quality.

People and relatives told us that staff and the registered manager were nice and approachable. Relatives told us the registered manager kept them informed of issues related to their family member's care.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 06 February 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about medicines management, infection control, and staffing. The inspection was also prompted by notification of a specific incident following which a person using the service sustained a serious injury. The information CQC received about the incident indicated concerns about the management of trip hazards and repairs to the premises. This inspection examined those risks.

We undertook a focused inspection to follow up on the specific concerns which we had received about the service. We also found there were concerns with staff training, consent, choice and control, a lack of dignity, person centred care and engagement. We widened the scope of the inspection to become a five key question inspection which included the key questions of safe, effective, caring, responsive and well-led.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to keeping people safe from avoidable harm and unsafe care, staff training and knowledge, infection control, maintenance and cleanliness, consent to care, people's experience of their care and how the service was managed.

Following this inspection we took enforcement action to cancel the registration of both the provider and the registered manager.

Follow up

The provider and the manager are no longer registered to provide this service.

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.

For details see our Safe findings below.

Inadequate ●

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not responsive

Details are in our responsive findings below

Inadequate ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

The Hollies

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

This inspection was carried out by three 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 care service.

Service and service type

The Hollies is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Hollies is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 05 April 2022 and ended on 19 April 2022. We visited the service on 05, 12 and 19 April 2022. In between 05 and 19 April 2022 we spoke with relatives of people living at the Hollies by telephone and reviewed documentation sent to us by the registered manager.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We observed how the staff interacted with the people who used the service and looked at how people were supported throughout the day. 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. We spoke with seven people, the registered manager, the clinical lead, the deputy manager, three care staff, and three visiting professionals. We spoke with 10 relatives of people using the service by telephone.

We looked at care and support records for eight people and medicine records for 10 people. We viewed records relating to the management of the service. These included quality audits, incident and accident records, training records and policies.

Is the service safe?

Our findings

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

At our last inspection we rated this key question as requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement was made and the provider was still in breach of Regulation 12 (Safe Care and treatment).

Using Medicines Safely

- Controlled drugs were not recorded accurately, and records did not reflect the stock held at the service. There was a gap in the medicine administration chart for one person who was prescribed a controlled drug. Due to this, as well as the inconsistency in records and stock, we could not be assured that the person had received their medicine as prescribed.
- We did not see any evidence that staff who administered medicines had undergone appropriate training and competency assessments were not routinely carried out. Recent concerns identified by a visiting healthcare professional in relation to the unauthorised covert administration of medicines indicated that, where staff had been trained, it was not effective.
- There was evidence from medicines audits that staff had been encouraged to retrospectively sign that they had administered medicines when they had forgotten to sign at the time. There was a risk that this would lead to medicines being signed for that had not been administered.
- Care plans for one person did not have information in relation to a high-risk medicine prescribed to them. This meant staff did not have guidance to know the appropriate action to take in the event of side effects.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Information in care plans and risk assessments was not consistent and staff were not clear about which guidance to follow. The records for two people at risk of choking had inconsistent information about what consistency of food and fluid they required. At lunch time staff provided one of these people with sausage and mash when the current guidance indicated they required a pureed diet. This placed the person at risk of harm by choking.
- Some known risks had not been assessed. For example, one person who had a specific medical condition did not have a care plan or risk assessment in place to guide staff about how to meet their needs and mitigate any risk of them becoming unwell.
- Fire risk assessments for people did not contain adequate detail on how to evacuate people safely and, identified that people's fire doors were in need of repair. No action was taken to address this or how people were to be kept safe before this work was completed. Staff we spoke with did not have a consistent understanding of emergency evacuation procedures. Fire evacuation practises had not been carried out to

ensure all people could be safely supported in the event of a fire. Faults in relation to fire doors and fire safety identified in a fire safety enforcement notice in September 2021 had still not been addressed at the time of the inspection. This placed people at serious risk of harm in the event of a fire.

- There was an incident in March 2022 when a person tripped on damaged flooring which resulted in serious injury. The damage to the flooring had been identified over two weeks before the incident but action had not been completed to address the risk. At the time of the last day of the inspection action to address trip hazards throughout the ground floor was only partly completed, leaving people at continued risk of harm.
- There was no evidence to show how incidents, accidents or near misses were used to encourage staff to reflect or learn and improve practice or to put measures in place to keep people safe.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks related to fire safety measures and trip hazards were also a breach of Regulation 15 (Equipment and Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Following the inspection the registered manager informed us that they had put a system in place to enable them to analyse incident, accidents, falls and near misses to identify trends and patterns and to improve the care provided to people as a result.
- The registered manager told us a review of all care plans and risk assessments was to be carried out. Following the inspection, they provided evidence they had reviewed the care plans relating to choking risks for two people.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The standard of cleanliness within the home was poor. One person said, "The place is filthy." Cleaning schedules and audits were ineffective and did not pick up the issues identified at the inspection. This included ingrained dirt on floors and door thresholds, in grouting around toilets and the shower area, dirty commode bowls left in people's rooms. Extensive damage to paintwork and plaster created an infection control risk particularly throughout the ground floor of the building. There was no evidence of enhanced cleaning in frequent traffic areas to reduce the risks associated with COVID-19.
- We were not assured that the provider was preventing visitors from catching and spreading infections. Staff failed to ask for proof of a negative lateral flow test on the first two days of the inspection. On the first day, the registered manager later asked us to provide this after staff had already given us entry to the home.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The registered manager was unable to confirm whether risk assessments in relation to COVID-19 had been completed for staff or people. They later provided evidence of risk assessments for people, but only those who had tested positive for the virus.
- We were not assured that the provider's infection prevention and control policy was up to date. The provider's infection control policy had not been updated to specifically cover how the risks related to COVID-19 would be controlled and prevented.

The provider had failed to assess, prevent and control risks associated with infection. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were somewhat assured that the provider was using PPE effectively and safely. We received feedback from visiting professionals that staff were not wearing personal protective equipment correctly. During the inspection we observed staff were now doing this.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.

Visiting in care homes

- People and their relatives did not report any concerns about the visiting arrangements in place at the home.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes to safeguard people from abuse such as policies, risk assessments and guidelines were not effective. Staff did not always understand them, and the registered manager did not monitor them to ensure people were protected from the risk of harm.
- Some people using the service told us they did not feel safe living at the Hollies due to the behaviour of other people they lived with. There was no evidence of monitoring or analysis of these incidents to help staff support all those involved well.
- While staff had received training in abuse awareness and safeguarding, not all staff understood what signs to look for that abuse may be occurring, or how to report concerns outside of the organisation. Staff did not recognise physical confrontations between people who used the service as potential safeguarding concerns. They failed to record and report these appropriately both within the home and to external bodies.

People were not protected from the risk of avoidable harm. This was a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment

- Staff were not deployed effectively to ensure adequate staff presence in areas where most people sat in the home. Staff did not have time to chat with people beyond tasks and at lunch time there were not enough staff to adequately support people to eat and drink. This meant some people did not get the support they required to eat their meal.
- The clinical lead was covering for the chef on the second day of the inspection and additional staff were not put on to cover them during this time. This meant there were fewer staff available to safely support the needs of people.

The provider had not ensured there were enough staff deployed throughout the home to ensure people's needs were met safely. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We noted that call bells were answered quickly during the day. Although people had to wait to tell staff that they needed support, once staff were aware, we saw they did their best to meet the person's needs as quickly as possible.
- The provider had a recruitment selection process that included all required pre-employment checks, such as references and a Disclosure and Barring Service (DBS) check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff training was not effective. Staff knowledge in relation to safeguarding, the Mental Capacity Act (MCA) and the Deprivation of Liberties Safeguards (DoLS), moving and handling, fire safety, positive behaviour support and safe administration of medicines was poor. For example, on the second day of the inspection an inspector and a visiting professional witnessed staff carrying out unsafe moving and handling techniques on three occasions. Staff did not have good knowledge of current guidance in place in relation to people's care.
- Senior staff with the responsibility for writing, reviewing and updating care plans and risk assessments told us they were not confident to do this. They were providing training to staff in relation to medicines but told us they felt they required further training in this area themselves.

People were not supported by staff who had the skills and knowledge to provide effective care. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us, and records confirmed, they had an induction when they started their employment at The Hollies. They also confirmed they had regular supervision. Staff told us they felt supported by the registered manager and senior staff.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, 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, whether appropriate legal

authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff including the registered manager did not have good knowledge or understanding of MCA and DoLS. They did not complete thorough and decision specific capacity assessments or provide evidence that an appropriate process was followed when best interest decisions had been made on people's behalf when they lacked capacity.
- The registered manager confirmed they had not chased up DoLS applications with the supervisory body to check on progress. Some people's care plans identified they had an active DoLS authorisation in place when this was not the case. The DoLS authorisation for one person had expired and no further application had been made.
- There was a lack of clarity regarding some people's capacity to make certain decisions because information was inconsistent. For example, one person's care plan indicated they had full capacity, but also that a DoLS had been applied for. The registered manager was unsure about the process to follow if a person's capacity was not clear, and the difference between a lack of capacity and a person with capacity making unwise choices. This put people at risk of being unlawfully restricted.
- Where a third party was acting as the power of attorney for a person, the registered manager had not obtained copies of the documentation to show that this was officially authorised.
- One person's care plan stated they had not made an advanced decision to refuse treatment, but then stated they had made a decision in relation to resuscitation on 19 March 2019, but not what this decision was. This left them at risk of not receiving a correct response in the event of a medical emergency.

People were at risk of being unlawfully restricted or of receiving care that they had not consented to. Where decisions were made on people's behalf there was a risk this was not done in their best interests. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

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

- The flooring on the ground and second floors were damaged and dirty, creating trip hazards in several areas. This put people at risk of injury. Although one person had sustained a serious injury after tripping on the damaged flooring, action to fully address the risk was not taken.
- The provider had not considered the suitability of the premises in relation to people's needs when admitting them to the home. The premises are located on a steep hill with steps at the front and a very steep slope leading from the back of the house to the road. This presented a risk both to people with mobility needs and staff, and limited people's ability to leave the building safely, especially in the event of an emergency. One member of staff explained how they took people down the slope backwards in their wheelchairs. This put both the staff member and the person at risk of injury.
- Although the service had two bathrooms and one small wet room, the registered manager confirmed the two bathrooms were never in use. This meant there was only one shower available to meet the needs of 21 people. This restricted people's choice over how to have their personal care needs met and also how often they were able to take a shower.
- People told us, and we saw the premises were in a state of disrepair. As well as the damaged flooring, and fire doors that were in disrepair, paintwork was damaged in multiple areas exposing plaster and wood. This created an infection control risk as well as impacting the appearance of the service. The corridors and turning spaces were tight for people using wheelchairs or mobility aids which contributed to the damage. Repairs were not carried out frequently enough to prevent the service from looking in need of redecoration.

The poor maintenance, lack of facilities and safety risks associated with the premises were a breach of

Regulation 15 (Equipment and Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- On 12 April, we arrived at the service at 7.30 am. One person was already up and dressed, and at 8.41am said they were hungry, but they did not have food until 9.03am. The person had been waiting a long time for their first meal of the day and due to a medical condition this may have put them at risk of becoming unwell.
- One person was assessed to be at low risk in relation to nutrition, but their care plan then stated they should be on a fortified diet. The plan then referred to the person needing support to eat smaller portions. This put the person at risk of receiving a diet that was not suitable to their needs.
- Some people who were struggling to eat their meal did not receive support leaving them to manage alone. This meant that, although they managed to eat their food, it would have been cold and unappetising due to the length of time it took them to eat.
- At mealtimes food arrived in the dining room and lounge before staff were ready to serve it. This meant that, by the time people were eating it, it was cold, this could impact have a negative impact on people's nutrition.
- The choice at breakfast was restricted to cereal or toast. Staff did provide eggs for one person, but could not remember who they were for, so decided between them who to give them to. One person requested a yogurt, which was followed by others also asking for this. Staff went back to the kitchen to look for yogurt but were unable to provide one for everyone who wanted one. This showed that people's choices were limited because options were only offered if people requested them, rather than being made readily available.

Poor support with nutrition and diet is a breach of Regulation 14 (Meeting nutrition and hydration needs) of the Health and Social Care Act Regulations 2008 (Regulated Activities) Regulations 2014.

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

- Feedback from other professionals varied and some did not feel that staff always acted on advice they provided. We found staff were not always aware of or following the most recent advice provided by external healthcare professionals. This put people at risk of receiving ineffective and unsafe care.
- There was evidence of referrals being made to health care professionals as necessary, such as district nurse teams, SALT and GPs. The GP visited the home on a weekly basis to ensure people received medical care as necessary.

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

- The service used a computerised system for their care documentation. The system generated a template for each section of the care plan based on staff responses to a set of assessment questions. Staff could then adapt the record to reflect the specific needs of the individual. Therefore, much of the language used in care plans was identical from one to the other. Staff had not always used information from assessments of need to personalise the care plans, and on examination we found many examples of gaps or inaccuracies in essential information, and care plans that were, essentially, a blank template.

Following the inspection the provider informed us that all care plans would be reviewed and updated by 18 June 2022

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- The lack of maintenance and cleanliness of the environment did not demonstrate a caring or respectful approach to care. As well as the general state of repair and lack of washing facilities, small, easily fixed issues were not addressed. For example, not replacing light bulbs and damaged furniture, colouring in pictures stuck to the walls with tape and poor levels of cleanliness throughout the home. This was not respectful and did not demonstrate that the people using the service were highly valued. One person said, "It's in a state... it's dirty, falling apart." and "They don't seem too caring about us."
- People did not always receive dignified care. There was a lack of recognition that some people required support to eat their meal leaving them to struggle and spill a lot of food. These people were treated as a source of entertainment by other people who were watching them. This was not addressed and was undignified for the people concerned.
- The mealtime experience was functional, and no attempt was made to set tables nicely or to offer condiments to encourage an enjoyable part of the day. At mealtimes people were left with sticky hands and faces. No napkins were provided so they had to wait for assistance until after their meal. This did not uphold people's dignity.
- A visiting professional carried out checks in full view of others in the lounge. Other people watched on and commented. At no time did staff offer to support people to a private space to have these checks completed. This was undignified and did not uphold people's privacy.

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

- People did not always feel they were able to make decisions about their care. For example, they did not think they had a choice about when to shower. They also said they did not feel able to ask for additional snacks or different meals and drinks than those offered. One person said, "You get that feeling you can't ask for a cup of tea. You have to wait for the trolley."

People did not receive care that was consistently dignified or respectful and that maintained their privacy. This was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw that staff were pleasant and showed kindness to people although there was a lack of interaction beyond task-based engagement.
- People gave us mixed feedback about how much staff spoke with them and said it was dependent on

which staff were on shift. One person said, "Sometimes they will talk to me. (Staff member's name) talks to me". However, everyone we spoke with said the staff and the registered manager were kind.

- Relatives said that they found staff kind and the registered manager approachable.
- Relatives told us they had been involved in making decisions about their family member's care. They confirmed that the manager spoke to them about any changes that were necessary.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- The care provided was task led. For example, there was a weekly rota for showers and people had one shower a week. People told us they did not think they could ask for more frequent showers or for their turn to be on a different day. The limited facilities made the practicalities of more frequent showers challenging.
- There was a lack of choice at mealtimes, and people told us they did not feel they could ask for alternatives. For example, one person said they would prefer a cup of tea with their lunch but were only presented with a choice of two fruit squash drinks. Another person said they had the sausages at lunch time but only because the other option was soup which they did not feel was enough for their main meal of the day. A wall hanging in the lounge and another in the dining room stated that the menu choice for the day was 'take it or leave it'. Although intended to be light-hearted, it may have led to people feeling they could not ask for anything different.
- The people who lived at the Hollies had very varied needs, and conflict arose between them as a result of this. It was not being managed well, which resulted in a reduced quality of experience for all. There was a lack of understanding from the registered manager about how people's life experiences might affect their present day reactions to others.

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

- People did not always feel they were able to make decisions about their care. For example, they did not think they had a choice about when to shower. They also said they did not feel able to ask for additional snacks or different meals and drinks than those offered. One person said, "You get that feeling you can't ask for a cup of tea. You have to wait for the trolley."
- Action to address issues relating to people's needs was slow. For example, one person had dental problems which increased the risk of them choking. The issue was first identified in 2017. The registered manager said the person refused this support. However, records showed that the person changed their mind and requested dental treatment in June 2021. An appointment was not made until April 2022. There was no documented evidence of attempts to make an appointment before this time.
- We carried out observations throughout the inspection. Some people sat all day in the same position and staff did not attempt to engage with them in any way beyond tasks such as drinks and meals.
- Staff would not always check with people before acting. For example, when switching lights on or off.

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 we spoke with said they were bored. One person said they would like to go out but there are never any staff who can take them. Another person said they watch tv, play cards, but not with staff and that they

never go out of the building except into the garden in the summer. Some relatives also told us their relative did not have enough to do and did not have an interest in the activities that were on offer.

- There was an activities coordinator who worked three mornings a week. The timetable of activities showed a range of activities such as craft, cooking, 'rainbow table' games. There was no evidence provided to show how people's social interests, hobbies or preferences had been considered when developing this programme.

End of life care and support

- The care planning system had a section related to end of life planning. Although these had been completed for some people, for others the generic template did not contain any personalised information to enable staff to know how the person wished to be supported at this time in their life.
- Some information recorded about people's end of life care was not consistent with the information in other parts of the care plan.

Meeting people's communication needs

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

- Some attempts had been made to present information in accessible formats within the home, such as providing pictorial menus and large print calendars on the walls of the dining room and lounge. However, on both days of the inspection the menu choice showing was not the one for that day, and the calendars were showing the wrong date.
- It was positive that one member of staff was able to speak the same language as one person who lived at the home. However, the opportunity had been missed for other staff to learn key phrases that may support them to communicate with the person more effectively.

People did not receive person-centred care due to the lack of consistent, thorough care planning and the task led approach to care. People did not have sufficient stimulation or engagement which put them at risk of isolation and poor mental wellbeing. This was a breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

- The provider had a system in place to log and monitor complaints made about the service.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last two inspections there was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the provider and registered manager oversight of the service. At this inspection we found that no improvement had been made and the provider is still in breach of this regulation.

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

- Urgent action required to keep people living at the service safe, such as repairs to flooring and fire doors was not addressed in a timely way.
- The registered manager and senior team did not have good understanding of the requirements of their roles. The senior team were still new and learning their roles, and for one of them, their job description was still under development. Staff tasked with reviewing and updating care plans told us they did not feel confident about doing this.
- Quality assurance systems were not effective and had not identified the concerns raised during this inspection such as in relation to care safety, consent, the premises, cleanliness of the building and person-centred care. Where other staff had completed these audits, the registered manager had not checked whether they had been done properly.
- The provider did not complete any formal quality monitoring and did not have sufficient oversight of the service or how it was being managed.
- The registered manager did not have good oversight of the care provided to people. They were unaware of poor practices in the home and of discrepancies in care documentation. They had not observed practice regularly to ensure staff training had been effective and that staff had retained their knowledge.
- There was no system in place to monitor incidents, accidents or falls to identify themes and patterns and to identify appropriate action to mitigate the risk. They had not ensured that information across care plans and risk assessments was consistent to ensure the correct guidance was available to staff.
- Where physical altercations took place between people using the service, these were not reported consistently both within the service and to external bodies such as the local authority safeguarding team and the care quality commission. The registered manager demonstrated a lack of insight into how to support all parties concerned in relation to these incidents
- Staff had limited access to the computer which meant they had to wait to enter information and it was clear that some records were not completed as a result. The registered manager did not have good oversight of this and did not pick up issues we identified.

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

- Although care plans contained some personalised information to encourage person centred care, the care provided to people was task-led. Choices for people in relation to meals, meaningful activity and personal care were restricted. Staff were too busy to be able to spend time with people beyond care tasks.
- The provider had not ensured that people were living in an environment that was pleasant, dignified or maintained to a safe and acceptable standard. The suitability of the premises in relation to people's needs, including the lack of facilities did not support the development of a person -centred culture and did not demonstrate that the people using the service were valued and important.

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

- The provider had carried out satisfaction surveys with people and relatives. However, no analysis of the responses received was completed and there was no evidence of how people's feedback was used to make improvements to the service.
- Although relatives meetings used to be held, the registered manager said these had not been well attended and therefore they were no longer in place. They did communicate with families individually in relation to issues about their relative living at the service. Residents meetings did not take place.
- The registered manager had not taken steps to identify effective ways to engage with all people using the service. They had stopped producing a newsletter and felt that many people using the service would not be able to make use of it. They had not considered how they might present information differently to enable more people to enjoy it.

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; Working in partnership with others

- We were not confident that the registered manager worked in an open and transparent way. In response to issues we raised with them, the registered manager minimised the extent of issues which we later found out were significantly more serious. For example, in relation to medicines management and fire safety issues.
- During and after the inspection, we have received feedback from external health and social care professionals raising concern about the willingness of the registered manager to engage, to respond to requests for information and in some instances, give them access to the home. This meant that people could not be assured that professionals involved in their care were able to work together to ensure well-coordinated good quality care.

The lack of management and provider oversight placed people at risk of harm and poor quality, ineffective care that did not respect them or meet their individual needs. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us they were kept informed of incidents that took place in relation to their family member.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving personalised care

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care to people was not always provided in a dignified way

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring that people were cared for in the least restrictive way possible. Capacity assessments, DoLS and best interest processes were not carried out effectively.

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care.

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

improper treatment

People were not protected from the risk of avoidable harm

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not protected from risks associated with eating and drinking

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment were not maintained to an acceptable standard and the premises did not meet people's needs

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of management and provider oversight and a lack of timely action taken to address risks when they had been identified.

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably skilled staff to meet people's needs safely or effectively

The enforcement action we took:

We took action to cancel the registration for both the provider and the registered manager.