Hollybank House (Derby) Ltd

Hollybank House

Inspection report

Chesterfield Road
Oakerthorpe
Alfreton
Derbyshire
DE55 7LP

Tel: 01773831791

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7 and 12 September 2017. The first day of our inspection visit was unannounced. Hollybank House was last inspected in May 2016 and was rated as Requires Improvement. Following our inspection the provider sent us a plan to show what action they were taking to rectify the breach. On this inspection, we found that improvements had been made, and the service now met all requirements of the relevant regulation.

Hollybank House provides personal and nursing care for up to 45 people. At the time of our inspection, there were 36 people living there.

The service had a registered manager at the time of our inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider was not consistently meeting the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS). The provider could not demonstrate the relatives had the correct legal authority to consent on behalf of people who lacked capacity to consent to their care. People and their relatives confirmed that staff sought permission before offering personal care. Appropriate arrangements were in place to assess whether people were able to consent to their care.

Systems were in place to monitor the quality of the service provided and ensure people received safe and effective care. However, the systems had not identified several issues in relation to checks on pressure-relieving mattresses, record keeping for topical medicines, and record keeping for people's fluid intake. The registered manager took immediate action to address this. There was an open and inclusive culture within the service, and staff had clear guidance on the standards of care expected of them.

People felt safe, and were protected from the risk of abuse and avoidable harm. People's care needs were assessed and recorded, and risks associated with their health needs identified. Risk assessments and care plans set out what staff should do to reduce the risk of avoidable harm. Accidents and incidents were monitored and reviewed, and action taken to reduce the risk of harm occurring.

People were happy with staff who provided their personal care. They were cared for by sufficient numbers of staff who were suitably skilled, experienced and knowledgeable about people's needs. Staff had guidance about how to meet people's individual needs. Care plans were regularly reviewed and updated to meet people's changing needs and preferences.

The provider ensured potential staff were suitable to work with people needing care. Staff received supervision and had training in a range of skills the provider felt necessary to meet the needs of people living at the service.

People had medicines available when they needed them and in accordance with prescribing instructions. Staff worked in cooperation with health and social care professionals to ensure that people received appropriate healthcare and treatment in a timely manner.

People felt cared for by staff who treated them with dignity, respect, and kindness. The support people received was tailored to meet their individual needs, but records did not demonstrate how people were involved in reviewing their care. People, relatives and staff felt able to raise concerns or suggestions in relation to the quality of care. The provider had a complaints procedure to ensure that issues with quality of care were addressed. The provider also sought people and relatives' views in order to take action to improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse and avoidable harm. Risks associated with care were identified and assessed. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA). People were supported by staff who were trained and experienced to provide their personal and nursing care. People were supported to have sufficient food and drink, and to access health services when needed.

Is the service caring?

Good

The service was caring.

People were treated with care, dignity and respect by staff who knew them well. Staff understood and demonstrated the importance of promoting independence and treating people with dignity. People and their families were supported to express their views about their future care towards the end of their lives, and staff knew how to support people and their relatives in the way they wanted.

Is the service responsive?

Good

The service was responsive.

People and their relatives' views on care was sought. People knew how to raise concerns or make complaints, and were confident this would lead to improvements in their service.

Is the service well-led?

Good

The service was well-led.

The provider had systems to monitor and review all aspects of the service, but these did not always identify areas where action

needed to be taken. People and relatives felt the service was managed well. People, relatives and staff felt able to make suggestions to improve the service, and raise concerns if necessary.

Hollybank House

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 12 September 2017. The first day of our inspection visit was unannounced. The inspection visit was carried out by one inspector and a specialist advisor with experience in providing nursing for older people, and people with dementia. The second day of our inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. This was returned to us by the service.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We also sought the views of the local authority and health commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

During the inspection we spoke with six people who used the service, and three relatives. We spoke with nine staff and the registered manager. We also sought the views of external health and social care staff. We looked at a range of records related to how the service was managed. These included eight people's care records (including five of these people's medicine administration records), three staff recruitment and training files, and the provider's quality auditing system.

Not all of the people living at the service were able to fully express their views about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

On our last inspection at Hollybank House we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found care and treatment was not being provided in a safe way because the provider was not consistently assessing risks, and action was not consistently taken to mitigate risks. Following our inspection the provider sent us a plan to show what action they were taking to rectify the breach. On this inspection, we found that improvements had been made, and the service now met all requirements of the relevant regulation.

People told us they felt safe living at Hollybank House. Relatives felt their family members were cared for safely. Staff had knowledge of risks and demonstrated they understood how to keep people safe from the risk of avoidable harm. Risk assessments were tailored to people's individual needs. They detailed what people and staff needed to do to ensure people received safe care. Risk assessments were reviewed regularly and updated to ensure staff had up to date information to keep people safe. People were protected from the risk of avoidable harm.

The provider ensured risks associated with the service environment were assessed and steps taken to minimise risks. Staff and records confirmed this was the case. For example, access doors to the kitchens and laundry were kept locked. This meant people were kept safe from hazards associated with cooking and cleaning activities.

People were kept safe from the risk of potential abuse. They felt safe, and people and their relatives felt able to tell staff about any concerns. Staff knew how to identify people at risk and were confident to recognise and report concerns about abuse or suspected abuse. They also knew how to contact the local authority or the Care Quality Commission (CQC) with concerns if this was needed. The provider had policies on safeguarding people from the risk of abuse, and staff knew how to follow this. Staff received training in safeguarding people from the risk of avoidable harm and this was supported by training records. This ensured people were kept safe from the risks associated with unsafe care.

Accidents and incidents were reviewed and monitored to identify trends and to prevent reoccurrences. We saw documentation to support this, and saw where action had been taken to minimise the risk of future accidents. This meant risks were identified and appropriately managed to reduce the risk of harm to people.

People, relatives, and staff felt there were enough staff and our observations on inspection supported this. Staff responded to people's need for care in a timely manner throughout our inspection. The provider regularly reviewed people's care needs and adjusted staffing levels to ensure people received the support they needed. There were enough staff to provide the personal and nursing care people needed.

People's files contained emergency information and contact details for key people in their lives. Staff knew what to do in the event of an emergency, and the provider had a business contingency plan in place. This meant people would be supported safely in ways that suited them if there was an emergency.

Staff told us, and records showed the provider undertook pre-employment checks, to help ensure prospective staff were suitable to care for people living at Hollybank House. This included obtaining employment and character references, and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. All staff had a probationary period before being employed permanently. This helped reassure people and their relatives that staff were of good character and were fit to carry out their work.

People felt staff supported them to manage their medicines safely. One person described how staff supported them with their medicines, and said staff did checks to make sure their medicines were given correctly. Relatives felt their family members received medicines as prescribed. Staff told us and records showed they received training to ensure they managed medicines safely. Staff knew what action to take if they identified a medicines error. There were checks in place to ensure any issues were identified and action taken as a result. Guidance for "as required" medicines was not consistently available for staff. We spoke with the registered manager about this, and action was taken immediately to rectify this. Medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation. This meant people received their medicines as prescribed.

Good

Is the service effective?

Our findings

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA), and people were at risk of not having their rights respected in this regard. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

Where people lacked capacity to make certain decisions, the provider did not consistently follow the principles of the MCA to ensure best interest decisions were made lawfully. For example, two people's relatives had signed consent forms for care and treatment on their behalf. The provider could not demonstrate the relatives had the correct legal authority to consent on behalf of people. We spoke with the registered manager, and they took action to rectify this during the inspection. People and their relatives confirmed that staff sought permission before offering care. Staff understood the principles of the MCA, including how to support people to make their own decisions. Where people had capacity to consent to their personal care, this was documented. Because provider could not demonstrate relatives had the legal authority to consent on behalf of people, this meant people were at risk of not having their rights upheld in relation to consent to care.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to provide restrictive care that amounts to a deprivation of liberty. The provider had assessed people as being at risk of being deprived of their liberty and had made applications to the relevant Supervisory Bodies appropriately for a number of people. People who were deprived of their liberty had access to Independent Mental Capacity Advocates (IMCAs). People deprived of their liberty also had a Relevant Persons Representative (RPR). IMCAs and RPRs ensure people have support to exercise their rights in relation to the MCA and DoLS.

People were supported by staff who were trained and experienced to provide personal and nursing care. One person said, "Staff know how I like to be supported. I get help with bathing and medicines. Staff know what they're doing." Relatives spoke positively about the quality of care staff provided for their family members. One relative said the skills and attitude of staff had improved their family member's quality of life. They said, for example, staff ensured that the right approach combined with the correct equipment meant their family member felt confident when bathing again.

All staff had a probationary period before being employed permanently. Staff told us they felt their induction gave them the skills to be able to meet people's needs. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of nationally agreed care standards linked to values and

behaviours that unregulated health and social care workers should adhere to. The provider had an induction for new staff which included training, shadowing experienced colleagues, being introduced to the people they would be caring for, and skills checks.

Staff undertook training in a range of areas the provider considered essential, including safeguarding, medicines, nutrition, falls prevention and caring for people with dementia. Staff also confirmed they could ask for additional training. Nursing staff had access to revalidation with the Nursing and Midwifery Council (NMC). This process ensures nurses maintain their nursing practice and keep up to date with skills training. They must undertake a specified number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse. The provider and registered manager had monitored what training staff needed, and ensured staff undertook training the provider deemed essential. This meant people were supported by staff who had the skills and experience to provide them with the individual support they needed.

Staff told us and evidence showed they kept daily records of key events relating to people's care. Information about people's care was recorded and staff shared key information with colleagues throughout the day and at shift handover. The provider held meetings for staff to discuss information relating to people's care. Staff also had individual meetings with their supervisor to discuss their work performance, training and development. This was in accordance with the provider's policy, and records confirmed supervision meetings took place. This meant that staff knew what action was needed to ensure people received care they needed.

People said they liked the food and were offered choices. We noted there was only one choice for meals written on the menu board, but people and staff confirmed other choices were offered for each meal. People were offered regular drinks and snacks throughout the day. People who needed adapted cutlery and equipment to enable them to eat and drink independently were given these. People who were at risk of not having enough food or drinks were assessed and monitored, and advice sought from external health professionals. Guidance about people's individual needs was available to all staff, including catering staff. Staff knew who needed additional support to eat or had special diets, for example, fortified diets or appropriately textured food and thickened drinks. People were supported to have sufficient to eat and drink.

People told us they were supported to access services when needed to maintain their health. One person told us about their recent GP appointments and other routine health checks. They said, "I always get help if I feel poorly – I don't panic as I know staff help me quickly." Evidence from staff and records supported this. Staff told us, and healthcare professionals confirmed people had access to external health services when needed. Healthcare professionals felt confident their instructions or guidance for people's health needs would be followed by staff. Care plans identified what people's health needs were and how staff should support them. Staff kept contemporaneous notes regarding any health concerns and action taken. Records confirmed people were supported to access a range of health and social care professionals, and any actions arising from appointments were followed up. This enabled staff to monitor people's health and ensure they accessed health and social care services when required.

Good

Is the service caring?

Our findings

People felt supported by staff who provided care in a dignified and compassionate way. One person said, "This is my home, and I'm pleased to call it my home. The staff are lovely." Relatives all spoke positively about the caring approach staff had towards their family members. One relative said, "[My family member] feels staff are outstanding. They are very attentive and caring. Staff are always so welcoming to family." Another relative said, "The care is great. Staff are super and kind." Relatives also described how staff took a "whole family" approach, in providing care to people whilst also supporting their relatives. We saw written feedback submitted by relatives and other visitors that was positive about the way staff provided care.

During our inspection, staff supported people in a caring, friendly and respectful way. Staff knew people well, calling them by their preferred names, and were knowledgeable about people's preferences. They ensured people were comfortable and took time to explain what was happening around them in a patient and reassuring manner. Staff spent time with people who appeared anxious or agitated, and we saw this had positive effects. We saw the provider had a "resident of the day" where staff spent extra time with a different person each day. Staff told us and evidence showed the purpose of this was to offer people (in turn) the opportunity to talk about their care needs and wishes, and to develop their relationship with each person.

People felt that staff supported them to remain as independent as they could be. One person said, "I can wash some of myself, but the girls [staff] do the rest. I can get dressed myself, but need help to manage my medicine." People's care records detailed what they could do for themselves, and what they needed support with, so the provider ensured people were supported to remain as independent as possible.

People were supported with their medicines and care needs in a dignified way. One person said, "I'm definitely treated with dignity. For example, if I have an accident, staff are discreet and private – there's no drama." Staff understood how to support people in ways that maintained their dignity. For example, by ensuring doors and curtains were closed when providing personal care and ensuring people were clothed in ways that maintained their dignity. During our inspection we saw staff demonstrate that they provided care in ways that protected people's dignity and privacy. The provider had been awarded the dignity award from the local authority for ensuring people's dignity in care at the service. This award is linked with the government's national dignity in care campaign. This meant people's dignity was central to staff values, and staff provided care in ways that upheld this.

Staff respected people's right to confidentiality, but were also clear when it was appropriate to share information about risk or concerns. We saw staff did not discuss people's personal matters in front of others, and where necessary, had conversations about care discreetly or in private. Records relating to people's care were stored securely. People's confidentiality was respected.
People were supported to spend private time with their friends and family if they wished. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting times. This showed people's right to private and family lives were respected.

People and their relatives were involved in discussions about their wishes regarding care towards the end of their lives. This included where people would like to be at the end of their lives, whether they would like to receive medical treatment if they became unwell, and in what circumstances. One person spoke with us about their advance care plan, and was clear they were in control of making decisions about their end of life care when the time came. A relative spoke with us about the support they and their family member got at this time, and praised staff for their sensitive and compassionate care. People had advance care plans in place which included, where appropriate, clear records of their wishes about resuscitation. Where people were able to make this decision for themselves, this was documented. Where people could not, evidence showed external medical professionals had followed the Mental Capacity Act 2005, and a best interest decision had been made. Staff received additional training to ensure they knew how to support people at the end of life. The provider demonstrated that arrangements for people's end of life care met the five priorities for care, which are nationally recognised best practice, and had been awarded the local authority's quality award for end of life care. This meant people were supported to express their views about their future care towards the end of their lives, and staff knew how to support people and their relatives in the way they wanted.

Good

Is the service responsive?

Our findings

People and relatives told us they were involved in discussing and reviewing care plans. One person said, "My care plan is in the office and is updated regularly. Staff make notes about things that are important to me, and I'm involved." A relative commented, "They [staff] try to involve me in all decisions." Staff confirmed they did speak with people and their relatives about care, but we found this involvement was not always recorded. We spoke with the registered manager and deputy manager about this. They confirmed these discussions were not consistently documented, and said they would take action to improve this. This meant that although people's care plans were reviewed to ensure they met current needs, there was a risk people's views and wishes were not taken into account and documented.

People were supported to maintain their interests and hobbies. One person told us, "I've made friends here. I do activities like crafts, skittles and play dominoes, and I like them all." Staff were knowledgeable about people's individual care needs and preferences. They also demonstrated they knew about people's life histories and what was important to them. For example, one person played the piano and organ, and staff encouraged them to continue this at Hollybank House. Staff told us, and records confirmed that it was important to the person for staff to recognise and respect their past experiences. The provider employed an activity coordinator, who offered a range of group and individual activities to suit people's interests. They told us, and we saw, that all staff were encouraged to support people taking part in activities throughout the day. This meant people were supported to remain active and participate in activities that were meaningful to them.

People's care and activity plans contained information about their likes and dislikes, hobbies and friendships, and key information about life events. Where it was not possible to obtain this information from people directly, staff asked relatives to provide information they felt was important about people's lifestyle choices. People told us and we saw their choices for staff gender were met by the provider. This meant, particularly where staff supported people with intimate personal care, people were supported by staff they were comfortable with.

People and relatives told us they had opportunities to provide feedback on the quality of their care. For example, in regular meetings for people and relatives, and talking with the registered manager. The registered manager had an "open door" policy, and throughout the inspection, we saw people, relatives and staff frequently discussing care with them. The provider also shared information on what was happening in the service, any feedback they had received and what actions they planned to take to improve the service. This was done through a regular newsletter, and in the minutes of meetings. This demonstrated the provider listened to people's views and suggestions to improve the quality of care and took action.

People and their relatives felt any issues or complaints would be handled appropriately by the provider. They felt able to raise concerns and knew how to make a complaint. One person said, "If there's anything wrong I'll say so, and it gets sorted." There was information around the service about how to make a complaint. The provider had a complaints policy and procedure in place, which recorded the nature of the complaint, what action was taken and who had responsibility for this. The provider reviewed complaints on

a regular basis to see whether there were any themes they needed to take action to improve. This meant the provider had a responsive system to resolve concerns and complaints.

Good

Is the service well-led?

Our findings

There were systems in place to monitor and review the quality of the service. The registered manager and provider carried out checks of the quality and safety of people's care. However, these did not consistently identify issues where action needed to be taken. For example, we found two pressure mattresses which were not set at the correct pressure for people's weight. Staff confirmed there were no regular checks to ensure the mattresses were at the right setting. We identified that staff were not consistently recording people's fluid intake, where it was identified this was a necessary part of their care. Staff confirmed this had been raised in a recent meeting as an issue. We also identified that record keeping for people's prescribed topical medicines were not consistently completed. The registered manager took immediate action to rectify these issues, including implementing checks to ensure staff were doing what was required of them. This meant the systems in place to check on the quality of care did not always identify issues that could place people at risk of harm.

People and relatives felt the service was managed well and spoke positively about staff and the registered manager. One relative said, "I cannot fault the care here." Another relative commented, "Everyone is dedicated to ensuring residents receive the best care." Staff spoke positively about their work and the support they received from the provider and from each other.

Staff understood their roles and responsibilities, and demonstrated they were trained and supported to provide care that was in accordance with the provider's statement of purpose. A statement of purpose (SOP) is a legally required document that includes a standard set of information about a provider's service, including the provider's aims, objectives and values in providing the service. During our inspection, staff were open and helpful, and demonstrated consistent knowledge of people's needs.

People, relatives and staff felt able to make suggestions to improve the service, and raise concerns if necessary. The provider also sought people and relatives' views about the service, responded to comments and complaints, and investigated where care had been below the standards expected. This assured us people, relatives and staff were able to make suggestions and raise concerns about care, and the provider listened and acted on them.

The provider appropriately notified CQC of any significant events as they are legally required to do. They had also notified other relevant agencies of incidents and events when required. The registered manager understood their duties and responsibilities with respect to providing personal and nursing care, and felt supported by the provider in their role.

The provider had policies and procedures which set out what was expected of staff when supporting people. The provider's whistleblowing policy supported staff to question practice and raise concerns regarding the practice of others. Staff said if they had concerns they would report them and felt confident the registered manager would take appropriate action. This demonstrated an open and inclusive culture within the service, and staff had clear guidance on the standards of care expected of them.

The provider undertook essential monitoring, maintenance and upgrading of the home environment. For example, since our last inspection in May 2016, a programme of refurbishment had begun to redecorate people's rooms, replace furniture, and replace flooring throughout the building as part of the provider's ongoing maintenance of the building.

The provider took timely action to protect people from the risk of avoidable harm and had ensured they received necessary care, support, or treatment from external health professionals. They also monitored and reviewed accidents and incidents. This allowed them to identify trends and take appropriate action to minimise the risk of reoccurrence. The service had established effective links with local health and social care organisations and worked in partnership with other professionals to ensure people had the care and support they needed.