Techcrown Limited

Hollywynd Rest Home

Inspection report

5-9 St Botolphs Road
Worthing
West Sussex
BN11 4JN

Tel: 01903210681

Date of inspection visit:
25 April 2017

Date of publication:
18 May 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 25 April 2017 and was unannounced.

Hollywynd Rest Home is a residential care home, which provides accommodation for up to 40 older people. At the time of our inspection there were 27 people living at the home. Nursing Care is not provided. Hollywynd Rest Home is a large, detached, older style property situated close to the town centre of Worthing. Communal areas included a large sitting room, open planned dining room with another sitting area and a conservatory which looked out on the garden. There was a sitting area on the ground floor corridor to allow people to sit and rest when needed. The home provides accommodation over two floors with a passenger lift and stair lift available to access all floors.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Both the registered manager and provider were available on the day of our inspection.

The last inspection took place on 22 and 23 December 2015. As a result of this inspection, we found systems were in place but not consistently used to identify risks. Guidance for staff on how to reduce risk was, at times, limited. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that care plans were being updated at the time of that inspection; however this was a work in progress and not all people had a care plan which reflected their needs. We also found that activities were available however; these were not scheduled in a way that ensured people's social needs were always met. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the last inspection, the provider wrote to us with their action plan to confirm that they had addressed these issues. At this visit, we found that the actions had been completed and the provider has now met all the legal requirements.

At this inspection, people described staff as kind and caring. People told us they felt they were treated with respect and dignity. Most observations reflected this. However, we observed examples where staff were not always caring, respectful or people's dignity and this was not consistently maintained. This is an area requiring improvement.

Systems were in place to identify risks and protect people from harm. Care records contained guidance and information to staff on how to support people safely and mitigate risks. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. Accidents and incidents were accurately recorded and were assessed to identify patterns and trends. Records were detailed and referred to actions taken following accidents and incidents.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People told us they felt safe at the home. Policies and procedures were in place and medicines were managed, stored, given to people as prescribed and disposed of safely.

There were sufficient staff in place to meet people's needs. The registered manager used a dependency tool to assess that staffing levels were based on people's needs. These were up to date and reviewed monthly. Robust recruitment practices ensured that new staff were vetted appropriately and checks were undertaken to confirm they were safe to work in a caring profession.

Staff received an induction into the service and senior staff checked competencies in a range of areas. Staff had received a range of training and many had achieved or were working towards a National Vocational Qualification (NVQ) or more recently Health and Social Care Diplomas (HSCD). Staff received formal supervision and annual appraisals from their managers.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff had received MCA training and our observations confirmed staff promoted choice and acted in accordance with people's wishes. However, not all staff demonstrated a clear knowledge of the MCA and DoLS in our discussions with them. We fed back to the registered manager at the time of our visit. During the inspection, the registered manager took sufficient action to ensure all staff understood the rights of people living at the home. Throughout our inspection, we saw that people who used the service were able to express their views and make decisions about their care and support. We observed staff seeking consent to help people with their needs.

People had sufficient to eat and drink and were offered a choice throughout the day. They had access to a range of healthcare professionals and services. People's rooms were decorated in line with their personal preferences.

People were involved in planning and reviewing their care as much as they could, for example in deciding smaller choices such as what drink they would like or what clothes to choose. Where people had short term memory loss staff were patient in repeating choices each time and explaining what was going on and listening to people's stories. Staff had good knowledge of people, including their needs and preferences. Care plans were individualised and comprehensive ensuring staff had up to date information in order to meet people's individual needs effectively.

People's privacy was respected. Staff ensured people kept in touch with family and friends. People were able to see their visitors in communal areas or in private. The service placed a strong emphasis on meeting people's emotional well-being through the provision of meaningful social activities and opportunities. People were offered a wide range of individual activities, which met their needs and preferences.

The registered manager told us complaints would be listened to and managed in line with the provider's policy. In the past 12 months, there had been no formal complaints. People said that they would be confident to make a complaint or raise any concerns if they needed to.

People and their relatives were involved in developing the service through meetings. People and their relatives were asked for their feedback in annual surveys. Staff felt the registered managers were very supportive and said there was an open door policy. Quality assurance systems were in place to regularly review and improve the quality of the service that was provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had detailed care plans, which included an assessment of risk. These were subject to a regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Medicines were managed in accordance with best-practice guidelines.

Is the service effective?

Good

The service was effective.

Staff had received Mental Capacity Act (MCA) training and our observations confirmed staff promoted choice and acted in accordance with people's wishes. However, not all staff demonstrated a clear knowledge of the MCA or with the Deprivation of Liberty Safeguards (DoLS) from our discussions with them. We fed this back to the registered manager who arranged support and further guidance for staff.

Staff were trained in a range of topics, which were relevant to the specific needs of the people living at the home.

People were supported to maintain good health and had regular contact with health care professionals.

People were provided with a balanced diet and had ready access to food and drinks.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff showed a caring and sensitive attitude towards people. However, there were times when we observed examples of staff not always caring and respectful.

People were actively involved in making decisions about their care. People spoke highly of the staff.

People and/or their representatives were confident their wishes related to end of life care would be followed.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support, which was responsive to their changing needs and met people's social, and leisure needs in an individualised way.

People made choices about aspects of their day to day lives. People and/or their representatives were involved in planning and reviewing their care.

People knew how to raise any concerns and told us that they would feel confident to do so.

Is the service well-led?

Good

The service was well led.

There was an honest and open culture within the stable staff team who felt well supported.

People benefitted from a well organised home with clear lines of accountability and responsibility within the management team.

Staff told us that the registered manager was approachable and that they were encouraged to discuss any issues or concerns.

There were effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

Hollywynd Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 April 2017 and was unannounced. Two inspectors undertook the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events, which the provider is required to send to us by law. We used all this information to decide which areas to focus on during the inspection.

On the day of our inspection, we met with nine people living at the service. Due to the nature of people's needs, we were not able to ask everyone direct questions. We did however, observe people as they engaged with their day-to-day tasks and activities. We looked around the premises at the communal areas of the home, activity areas and three people's bedrooms.

We spoke with the provider, registered manager, administrator, activity co-ordinator, one senior care staff, three care staff and the activity coordinator. We looked at the care plans and associated records for six people. We reviewed other records, including the registered manager's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for six staff were reviewed, which included checks on newly appointed staff and staff supervision records.

This service was last inspected on 22 and 23 December 2015 when two breaches of Regulation were identified.

Good

Is the service safe?

Our findings

At the last inspection in December 2015, we found systems were in place but not consistently used to identify risks. Guidance for staff on how to reduce risk was, at times, limited. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards.

People's risks were identified, assessed and managed safely. Risk assessments relating to people's mental health, physical health, personal health, moving and handling, behaviour, skin integrity, nutrition and falls had been completed and were stored within people's care plans. Risks were assessed as high, medium or low. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. We looked at risk assessments for six people and these contained advice and guidance for staff on how to manage and mitigate potential risks to people. For example, where people were at risk of developing pressure ulcers they had been assessed using Waterlow, a tool specifically designed for this purpose. People assessed at risk had pressure relieving equipment being used to maintain their skin integrity; staff ensured cushions were moved with the person when they moved.

Our observations on the day confirmed staff were mindful of people's rights to take risks. Staff encouraged and supported people to maintain their independence. Care staff ensured they prompted people to dress themselves and assisted with ensuring people dressed in the correct order. People were wearing appropriate clothes for the weather. Staff were visible around the home and quickly noticed if anyone was trying to mobilise on their own without waiting for help if they needed assistance. The people we spoke with did not feel there were any restrictions placed on their actions or movements. One person said, "I do what I want here, really. No-one tries to tell me what I can and can't do". Another person told us, "I don't think about it really. I just come and go as I would in my own home. I can't really go out of the home much but that's only because I can't walk far. They have taken me out though". Accidents and incidents were also logged and risk assessments reviewed and updated if needed. Senior staff reviewed people's risk assessments on a monthly basis to ensure they were in line with their current needs.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. These checks included the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff, in how to support people to evacuate the premises in an emergency.

People were protected from avoidable harm by staff that had been trained to recognise the signs of potential abuse. We spoke with nine people who also told us they felt well cared for and safe. People told us they felt safe. One person told us, "I do feel safe here. I know my family do too. They were concerned about me being at home on my own. It's much better here". Another person said, "I am safe. It's not like being in your own home but there's always someone around if I need them". We asked staff about their understanding of safeguarding and what action they would take if they suspected abuse was taking place.

Without exception, all the staff we spoke with told us they would report any concerns they had to the registered manager. The provider's policy relating to safeguarding procedures was kept in the office and the staff told us they would also check with this policy to ensure that appropriate action was taken. One staff member told us, "I would always report it [abuse] to the manager". Another staff member said, "I have had training since I've been here and I do feel confident, I'd know what to do if I needed to".

Staffing numbers were determined by using a dependency tool, which looked at people's level of need in areas such as mobility, nutrition and maintaining continence, although these remained flexible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. We saw that people received care and support in a timely manner. Care plans detailed whether people could use their call bells effectively and monitored people accordingly. Staff were attentive to people's needs, knowing them well and interpreting body language. For example, one person became agitated in the lounge and staff discreetly assisted them, ensuring they were comfortable in a quieter environment.

Records, and our observations, confirmed there were sufficient skilled and experienced staff deployed to ensure the safety of people who lived at the home. On the day of the inspection, there was the provider, registered manager, administrator, one senior care worker, four care workers, a chef, a kitchen assistant, a person in charge of maintenance, a gardener and a housekeeper alongside the activity co-ordinator. Staff told us there was always enough staff to respond immediately when people required support, which we observed in practice. One staff member told us, "It's pretty good most of the time and the manager is really good if we are short; they'll help out". Shifts had been arranged to ensure that known absences were covered. Rotas also confirmed the use of agency was minimal and people were being supported by a stable team. The service had a 24 hour on call system in case of unforeseen events and if additional staff were needed.

Staff files showed that safe recruitment processes were in place. Checks had been made with the Disclosure and Barring Service to ensure that new staff were safe to work in the care profession. In addition, two references were obtained from previous employers before staff commenced employment. Checks were also undertaken to ensure that overseas staff had the required documentation in place and the right to undertake paid employment in the UK.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff did so safely and in line with the prescription instructions. Medication Administration Records (MAR) were in place and had been correctly completed to demonstrate medicines had been given as prescribed. All staff was trained to administer medicines. The registered manager completed an observation of staff to ensure they were competent in the administration of medicines. Medicines were locked away as appropriate and were stored in a locked drugs cabinet within a locked storage room. The senior carer for each shift held the keys to the medicines storage room. A refrigerator dedicated to medicines storage was also in the room. The fridge temperature and room temperature were within recommended ranges to ensure the efficacy of the medicines; daily checks were made and temperatures recorded. We checked a sample of the medicines and stock levels and found these matched the records kept.

Good

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Appropriate DoLS applications had been made, and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

Staff had received MCA training and our observations confirmed staff promoted choice and acted in accordance with people's wishes. However, not all staff demonstrated a clear knowledge of the MCA and DoLS in our discussions with them. We fed back to the registered manager that staff would benefit from additional support to discuss the MCA and DoLS to ensure the training had been embedded. During the inspection the registered manager created a pocket guide on the principles of the MCA and distributed it to staff on duty, in order to ensure all staff understood the rights of people living at the home. The registered manager told us, she would raise this subject in staff supervision with all staff in order to gauge each staff member's knowledge of the Act with a view to refresher training. Throughout our inspection, we saw that people who used the service were able to express their views and make decisions about their care and support. We observed staff seeking consent to help people with their needs.

Staff received training in a range of areas, which the registered manager had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, fire safety, health and safety, infection control, food hygiene and safeguarding. In addition to the mandatory training, the registered manager had ensured specialised training was given to care staff to be able to meet the individual needs of people being supported. This included staff completing courses in care planning, dementia: interaction and communication, dignity and choice, equality and diversity, nutrition and hydration, person centred care, pressure area care and skin tears. We looked at the staff training certificates contained in staff files, which confirmed that staff had received essential training to enable them to support people effectively.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved

through assessment and training. To achieve these qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard. This ensured people received effective care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities.

All of the staff we spoke with had received recent, formal supervision or a yearly appraisal. Records showed that at the meetings staff discussed their work, training, residents' needs, any problems, staffing and any suggestions for improvements. Records showed the discussions that had taken place, together with a review of actions agreed from previous supervision meetings.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. The kitchen had an information board which, displayed people's dietary needs. For example, for those who required a soft diet or who lived with diabetes. We observed good communication between kitchen staff and care staff, who advised the chef of changes made to people's diets following input from visiting professionals, such as dieticians and Speech and Language Therapists. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. Plate guards were used, where needed, to help people to eat their meal independently. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff.

We observed the lunchtime and tea time meal in the dining room. The atmosphere was calm and relaxed and there was music playing at tea time which people told us they enjoyed. Tables were nicely laid with tablecloths and condiments. Staff assisted people who required support with eating their meal in a discreet and unhurried way. Fruit and biscuits were always available if people wanted a snack. People's food and fluid intake was routinely monitored, whether or not they were at risk of malnourishment. We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas. People we spoke with told us, they were happy with the food and drink provided. One person told us, "Yes, it's great. There's always choice and plenty of it on offer". We noted issues related to food and drink were regularly discussed at residents' meetings.

People were supported to maintain good health and had access to a range of healthcare services and professionals. Care records documented the involvement of healthcare professionals such as the GP, chiropodist, district nurse, optician, dietician and speech and language therapists. If needed, staff would support people to attend their hospital appointments. Advice and guidance given by these professionals was followed by staff.

During the inspection we undertook a tour of the home that was accessible to people. Accommodation was over two floors and there was a passenger lift and also a stair lift to provide access to the upper floors. We saw that people could move freely around the home. There were two lounges one of which included the dining area. Communal areas were warm and cosy which gave a nice homely feel. The kitchen and laundry were situated on the ground floor, bedrooms were situated on all three floors and some of these were en-suite. People were involved in the choice of furnishing for their rooms and were able to choose their favourite colours and personalise their rooms with photos and items of their choice. There were communal bathrooms and WCs situated on the on the ground and first floor.

Requires Improvement

Is the service caring?

Our findings

At this inspection, people described staff as kind and caring. People told us, they felt they were treated with respect and dignity. Whilst we saw that some staff demonstrated a respectful, warm and polite approach, we saw some examples where staff were not caring or respectful. People's dignity was not being consistently maintained.

During this inspection, we heard a staff member speak to colleagues for assistance because a person had become incontinent. There were other residents present and could observe the conversation between staff. The staff member stated, "I am going to take [name of person] to the toilet, he's wet himself. He has been left like that, CQC are walking around, so don't want to leave him like that. It will be on the front page of newspaper." Whilst observing lunch we heard a staff member ask a person who used the service "are you in a meadow, darling?" referring to the person who had paused eating and had their wide mouth open. This was not a respectful way to speak of this person and the way they were eating. Another staff member was heard to be encouraging the same person, to eat in an infantile manner with comments such as, "Just two more mouthfuls" and "good girl." For the same person the staff member put too much food on the fork, causing it to drop on the person. Another staff member spoke loudly from the dining room into the lounge asking their colleagues "has [name of person] been to the toilet yet? Or did she go before lunch?" These examples showed a disregard for the person's dignity and a lack of respect for the people involved. This is an area requiring improvement.

We fed back our observations to the registered manager and provider during the inspection. The provider arranged an immediate staff meeting during the inspection to discuss our observations and the registered manager reminded staff of their responsibilities to being caring, respectful and compassionate. The registered manager also arranged training for June 2017 for all staff to attend 'Compassion in Care and Dignity Awareness' training.

We mostly observed examples where staff demonstrated a kind and considerate approach. For example, we saw one staff member softly touch the cheek of a sleeping person in order to rouse them gently for their lunch. On another occasion, we saw that a staff member reassured and comforted a person as they assisted them to mobilise, showing concern for their wellbeing. The people we spoke with told us that staff treated them with kindness and consideration.

Throughout our visit staff were mostly attentive to people they were caring for and demonstrated they knew people very well, including people's relatives. Staff knew people by name, and some of the conversations indicated they had also looked into what they liked, and what their life history had been. People were comfortable around staff. We noticed when two people were distressed; staff were attentive and kind towards them. We also saw a staff member walking along a corridor with one person linking their arm and they were walking at a slow pace.

The premises were spacious and allowed people to spend time on their own if they wished. We saw people spending time in the lounge areas, in their bedrooms and in the smaller seating areas. People looked well

cared for. They were tidy and clean in their appearance, which was achieved through good standards of care.

We observed a high level of engagement between people and staff. Consequently, people, where possible, felt empowered to express their needs and receive appropriate care. We looked at people's care plans and daily records in order to ascertain how staff involved people and their families with their care as much as possible. Care plans and risk assessments were reviewed regularly by staff and signed by people, relatives or representatives. We found evidence that people or their representatives had regular and formal involvement in ongoing care planning or risk assessment. Consequently, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately.

Staff were able to describe to us how they upheld people's privacy and dignity when providing personal care and support for example ensuring bedroom doors were closed. During our inspection, we observed staff knocking on people's doors before entering and closing doors when providing personal care. We saw that people were dressed appropriately suitable for the time of year and people were supported to maintain their personal appearance so as to ensure their self-esteem and self-worth.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. The registered manager had asked relatives/representatives about people's end of life preferences which were recorded. This was done sensitively and at a time to suit people. There was information, which showed the registered manager had discussed with people if they wished to be resuscitated. Appropriate health care professionals and family representatives had been involved in these discussions. The registered manager demonstrated their passion and commitment to supporting people and their relatives before and after death.

Good

Is the service responsive?

Our findings

At the last inspection in December 2015, we found that care plans were being updated at the time of that inspection; however this was a work in progress and not all people had a care plan, which reflected their needs. We also found that activities were available however; these were not scheduled in a way that ensures people's social needs were always met. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards.

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how their individual needs could be met. The assessments completed prior to an individual moving into the service formed the basis of each person's care plan.

We observed people received personalised care that was responsive to their needs. Care plans provided advice and guidance to staff about people's care and how they wished to be supported. Care plans included information on people's personal care, health care, mobility, social care, communication, religious and cultural preferences, dietary needs and medication. Information about people's daily routines, likes, dislikes and preferences were contained in their care plans. For example, one person suffered from chronic pain brought on by degenerative disease. We noted this person's pain levels were monitored regularly and recorded. Their care plan contained a pain management risk assessment which included the type and severity of pain experienced and measures needed to provide relief. For another person they were at risk of developing pressure sores. We noted risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration and their diabetic state. Care plans were reviewed monthly to ensure they met people's needs and were in line with their preferences. Where people wished, their loved ones were involved in reviews and relatives told us that they had been involved where appropriate.

Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. The daily records gave clear information about how people were so that staff on each shift would know what was happening. Staff were responsive to changes in need and referred people to appropriate health professionals in a timely way. For example, one person had developed a small reddened area on their sacrum [base of spine]. The registered manager had referred the person to the Community Nursing Service who were visiting regularly to assess and monitor. Staff used clear body maps to monitor people's skin and to show why and where topical creams were required.

There were several visitors during the inspection and the front door was always answered promptly by staff that welcomed people and ensured that they signed in the visitor's book before entering the service.

The service placed a strong emphasis on meeting people's emotional well-being through the provision of meaningful social activities and opportunities. People were offered a wide range of individual activities,

which met their needs and preferences. We looked at documentation related to meaningful occupations and activities at the home and spoke with the provider's activity co-ordinator, appointed in December 2016. We were told they worked 18 hours per week over five days. We noted there were a wide variety of social, educational and occupational opportunities for people living at the home. These included: musical bingo, Great British painting competition, reminiscence therapy, board games, play your cards right, flower arranging, card making, home baking, film afternoons, exercise classes following assessment by physiotherapist, sensory input via computer for people with dementia, gardening and 'The Road Trip', which were virtual visits to areas of interest around the country.

There was also one to one input for people who did not like to engage in communal activities. These included board games, reading or discussions. The activity co-ordinator also chaired residents' meetings. We looked at the minutes of the latest of these, held on 2 April 2017. We noted the meeting was well attended; there was an agenda, suggested by residents and action planning devised as a result of the meeting. There were timelines attached to these with named a responsible person or people. We asked about how activities were conducted when the co-ordinator was not on duty. We were told care staff had time in the afternoons to engage in these; the staff we spoke with confirmed this.

The people we spoke with were satisfied with the activities and occupations on offer. One person told us, "I don't join in much but only because I don't really want to. I do see [activity co-ordinator] quite often though. There seems to be a lot going on". Another person said, "Yes, that seems to have got a lot better lately. I did go to the last residents' meeting and it was quite lively. We talked about what was coming up and we could have our say if we wanted".

The service sought annual feedback using a survey, which was sent to people and relatives. Survey responses were positive overall and where responses showed that improvement could be made, these were actioned.

People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the registered manager, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. The registered manager told us, there had been no formal complaints within the last year. People said that they would be confident to make a complaint or raise any concerns if they needed to.

Good

Is the service well-led?

Our findings

People and staff we spoke with told us Hollywynd Rest Home had really good leadership.

Hollywynd Rest Home had the benefit of strong focused leadership. A registered manager worked five days a week and there was a deputy manager and senior care staff who supported the registered manager. The registered manager said that she had an excellent relationship with the management team, and staff at the home. Staff and the management commented that they were all comfortable about being able to challenge each other's practice as needed.

During the inspection, the registered manager continuously demonstrated her in-depth knowledge of each person living there and of her staff team. Any question we asked was met with detailed information. For example, during the inspection, the registered manager stopped on many occasions to speak with the people and provided reassurance when it was necessary. People were encouraged by the management team to be involved in the inspection process as much as they wanted.

There was an open, positive culture within the home. This was led from the top down. Staff told us the manager was visible, one staff member added, "I do think it's well run. The manager is great and very approachable. Where I worked before, the manager's door was always shut. It's different here; the manager is always around". Another staff member said, "I think the manager is really good. They are very 'hands on' and they will help out with the care. They're very friendly too".

The registered manager told us that what they had achieved to date is down to the whole staff team, demonstrating a respect for others input into the service. There was a culture of continual reflection by the staff and management team. They were passionate, creative and dedicated in their approach to improvement, and a visible presence in the service, accessible at all times by operating an 'open door' policy. We observed this during the day; the registered manager shared an office with all levels of staff, which resulted in a culture of shared learning and information sharing to support the running of the service. For example, staff came in regularly and asked questions, passing on important information about people and their well-being.

The registered manager carried out a programme of monthly audits and safety checks. The provider had a quality assurance system, based on seeking the views of people, their relatives and other health and social care professionals. There was a systematic cycle of planning, action and review, reflecting aims and outcomes for people who used the service. The registered manager provided evidence of completed monthly audits, which included care plan audits, infection control, fire systems and maintenance logs. The results of this monitoring were continuously delivered through changes and improvements in the way they worked with each individual. This could be directly correlated with the improvements in wellbeing, health and reduction of anxious behaviours for each person living at the service. This was evidenced through records of the care provided and planned and we could see how this had a positive impact for each person.

Records were kept securely. All care records for people were held in individual files. Records in relation to

medicines were stored securely. Records we requested were accessed quickly, up to date and were fit for purpose.

Staff told us that they met together through handovers during the day, staff monthly meetings and residents' monthly meetings. We looked at the meeting minutes of recent staff meetings, the latest of which was held on 22 March 2017. We noted issues of importance to staff was discussed and resolutions found and agreed upon. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. The meetings were well attended; the staff we spoke with were happy with the process. Without exception, staff told us, the registered manager had an open door policy where they could talk to them anytime they needed to. Staff were aware of the whistle blowing procedures should they wish to raise any concerns about others or the organisation.

People attended monthly 'resident meetings' where they could give their opinions and feedback. Relatives were also invited to these meetings. These meetings were chaired by the registered manager and solely focused on the areas that people and their relatives wanted to discuss. This allowed people the opportunity to discuss any changes to the service they felt necessary, while promoting their independence. These meetings were also attended by the management of the service to help identify actions and minute discussions. The majority of people attended these monthly meetings; this helped to demonstrate that people and their opinions were valued. The meeting minutes viewed evidenced people were being kept up to date with any changes in the service, and encouraged to suggest forthcoming activities.

Information leaflets were available in the entrance to the home about local help and advice groups, including advocacy services that people could use. These gave information about the services on offer and how to make contact. There was a copy of the most recent inspection report and the quality ratings given at the last inspection were displayed in the home. There was a suggestion box in the entrance hall of the home where people could raise issues or make suggestions.