The Hollies Nursing And Residential Home Limited

Hollies Nursing and Residential Home Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Hollies Nursing and Residential Home Ltd provides personal care and nursing care for up to 31 people, some of whom are living with dementia. When we inspected there were 29 people living in the home.

People's experience of using this service and what we found
The service was not being well led. The provider's quality assurance systems and audits were ineffective. There had been a lack of oversight by the provider which had resulted in a number of shortfalls that placed people at risk of not receiving proper and safe care.

People's individual's risks including the risk of falls, choking and for the deterioration of people's conditions were not routinely identified. This meant measures were not always in place to reduce these risks. Record keeping was generally inconsistent across the home with some records lacking in detail or not up to date.

There were significant gaps in the reporting and management of accidents and incidents. The provider had failed to notify local commissioners about incidents that had occurred. Medicines were not always managed safely across the home. Systems and processes to safeguard people from the risk of abuse were poorly developed. Staff lacked guidance to identify and report allegations of abuse, such as unexplained bruising.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We found blanket restrictions in place without first assessing people's ability to make decisions of varying complexities.

People were not always supported by staff who had the right competences, induction and supervision to meet their needs. Staff were supporting people who challenged the service without the necessary training.

The home had experienced a high turnover of staff, and as a result was running on a high level of agency nurses and care staff. Systems for communication to staff had not been effective and up to date information to support people was not readily communicated. The home had a core group of experienced care staff who had worked hard across the pandemic to provide a degree of consistency to people.

People were protected from the risks associated with the spread of infection, including from COVID-19.

The provider had recently brought in an external interim manager who had experience of supporting homes to improve. They had prioritised a number of areas for improvement, including reviewing people's needs to ensure they received safe care and treatment.

There was a formal suspension on admissions until commissioners were assured improvements had been made. The provider had draw up an action plan for improvement, including plans to establish a robust

quality assurance system designed to ensure the safe running of a nursing home.

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

Rating at last inspection
The last rating for this service was Good (published 23/09/2020).

On 26 November 2020, we carried out a targeted inspection to ensure the Infection Prevention and Control (IPC) practice was safe. A rating was not given at that time as we did not assess all areas of the key question. We were assured of the IPC measures in place.

Why we inspected
We received concerns in relation to the management of medicines, safeguarding, staffing and the management of the home. As a result, we undertook an unannounced focused inspection to review the key questions of safe and well-led.

The inspection was prompted in part by a notification of a specific incident. Following which a person using the service died. We are undertaking further enquiries separate to this inspection.

The information CQC received about the incident indicated concerns about the management of choking and we examined those risks in general.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

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

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicine management, risk management, safeguarding people

from abuse, staffing, consent, quality assurance systems and governance. Please see the action we have told the provider to take at the end of this report.

Full information about the Care Quality Commission's, (CQC), 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore 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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Hollies Nursing and Residential Home Limited

Detailed findings

Background to this inspection

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

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 two medicines inspectors.

Service and service type
Hollies Nursing and Residential Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. The registered manager was not available for this inspection. The registered manager 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 the inspection, there was a management consultant responsible for the day to day management of the home.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at the information we held about the service. This information included statutory notifications the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also spoke with the local authority safeguarding and contract monitoring team and local commissioning teams.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spent time in the communal areas observing how staff provided support for people to help us better understand their experiences of the care they received. We spoke with nine people living in the home and with three relatives. We also spoke with the management consultant and one of the directors. We spoke with eight staff working in various roles at the home.

We had a tour of the premises and looked at a range of documents and written records. These included nine people's care and support records, four staff recruitment records, training and supervision records, staff rotas, minutes from meetings and complaints and compliments records, maintenance and servicing certificates and records related to the auditing and monitoring of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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

- People were exposed to the risk of harm and receiving unsafe treatment. The providers systems for the management and mitigation of risk were poorly developed.
- Staff were not effectively using assessment tools to assess and reduce these risks, including the risk of falls, choking and the deterioration of people's conditions which were not routinely identified. For example, those at risk of weight loss were not being weighed as frequently as required, a person at risk of dehydration and falls had blank assessments and other risk assessments were only partially completed.
- Referrals for more specialist advice were being missed, such as to the tissue viability nurse to reduce the risk of pressure ulcers worsening.
- Reviews were not carried out following incidents, falls or unexplained injuries. Accidents and incidents records were not always fully completed or analysed to determine whether there were any trends or patterns, to prevent any reoccurrence and to ensure people's safety. Risks were not effectively communicated or shared with the staff so that lessons could be learnt.
- People's individual fire risk evacuation plans were not being regularly reviewed.

Systems were not robust enough to demonstrate risks to people's safety were effectively managed. This placed 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.

The interim manager responded during and following the inspection. They confirmed risk records and accident and incident records were being reviewed and updated with appropriate referrals to healthcare professionals. Training was being provided for staff. An improvement plan was in place to address the issues and had been shared with commissioners.

- Equipment was serviced and maintained. Internal checks had been carried out to ensure equipment was clean and fit for use.

Using medicines safely

- The provider did not have effective systems for the safe and effective management of people's medicines. Controlled drugs were not managed safely. Storage was not secure, and the disposal of controlled drugs was not safely managed. There was a risk they could be mishandled or misused.
- Thickeners used to help people with swallowing difficulties were not recorded properly. Times for administering medicines were not consistently recorded for medicines that required specific time intervals between doses, for example paracetamol. There were out of date eye drops in stock with no assurance these were not in use.

● We were told by the interim manager that no recent audits had been completed for medicines handling in the home.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure people's when required medicines were managed in a safe or effective way. This placed 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

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse. The provider failed to follow the Local Safeguarding Authority's protocol for safeguarding and ensure staff were familiar with the processes. Staff had failed to identify and report a number of unexplained injuries, near misses and incidents that caused people to sustain injuries.
● A high number of reportable safeguarding allegations had been made by visiting external professionals, as these had been missed by the home. We found a record of unexplained bruising which had not been referred for further investigation to the safeguarding team. The interim manager immediately actioned this during the inspection.
● Staff were supporting people who presented behaviours that may challenge the service and some restrictions were in place to protect people from harm. For example, safety gates were in place across several bedroom doors to restrict people's movement. However, staff were not trained in the use of restrictive practices to ensure these were a proportionate response.
● The Mental Capacity Act 2005 (MCA) guidance had not been applied to ensure people were not being unlawfully deprived of their liberty or subject to degrading treatment.

Safeguarding processes were either not in place or robust enough to demonstrate people were protected from the risk of abuse. This placed people at risk of harm. The provider had failed to regularly monitor and review the approach to, and use of, restraint and restrictive practice. 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.

Systems were either not in place or robust enough to demonstrate compliance with the MCA 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels in the home were not always sufficient to meet people's needs. The home had experienced a significant turnover of staff and was running on high levels of agency nurses and care staff. There was only one permanent nurse who worked on nights. Staff and relatives told us that on occasions not all shifts had been fully covered.
● Staff told us, "We are often short staffed. If a staff member phones in sick, the senior will contact the agency but sometimes they can't supply anyone, and we are left short staffed." and "There are not enough permanent staff and sometimes agency staff let you down at the last minute." The interim manager and provider were actively recruiting staff and had interviews arranged over the next few weeks.
● Staff told us, "We don't have any time to spend with people", and "Some staff rush people as we are short staffed." We observed a number of staff sitting with a people who had been assessed for one to one support , however, we did not see any meaningful interactions from staff other than task based actions.
● The use of agency staff was not structured. There had been no formal induction or systems for checking agency staff had the required skills and qualifications for the role. The new interim manager was addressing

these issues and had put in place checks and inductions to the home.
● We found HR practices in regard to disciplinary procedures were not followed in line with national best practice timescales and protocols.

We found no evidence people had been harmed however, the provider had failed to ensure sufficient numbers of suitably competent, skilled and experienced staff were deployed. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although no new permanent staff had been recruited for several months, recruitment records were found to be satisfactory.
● The home had a core group of experienced care staff who had worked hard across the pandemic to try to offer continuity of care to people.

Preventing and controlling infection
● The provider was preventing visitors from catching and spreading infections and promoting safety through the layout and hygiene practices of the premises. Staff were using personal protective equipment (PPE) effectively and safely.
● Testing for people using and visiting the service and for staff was in place. Staff vaccination was being kept under review and was on target to ensure all staff were vaccinated against COVID-19.
● We discussed areas of the home that required upgrade such as carpets, walls and furnishings. The provider had a plan to improve the home to address these areas and sent this to us after the inspection.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- The provider failed to ensure the service was well-led and people were at risk of not receiving proper and safe care. The provider's quality assurance systems and audits were ineffective and there had been a lack of provider oversight. There were no formal systems in place to monitor the managers practice or the day to day management of the home. There were no systems in place for other staff to use in the absence of the manager and this had led to important procedures not being followed and standards that went unchecked, such as reporting of CQC notifications.
- Since 2018 over three consecutive inspections there had been repeated shortfalls and breaches that we found again on this inspections in areas of medicines management, risk management and good governance.
- Staff were not clear on their job role and responsibilities. The high use of agency staff, and unclear lines of accountability and leadership had led to poor communications and poor outcomes for people.
- People were at risk of harm because their safety and welfare had not been adequately assessed. We found examples where people had not achieved good outcomes because staff lacked the knowledge and skills to be able to identify how to keep people safe.
- The provider had not ensured nation best practice guidelines and legal requirements were implemented in the home. This included NICE guidelines in oral care, falls management and MCA 2005 requirements.
- The service did not always work in partnership with others. We saw times when referrals should have been made, which had not been done in a timely manner. Advice from professionals was not always followed. For example, when people had been losing weight or were at risk of choking.
- Systems for learning from incidents, accidents and near misses had not been adequately implemented. Staff could not demonstrate whether they had reviewed what could be learnt from incidents and events to reduce re-occurrences.
- The provider's systems to manage safeguarding incidents were ineffective. The provider had failed to notify CQC and local commissioners about recent incidents that had occurred. This meant that CQC could not undertake its regulatory function effectively. We could not be assured the provider understood the duty of candour and their responsibility to be open and honest when something went wrong.

This was a potential breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

Systems were not robust enough to demonstrate safety and quality was effectively monitored and managed. Records with regards to care and treatment and the management of the regulated activity were not accurate or kept up to date. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider was engaging and working in partnership with the local commissioning teams in developing an improvement plan for the service. This included introducing an effective quality assurance system with staff skilled and trained to deliver a programme of improvement.
● The new interim manager had, within a short space of time, helped to support staff and provide clear and effective leadership. Staff told us they welcomed the support and structure. One staff member said, "Its onwards and upwards now." Another said, "We are puling together better as a team to get back to the glory days."
● Daily 'Flash' meetings had been introduced with staff representatives from all departments, including housekeeping. Staff were motivated and eager to offer to take on additional champion roles and provide a better service to people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had failed to ensure people were receiving care that met their individual needs. Care plans were not consistent, accurate or kept up to date to give staff the instructions they needed to provide person-centred care. Some blanket decisions were in place as people's capacity to consent and make decisions was not carried out in line with Mental Capacity Act guidelines.
● The provider had failed to promote a positive culture that was person-centred, open, inclusive and empowering. Staff supervisions and meetings had not taken place for several months. Staff did not feel able to speak up or have their say on matters of running the home. Some staff told us of a bullying culture.
● There had been no surveys or questionnaires in the past twelve months to seek feedback from relatives, people in the home or other stake holders. Staff and relatives reported a lack of communication and information from the provider regarding significant events in the home.
● Staff morale was low, and they told us they felt stressed, unsettled and did not feel valued by the provider. A number of staff members told us they had worked in the home for many years and had not had any recognition from the provider for this loyalty. One staff told us, "A lot of us would have left before but we feel very attached to our residents and don't want to let them down." We reported this to the provider who was looking to develop a staff retention programme.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were either not in place or robust enough to demonstrate compliance with the Mental Capacity Act (MCA). The provider failed to ensure people's care and treatment was in line with principles outlined within the and associated Deprivation of Liberty Safeguards. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding processes were either not in place or robust enough to demonstrate people were protected from the risk of abuse. The provider had failed to regularly monitor and review the approach to, and use of, restraint and restrictive practice. Regulation 13 (1) (2) (3) (4)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably competent, skilled and experienced staff were deployed. Regulation 18 (1) (2)(a)