HICA

The Hollies - Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Hollies – Care Home is a residential care home. The service offers accommodation and personal care to people aged 65 and over and people living with dementia. At the time of the inspection, 37 people were using the service.

People's experience of using this service and what we found
Risks to people's safety and wellbeing were not always assessed, effectively managed or reviewed following incidents. Advice and guidance were not always sought from relevant professionals where concerns were identified around people's medicines or further instruction was needed to support the safe administration of medicines.

Records relating to recruitment were not always appropriately completed. Induction processes were in place to ensure staff had the skills and knowledge required for their role, but records were not always in place.

Staff ensured people lived in a clean and tidy environment. Infection prevention and control (IPC) practices had been updated to follow government guidance. However, on one occasion isolation processes were not implemented in a timely manner.

Quality assurance systems were in place but had not identified or addressed all the shortfalls found during the inspection which placed people at risk of receiving a poor-quality service. The management team monitored accidents and incidents, but analysis was not always completed which made it difficult to learn from identifying patterns and trends.

Staffing levels were appropriate to meet people's needs and staff were deployed to ensure they monitored communal areas for people's safety. Staff were trained in safeguarding and appropriate referrals had been made to the local authority.

Staff were kind and caring and people's relatives provided positive feedback. Staff were positive about the impact the manager had on the service in a short space of time.

People 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 policies and systems in the service supported this practice.

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published11 July 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 02, 07 and 08 May 2019. 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 safe care and treatment and governance systems.

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 and Well-led which contain those requirements.

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 ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed and remains requires improvement. 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 – Care Home 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 monitor the service.

We have identified breaches in relation to risk management, medicines and quality assurance at this inspection.

Please see the action we have told the provider to take at the end of this report. 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Hollies - Care 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 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 first day of inspection was carried out by two inspectors. The second day of inspection was carried out by one inspector.

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

The service did not have a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at information sent to us since the last inspection, such as notifications about accidents and safeguarding alerts. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.
We contacted the local authority and Healthwatch for feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 members of staff including the operations & compliance manager, the manager and a manager from another of the provider's services. We also spoke with four team leaders and three care staff. We observed staff interactions with people using the service and spoke with four relatives.

We looked around the home to review the facilities available for people and the infection prevention and control procedures in place. We also looked at a range of documentation including care files and daily records for five people and medication administration records for four people. We looked at four staff recruitment files and reviewed documentation relating to the management and running of the service such as staff rotas and training.

After the inspection
We reviewed the provider's governance records and action plans.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to effectively assess and mitigate risk to people. 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

• Risks to people's safety and wellbeing were not always effectively managed. For example, one person was at risk of falls and required appropriate clothing, footwear and glasses to maintain their safety. However, we observed them walking without their glasses and no laces in their shoes.
• Risks were not always reviewed following incidents. One person had absconded from the service on two occasions. However, there was no risk assessment in place to show how this risk would be managed to prevent it happening again.
• People's needs were assessed prior to people moving to the service. However, care plans did not always contain appropriate risk assessments or guidance for staff to manage the risks. For example, one person's assessment identified they had talked about ending their life, but no risk assessment had been completed to ensure the environment would be safe for them.
• Staff supported people to change their position to protect people's skin from developing pressure sores. Though records did not always show this was completed at the required times.

We found no evidence that people had been harmed. However, risks were not effectively managed which people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded immediately during and after the inspection. They confirmed all care plans and risk assessments would be reviewed to ensure they contained appropriate information.

• Behavioural support plans were person-centred and guided staff to reduce people's distress or anxiety.
• The provider maintained the safety of the building and equipment through regular checks, servicing and maintenance.

Using medicines safely

At our last inspection the provider had failed to operate safe medication systems. 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

• Records did not always show concerns around people's medicines were addressed with relevant healthcare professionals. We found one person was regularly not taking their medicine due to being asleep. Records did not show staff had raised the issue with the GP to discuss changing the time the medicine needed to be administered.
• The provider's policy had not been followed regarding the administration of covert medicines. For example, one person's medicine care plan did not guide staff what food or drink should be used when covertly administering their medicine. There was also no record the pharmacist has been contacted for advice and guidance around this.
• Staff were knowledgeable how to administer people's 'as and when required' medicines. Protocols were in place to guide staff, though they were not always detailed enough to ensure staff administered the medicines consistently.
• Temperatures of the medicine fridge were not always taken, and records did not show action had been taken to ensure medicines were still safe to administer when they were outside of the acceptable range.

We found no evidence that people had been harmed. However, the failure to ensure the safe management of medicines placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider's recruitment procedures promoted the safe recruitment of staff. Though records were not always fully completed and did not show shortfalls found in job applications had been followed up during interviews.
• Induction and training processes were in place to ensure staff had appropriate skills and knowledge for their role. However, induction records were not always in place and competency assessment records were not always detailed.
• Staffing levels were appropriate to meet people's needs. The manager monitored and adjusted staffing levels when required and deployed staff to ensure they were always present in communal areas to promote people's safety.

Systems and processes to safeguard people from the risk of abuse
• Staff were trained in safeguarding and followed processes to report concerns.
• Safeguarding referrals had been submitted and the senior management team monitored referrals made by the service.

Preventing and controlling infection
• We were somewhat assured that the provider was admitting people safely to the service. Processes were in place to isolate people new to the service and people returning from hospital stays. However, we found on one occasion isolation processes had not been implemented for a person following their stay in hospital.
• We were somewhat assured that the provider was using PPE effectively and safely. PPE was not always stored appropriately.
• 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 accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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

Learning lessons when things go wrong
• Accidents and incidents had been responded to appropriately. Monitoring systems were in place to support learning and reduce the risk of them happening again.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider had failed to operate effective systems to improve the quality and safety of the service and to keep accurate and complete records. 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

• Following the last inspection, the provider had failed to take the necessary action to improve the safety and quality of the service.
• Quality assurance systems were in place but had not identified or addressed all the shortfalls found during the inspection. These included risk management, medicines and recruitment records.
• The provider was working to address shortfalls in the service. Audits showed some improvements had been made, but further improvements were required. Following audits, action plans were implemented and monitored by the senior management team.
• Accidents and incidents were monitored though data was not always correctly recorded, and analysis was not always completed which made it difficult to accurately analyse information and identify patterns and trends.

The failure to operate effective systems to improve the quality and safety of the service and to keep accurate and complete records placed people at risk of receiving a poor-quality service. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider's systems had not ensured all notifiable incidents were reported to CQC. The manager understood their legal responsibility to notify CQC about incidents that affected people's safety and welfare. Incidents had been appropriately managed and referred to relevant organisations. However, we found several incidents had not been reported to CQC from before the manager started working at the service.

These related to allegations of abuse.

This was a breach of regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of the inspection process in relation to this matter.

• The service was being managed by the senior management team and a deputy manager as there was no registered manager in place. During the inspection, the provider appointed the deputy manager to be the manager of the service and they started the process to register.
• Processes were in place to support learning across the provider's services. Key themes and topics were discussed during regular meetings with management teams from the provider's other services.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
• Staff did not always feel valued and this impacted on morale. Staff told us, "We're an afterthought" and "One thing that could be improved on is more positive comments or praises to the staff, as the job can be difficult at times and it would help boost staff morale."
• Since being in post, staff were positive about the support offered by the current manager and changes made in a short space of time. A staff member said, "Our manager recently left, and our new manager, who has only been here for a month, has had a major impact on the home, and improving it in the short time she has been here. She seems very supportive of all the staff and the residents."
• Staff were kind and caring and supported people to achieve good outcomes. A relative told us, "I've always had praise for the staff over the years. I don't have anything but good to say about them. [Person's name] has been with them for a number of years and the reason they're still here is because of them, it's about how well they are looking after them."
• Advice and guidance were not always sought from healthcare professionals which risked compromising people's wellbeing. On two occasions advice was not sought in relation to people's medicines.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Systems were in place to gather feedback from people, their relatives and staff. Some feedback had been sought from staff and people's relatives. The senior management team acknowledged they had not fully used these systems due to the COVID-19 pandemic.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to effectively manage risks to people's safety and wellbeing and had failed to ensure the safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to operate effective systems to improve the quality and safety of the service.