Evergreen Healthcare 2004 LTD

The Hollies Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Hollies Residential Home is a residential care home providing personal care to up to 40 older people as well as younger adults. At the time of our inspection there were 26 people living at the service (two people were in hospital), some people lived with dementia.

People's experience of using this service and what we found
People and relatives provided positive feedback about the service, the staff and the management. Comments from people included, "[I feel] very safe here, I trust everyone"; "All of the carers are nice to me" and "The girls are all kind here. They help me when needed. I get myself ready for bed and I use the call bell to let them know to bring my commode in."

Although people and relatives were happy with the care and support, we found serious concerns about people's safety. Although some improvements to safety had been made, risks to people's safety had not always been well managed. Timely action had not always been taken in response to people falling and injuring themselves. A range of risks to people had not been properly assessed or managed. Fire risks identified were reported to the fire service.

There were not enough staff deployed at night to keep people safe. Following a visit from the fire service, staffing numbers at night were increased.

Medicines management had improved. Medicines administration records (MAR) were mostly complete. Medicines had mostly been given as prescribed. However, there were some areas for improvement in relation to recording prescribed meal supplements and administration of medicines that were prescribed to be taken once a week. Prescribed creams, lotions and eyedrops had not been dated on opening. This meant the provider could not be assured that medicines had been used by the date the manufacturer had recommended. Medicines that required returning to the pharmacy had been appropriately documented and completed in a safe manner.

The environment required improvements. There was no signage to support people living with dementia (as well as new people to the service) to orientate themselves. We made a recommendation about this.

Whilst management oversight of the service had improved, there was still insufficient oversight of the service by the provider and registered manager to pick up and address the risks found by inspectors. Improvements to the service were still being developed and embedded. Records continued to be an area of concern across the service; records were not always complete and accurate.

People were not always assessed to check their capacity to make particular decisions when this was in doubt. Records were not always kept to show how decisions were made in people's best interest. Mental capacity assessments were in place, these were not decision specific and showed a lack of understanding

about the Mental Capacity Act 2005. People told us they made choices about their lives. It was not clear that people who lacked capacity were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

The provider had effective safeguarding systems in place to protect people from the risk of abuse. Safeguarding concerns had been identified and reported to the local authority appropriately. Staff knew and understood their role in keeping people safe.

Staff had been recruited safely to ensure they were suitable to work with people. People were supported by regular staff who they knew well. Staff were well supported by the management team.

At this inspection the provider was admitting people safely to the service. People had moved into the service and had been isolated in their rooms for the required period in line with COVID-19 guidance. The provider was accessing testing for people using the service and staff. The provider had not been following the COVID-19 government guidance to only test people if they had symptoms. People were being tested monthly. Staff were being tested daily. People were supported to access healthcare services when they needed them.

The service was mostly clean; the provider was promoting safety through the layout and hygiene practices of the premises. However, dining room chairs in the service had become damaged and worn which presented as an infection control risk. After the inspection the registered manager arranged for these to be replaced.

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 inadequate (published 04 March 2022). 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 some improvements had been made and the provider was no longer in breach of regulations 13, 18 and 19. However, we found the provider remained in breach of regulations 9, 11, 12, 17 and 20 (person-centred care, need for consent, safe care and treatment good governance and duty of candour.)

This service has been in Special Measures since 04 March 2022. During this inspection the provider demonstrated that improvements have been made, however the service remained inadequate in safe and well-led. Effective had improved to requires improvement.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 30 November 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

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.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained the same. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Hollies Residential Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 continued breaches in relation to person-centred care, need for consent, safe care and treatment, good governance and duty of candour. We have made a recommendation about the considering current guidance on dementia friendly signage.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

The Hollies Residential Home

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

Service and service type
The Hollies Residential Home 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 Residential Home is a care home without nursing care. The Care Quality Commission (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 CQC 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
The first day of this inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who commission the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. A local authority commissioner told us they had carried out contract monitoring visit and had given the provider an action plan.

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 spoke with 10 people who used the service about their experience of the care provided. We spoke with one person's friend. We received written feedback through our website from seven relatives. We observed staff interactions with people and their care and support in communal areas. We spoke with 11 members of staff including housekeeping staff, kitchen staff, care staff, senior care staff, the manager, the office manager and the registered manager.

We reviewed a range of records. This included six people's care records and multiple medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, building related maintenance records and quality assurance records. We spoke with a further two staff members.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At the last inspection in November 2021, risk assessments were inconsistent. They did not provide clear guidance to staff about how to meet people's needs safely. Risks of harm had not always been considered. Fire risks had not always been well managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 in relation to risk management.

● At the last inspection, risks to people had not always been identified to ensure staff had the guidance necessary to follow a specific plan to prevent harm. There was inconsistent risk assessment practice across the service. At this inspection, this remained the same. One person's care records evidenced they had fallen from their bed three times in seven days and sustained a head injury. Registered persons had not reviewed the suitability of the person's bed until two days after the last fall. Action to put safety measures in place had not been taken until identified by the inspectors.
● The same person's mobility risk assessment had not been reviewed on their discharge from hospital 12 days before the inspection. The person was admitted back to the service unable to weight bear. Their risk assessment stated they should be encouraged to walk morning and evening to maintain their mobility. Although staff had not supported the person to mobilise, the failure to update their risk assessment placed them at risk of receiving unsafe care.
● Risk assessments were not always in place where people had health conditions, which carried potentially serious risks. For example, when people were diagnosed with diabetes their risk assessments did not state what their blood glucose level range should be and how to manage their care if the blood glucose level was outside of normal ranges. Staff gave varying accounts of how often blood sugars for one person should be monitored. Daily records showed inconsistencies in reporting which reflected the staff members confusion. This meant staff did not have information about how to support people and keep them safe.
● At the last inspection, building related risks had not been well managed. At this inspection some improvements had been made to the building, but risks remained. Window restrictors had been fitted to most upper floor windows and radiator covers had been fitted to radiators in bedrooms. However, risks remained in relation to risks of burns from hot surfaces because the door to the hot water tank room had been left unlocked and unattended. We reported this to the registered manager who took immediate action to lock the room and speak with staff authorised to enter the room. Window restrictors were found to have the keys still in each of the locks on the first day of the inspection. These were removed when we reported this to the registered manager. One window had not had a window restrictor fitted on the first day, this had

been rectified by the second day.
● At the last inspection, doors in one part of the building had large gaps underneath which meant they would not be effective in the event of a fire. Personal emergency evacuation plans (PEEPs) did not provide all the information staff needed to understand how to safely evacuate people in an emergency. At this inspection gaps under the doors in one part of the building remained, PEEPs had been updated however still lacked important information and doors to a room containing large hot water tanks and lift machinery were found unlocked on both days of the inspection. This had the potential to cause serious injury.
● At this inspection, we found fire doors wedged open on both days of the inspection, this would prevent the doors closing in the event of a fire. We reported fire safety concerns to Kent Fire and Rescue Service.
● At this inspection we found that legionella risk had not been adequately managed. The provider had not ensured that they were testing hot and cold-water outlets throughout the service monthly to ensure that the water was at a safe temperature. This put people at risk of harm.
● During the inspection we witnessed staff carrying out a moving and handling task with a person that put them at risk of harm. We reported this to the registered manager. Staff had not been competency assessed to check that they understood their moving and handling training and that they demonstrated safe practice. The registered manager told us they planned to provide competency based moving and handling training to staff.
● Risks of people leaving the service undetected had not been well managed. Earlier in 2022 a person had left the service and was found by the police and returned. To mitigate risks the provider had recorded that they had fitted alarms to the fire exits within the service. On 13 June 2022 we observed staff entering and leaving the service by the doors and alarms were not sounding. We checked doors elsewhere in the service and found these did not sound. We discussed this with the registered manager, they told us the person who left was no longer living at the service. Risks to other people living at the service (including those living with dementia) had not been considered.
● One person's accident records showed that relevant action had not always been taken to keep them safe. They had fallen seven times in 2022, many of these falls were unwitnessed and one of these occurred in a restricted area of the service. Action had not been taken to address accessibility to vulnerable people to the restricted area. The person had not been referred to the falls clinic for further advice and support. This put the person at risk of further falls.

The provider has failed to manage risks relating to the health, safety and welfare of people. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Accidents and incidents had been recorded by staff. The registered manager checked and recorded the number of incidents each month, including the number of falls in total. The registered manager used the data to identify patterns and trends and take relevant action. For example, the registered manager had identified that falls were occurring at a certain time of day so increased the staffing and analysis showed that falls reduced. However, relevant actions had not always been taken as identified in the examples above.

Using medicines safely

At the last inspection in November 2021, the provider had failed to manage medicines safely which put people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 regarding medicines. However, there were some further areas for improvement that were

required.

● At this inspection, medicines management had improved. Medicines administration records (MAR) were mostly complete. Medicines had mostly been given as prescribed. However, it was not clear if one person had been given their prescribed meal supplement as no staff member had signed the MAR to evidence it had been given. We checked the person's weight records, these showed their weight to be stable. Staff told us they gave the meal supplement when the person refused meals. The same person's MAR showed that they should be administered a particular medicine once a week on a Wednesday. The MAR showed that staff had been administering the medicine once a week on a Sunday, which did not meet the prescriber's instructions. Staff told us they had always given the medicine on a Sunday.
● At this inspection, we found that prescribed creams, lotions and eyedrops had not been dated on opening. This meant the provider could not be assured that medicines had been used by the date the manufacturer had recommended.
● At this inspection, medicines that required returning to the pharmacy had been managed in a safe way. Medicines were stored safely in a locked medicines room. Medicines had been stored at the correct temperature to ensure they were safe to use. Medicines in stock tallied with records.
● At this inspection, the provider had reviewed medicines policies and procedures and practice. Medicines auditing had taken place. Staff were trained to administer medicines and we observed good practice when staff were completing the medicines round. The registered manager had carried out medicines competency checks to ensure that staff practice was safe and followed medicines administration policies, procedures and good practice.

Preventing and controlling infection
● We were somewhat assured that the provider was accessing testing for people using the service and staff. The provider had not been following the government guidance to only test people if they had symptoms. People were being tested monthly. Staff were carrying out COVID-19 testing each day.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Dining room chairs in the service had become damaged and worn which presented as an infection control risk. Other areas of the service had been adequately cleaned.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 using PPE effectively and safely.

We have also signposted the provider to resources to develop their approach.

● People were able to see their family and friends at a time that suited them and staff supported people where they needed this. We observed relatives taking their loved ones out into the community as well as visiting the service.

Systems and processes to safeguard people from the risk of abuse

At the last inspection in November 2021, the provider did not have effective safeguarding systems in place to protect people from the risk of abuse. The provider and registered manager had not always recognised when abuse had occurred and so had not reported this appropriately. 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) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● At this inspection, the management team had appropriately raised safeguarding concerns when they had occurred.
● People told us they felt safe. Comments included, "I feel safe here" and "I feel safe here, people [staff] are here to help me."
● Staff told us they felt comfortable to report concerns to the provider and management team. They felt that concerns were taken seriously, and appropriate action was taken. Staff knew how to escalate concerns to outside organisations such as the local authority safeguarding team and CQC if necessary. One staff member said, "I would report abuse to [registered manager or director or care manager], it would definitely be acted on. I could call CQC."

Staffing and recruitment

At the last inspection in November 2021, staff had not always been recruited safely. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● At this inspection, improvements had been made, the provider had explored each staff members full employment history and had retained interview selection notes. Staff were recruited safely. Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
● At the last inspection, staffing rotas evidenced that there may not be enough staff deployed on night shifts to meet people's needs and to safely evacuate people in the event of a fire. We spoke with the provider and asked them to urgently review staffing levels at night. They agreed to do this and agreed to use people's personal emergency evacuation plans to assess the required level of safe staffing. This was an area for improvement. At this inspection, the staffing levels at night were still the same, the provider had not utilised fire drills with staff to assess whether the staffing levels were appropriate to safely meet people's evacuation needs. We reported this concern to Kent Fire and Rescue Service, who attended and found that there were not enough staff deployed at night to keep people safe. The provider was advised to increase the number of staff immediately, this was done.
● At the last inspection, the provider did not use the dependency tool to inform the staffing rota to match people's needs to how many staff were required, this meant they could not be assured that they had deployed the right amount of staff at the right time. This was an area for improvement. At this inspection this remained the same.
● We observed that staffing levels were appropriate to meet people's needs during the day. Call bells were answered quickly. People told us, "I have the call bell with me, they answer it when I use it"; "I have the bell around my neck in case I fall" and "I have a call bell and it does work."

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At the last inspection in November 2021, the provider had failed to assess people's needs and choices. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At the last inspection, prior to people moving to the service their needs were assessed. These assessments were not sufficient or robust to ensure that people's needs were fully understood to enable staff to form care plans and risk assessments. At this inspection we found the same, although some assessments had improved, there was inconsistent practice. For example, we found conflicting information on one person's assessment and care plan about whether they had been diagnosed with dementia. Assessments in relation to people were stored in different places and staff were not always sure how to access the information they needed.
● The registered manager showed us that they were developing assessments and documents to look at calculating malnutrition, oral care, skin integrity, bed rails. We saw some evidence that some of these tools had been used within the service, however the practice was not consistent and had not been fully embedded.

The failure to assess people's needs and choices and design care and treatment to meet people's preferences and needs is a continued breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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).

At the last inspection in November 2021, the provider had failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

We checked whether the service was working within the principles of the MCA.
● At the last inspection, MCA assessments were not lawful and were not decision specific. Some included general comments which included, 'at the time of the assessment the resident showed that they lacked capacity, a referral needs to be arranged to have their capacity assessed by a professional.' At this inspection many MCA assessments remained the same.
● Some specific MCAs had taken place but decision making, and best interest decisions had not always been appropriately recorded. For example, one person's bed rails assessment showed they lacked capacity to consent. A staff member had recorded they had involved the person's relative in the decision. However, the contact with the relative had not been recorded to evidence they had been involved and had agreed to the bed rails.
● The registered manager explained the electronic care plan system did not enable the service to enter MCA's for specific decisions and as a result they were in discussion with the electronic care plan system provider to make changes.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection, one urgent DOLS application had been made.
● People confirmed that they made their own choices. Comments included, "I am allowed to get up and go to bed when I choose, I usually go to bed at 21:30"; "I get up when I want. I spend the mornings downstairs and the afternoons in my room as I like to watch my TV" and "The staff make sure I understand, they are patient."

Staff support: induction, training, skills and experience

At the last inspection in November 2021, the provider had failed to ensure staff had the appropriate training to ensure people's needs were met. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18. However, there were some further areas for improvement that were required.

● At the last inspection, staff training and induction was not adequate to provide staff with the guidance and skills to safely carry out their roles. Staff had not received all the relevant training to support them to meet people's needs. At this inspection training had improved, most staff had completed training to meet people's needs, this included dementia training, diabetes awareness and catheter training.
● Staff had completed moving and handling training through e-learning , however had not been

competency assessed to check that they understood the training and that they demonstrated safe practice.
● Staff records confirmed new staff had not been enrolled on to the Care Certificate as part of their induction process. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff told us they felt well supported by the management team and that they had regular support in the form of supervisions and appraisals. Staff told us they could ask for additional training and were supported to complete work based vocational qualifications. One staff member said, "I have just had an appraisal with [registered manager]. I can ask for training and they (management team) sort it."

Adapting service, design, decoration to meet people's needs
● At the last inspection in November 2021, the design and layout of the building did not fully meet people's needs. Some people lived with dementia. There was no dementia friendly signage around the service to provide way marking to communal areas of interest such as dining room, lounge, coffee shop. Toilets and bathrooms and people's rooms did not have dementia friendly signage to help people understand what was behind the door. We raised this as an area for improvement. At this inspection, this had remained the same.
● We observed one person walking in the corridor, they stopped to chat. They asked us which way they should go, as they "Get a bit lost."

We recommend the provider consider current guidance on dementia friendly signage and take action to update their practice accordingly.

● People had access to well-maintained gardens, we observed people sitting in the garden as the weather was nice. Since the last inspection, the conservatory had been redecorated and refurnished.

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

At the last inspection in November 2021, the provider had failed to meet people's nutritional and hydration needs. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

● At the last inspection, food and drink did not always meet people's assessed needs. At this inspection, improvements had been made. Food and fluid met people's assessed needs, no one required a pureed diet.
● People told us they enjoyed the food; people were able to choose their food from an option of two meals. Although staff and kitchen staff told us people would be offered another option if they did not like either of the meals on offer, we observed this did not happen on the first day of our inspection. One person did not want either option of the meal and was only offered a yoghurt as a third option. This is an area for improvement.
● People fed back that there was not a vegetarian option of food available on the menu each day. Kitchen staff told us that vegetarians were catered for. However, the vegetarian option was not printed as an option to enable people to have a further choice. This is an area for improvement.
● We observed people were offered drinks frequently to stay hydrated. People were offered ice lollies when the weather was hot to help cool them down and also stay hydrated. Fruit was available in communal areas for people to snack on. Staff told us people could have snacks and food day and night.

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

● People were supported to access healthcare services when they needed them. For instance, people regularly saw a GP, chiropodists and district nurses. People attended appointments with their healthcare specialists and consultants when required. We observed staff taking action to seek medical advice during the inspection when a person sustained an injury from a fall during the inspection.

● Records evidenced that the service worked closely with people's local authority care managers and healthcare providers to provide updates and information about people's health and wellbeing. The service worked closely with the local hospice. Hospice staff visited the service to review people who were nearing the end of their life.

Inadequate

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 inadequate. At this inspection the rating has remained 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.

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

At the last inspection in November 2021, the systems to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. Records were an area of concern across the service. Records were of poor quality and did not include a complete, accurate and contemporaneous record of care provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At the last inspection, the systems to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. At this inspection, although audits had taken place and some improvements made, they were not always robust enough to identify concerns found during the inspection in relation to risk management, assessment of people's needs, MCA and DoLS.
● At the last inspection, the provider had not completed a thorough review of building safety following a serious injury to a person. This meant sufficient measures were not in place to ensure that people were protected from the risks of burns from pipes and hot surfaces. At this inspection, although some improvements had been made, building related risks remained in relation to risks of burns from hot surfaces as well as risks of falls from height. These had not been identified by registered persons.
● At the last inspection, records were an area of concern across the service. Records were of poor quality and did not include a complete, accurate and contemporaneous record of care provided. At this inspection, some records had improved. Records relating to food consumed by people were in place. However, some records had not improved. Dates of care entries had been entered incorrectly, for example the year had been recorded as 1922 instead of 2022 in many people's care records. This had not been identified through checks and audits.
● Records of support in relation to oral care were not always made. This meant registered persons could not be assured that people had received oral care according to their assessed needs. Records of fluid output for people who had catheters were inconsistent, this meant registered persons could not be assured people's catheter care needs had been met according to their assessed needs.
● Records of personal care did not always provide information of being offered baths or showers and where these had been declined. For example, daily records showed that people had frequently received a strip

wash only. Records of bowel movements were not complete. One person's bowel chart had five entries of bowel movements in 27 days. This meant that registered persons could not be assured that people had been supported appropriately.
● At the last inspection, people were at risk because the provider had not acted to ensure they had enough oversight of the service. Since the last inspection the provider had employed a new experienced registered manager who was working with the provider on their action plan to improve the service. These improvements were ongoing and required further review and embedding.

Registered persons had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider and registered manager understood their role and responsibilities, had notified CQC about all important events that had occurred.

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

At the last inspection in November 2021, the provider and registered manager did not fully understand their responsibilities under the duty of candour when incidents occurred. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 20.

● At the last inspection, the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. When a serious injury had occurred in relation to a burn, the notification form submitted to CQC by the registered manager evidenced that they had assessed the incident as not meeting the duty of candour. There was no evidence to show that the provider had met with and apologised to the person and their relatives.
● At this inspection, we identified an incident which had occurred where a person had left the building unnoticed. This met the threshold of a duty of candour incident. There were no records in place to evidence that the provider had formally met with the person and their relatives to discuss what went wrong and there was no record of an apology. The registered manager told us they had met with the person's relative to discuss the incident and to explain that the service was unable to meet the person's needs. The registered manager told us that this meeting was informal and not recorded.

The failure to be open and transparent with people and their relatives following a notifiable safety incident is a continued breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their rating in the service and on their website.

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

● Staff told us that they were able to share their ideas and felt listened to. Staff meetings had taken place regularly. Staff told us they felt that communication, the culture and the feeling of the service had greatly improved. Comments included, "[Registered manager] is responsive to suggestions" and "The service has changed for the better. The decoration is starting to look nice. The culture has improved, it is a happier place."

● The provider had sent out surveys to people and relatives to gain feedback about the service since the last inspection. Survey results evidenced people were satisfied with their care and support.

● People met with the activities staff member on a weekly basis to discuss activities and provide feedback.

● Relatives told us, "Whenever, I have had questions, about mum's current state, or her care, they have been very willing and positive with their responses"; "I am completely satisfied with the care my aunt receives and rate The Hollies very highly. I think they have done particularly well over the past couple of years coping with the pandemic and challenges that created" and "I can't speak highly enough to praise and thank The Hollies for the care and compassion they gave to my mum, not only whilst she was healthy but also in her last days."

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

● Compliments had been received through The Hollies social media pages. One read, '[Person] has always been happy and content here. She is well looked after and cared for by everyone in the home. She has nothing but praise for the staff who make her life worthwhile again.'

● Written compliments and thank you cards had been received. One read, 'It was with great sadness that I had to move mum from The Hollies but following her stroke her needs changed significantly. She was always happy there and as a family we feel she received amazing care from all the staff. Her appearance always looked spotless with her hair done and clean clothes and her mental health improved significantly with all the stimulation from staff and activities she became involved with. The home felt like home to us as a family when visiting and we were always made welcome.'

● People and their relatives knew the registered manager and felt that there was an open culture. Comments included, "I can talk to staff if I need anything and they help me"; "I know [director] and [registered manager], I can talk to them" and "[Registered manager] talks to me when I see him."

● There was a calm, homely atmosphere at the service. Staff told us they enjoyed coming to work. One staff member said, "I love coming to work and I am enjoying the changes."

Working in partnership with others

● At the last inspection, the provider and the registered manager had not been keeping up to date with local and national developments within health and social care. They had not taken opportunities to update their skills and knowledge to benefit the experience of people using the service. This was an area for improvement. At this inspection, the registered manager had kept up to date with local and national developments within health and social care.

● The registered manager had signed up to well known, reputable websites to find advice and guidance such as Skills for Care. Skills for Care supports adult social care employers to deliver what the people they support need and what commissioners and regulators expect. The registered manager was scheduled to attend a local forum in July 2022.

● The registered manager had worked closely with the health care professionals such as community nurses, the local hospice and people's GP. The service utilised the skills of a private physiotherapist who worked with people upon discharge from hospital to increase people's mobility as much as possible.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Registered persons had failed to assess people's needs and choices Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Registered persons had failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider has failed to be open and transparent with people and their relatives following a notifiable safety incident. Regulation 20 (1)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to manage risks relating to the health, safety and welfare of people. Regulation 12 (1)(2)

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulation by XX September 2022

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Registered persons had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. Registered persons had not maintained accurate and complete records in relation to the service and people's care. Regulation 17 (1)(2)

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulation by XX December 2022