Mrs Dorothy Woodcock

The Hollins Residential Care Home

Inspection report

260 Congleton Road, Butt-Lane
Talke
Stoke On Trent
Staffordshire
ST7 1LW

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08 December 2015

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 December 2015. The provider was given 24 hours' notice because the service was a small care home supporting one person. The person and provider are often out during the day; we needed to be sure that someone would be in.

Our last inspection took place in April 2013 and at that time we found that the provider was meeting the regulations that we inspected against.

The Hollins Residential care Home is registered to provide accommodation and personal care for up to two people who may have a learning disability. At the time of our inspection, one person was using the service.

The provider is registered with us as a single provider and therefore there is no requirement for a registered manager. The service is managed by the provider.

The person who used the service felt safe and the provider recognised some situations that could be considered abusive. However, the provider and staff member were unaware of local safeguarding adult's procedures which meant there was a risk that safeguarding concerns could go unreported.

People's risks were not always assessed and managed individually to promote people's safety and wellbeing. The provider said they completed risk assessments daily however this was not documented so there was a risk that people were not supported safely and consistently.

The person who used the service told us they had their medicines when they needed them and we saw that medicines were stored safely. There were enough staff to safely meet the person's needs.

The person was supported and encouraged to make decisions about their care. However, the provider and staff member were unaware of their legal responsibilities under the Mental Capacity Act 2005 which meant that the person's legal and human rights may not have been upheld.

We observed that staff had the skills to support people effectively. However, the provider and staff member had not been trained to support the person in line with best practice.

People had enough to eat and drink and were offered choice and flexibility about their food and drinks. They were encouraged to stay healthy and had access to health professionals when they needed them.

People were treated with kindness and compassion by staff who knew them well. People's privacy was respected and they were encouraged to be independent and participate in the running of the home and the local community.

People received care that met their preferences and they were enabled to follow their interests. The person

felt able to approach the provider with any issues or concerns.

There was a homely and relaxed atmosphere at the home and the person was treated as part of a family.

The provider acted upon issues as and when they arose, however there was no formal recording of this. The provider was unaware of the requirements of registration with us.

There were no daily records or recording of medication administered to the person who used the service. There were no records in relation to staff employed at the service. This meant there was a risk that the person may receive inconsistent or unsafe care if the provider were unavailable.

These issues resulted in a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

The person felt safe; however the provider and staff did not understand safeguarding adult's procedures or recognise when these were needed. Risks were not always assessed to ensure that people received safe and consistent support. The person told us they had their medicines as they needed them and there were enough staff to meet the person's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We observed that staff had the skills to support people, however they did not have the knowledge to ensure that people's legal and human rights were always respected. The person was supported to make their own choices and have enough to eat and drink. Healthcare needs were monitored and access to professionals was arranged when required.

Is the service caring?

Good

The service was caring.

The person was supported by staff who were kind and compassionate and knew their needs very well. The person was involved in planning their own care and their privacy and dignity was respected and promoted

Is the service responsive?

Good

The service was responsive.

The person received care that was individual to them and their routines were flexible to meet their needs and preferences. The person was encouraged to pursue hobbies and interests and have access to the local community. The person felt able to raise any issues or concerns to the provider.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider was not aware of their requirements of registration with us. Systems and processes were not in place to ensure that the quality and safety of care was monitored. There was a homely atmosphere and the person was treated as part of a family. Issues were dealt with as they arose though this was not formally documented.

The Hollins Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 December 2015 and was announced. The provider was given 24 hours' notice because the service was a small care home supporting one person. The person and provider are often out during the day; we needed to be sure that someone would be in.

The inspection team consisted of one inspector.

We reviewed information we held about the service and contacted commissioners for their views on the support provided to people. Commissioners are people who work to find appropriate care and support services which are paid for by the funding authorities.

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. They did not return a PIR and we took this into account when we made the judgements in this report.

We spoke with the one person who used the service, the registered provider and the one member of staff. We did this to get their views about the care and check that standards of care were being met. We looked at the person's care records to see if they were accurate and up to date.

Requires Improvement

Is the service safe?

Our findings

The person who used the service told us they felt safe. They said, "I'm safe because I like it here." They said they would go to the provider if they felt unsafe. The provider was able to give some examples of situations which could be considered abusive and would give cause for concern. They described how they would support the person to see a doctor if they had concerns. However they were not aware of all the types of abuse or their responsibilities under safeguarding adult's procedures. The agreed local authority safeguarding procedure is that staff should immediately report safeguarding concerns and incidents to them, so they can consider if any action is required to manage or minimise further incidents from occurring. The staff member and provider were not aware that any concerns should be reported to the local authority. The provider did not have systems and processes in place to ensure that concerns were reported immediately. This meant there was a risk that safeguarding concerns were not always identified and could go unreported.

Risks were not always assessed and monitored to keep people safe and promote their freedom. We found that some risks were assessed, for example, the person who used the service told us, "I use this mat in the bath so that I don't slip." The provider told us that they visually assessed the environment every day to ensure it was free from hazards, which they were able to do because the service was small with only one person being supported. However, staff and the provider told us that the person would, on occasion, give people information which was false because of their lack of understanding of a situation. This had not been risk assessed in order to keep the person safe. The person told us they had fallen and the provider said this had not happened. The provider said they did not keep records of accidents or incidents so we could not check whether an incident had occurred or if the information had been used to inform a risk assessment. There was a risk that the person may not be taken seriously when incidents or accidents did occur.

The person who used the service told us they always had their medicines when they needed them. They said, "I take tablets with my breakfast and before bed, [the provider] helps me." We saw that medicines were kept in a locked cabinet to protect the person from the risks associated with them. The person who used the service said, "If I have a pain, I tell [the provider] and they give me something for it." The provider told us that they were only person who would administer medication. For this reason, they said they did not need to keep a record of administration as they were the only person responsible for administering the medication to the one person who used the service. There was no contingency plan in place in case of the provider's absence which meant there was a risk that the person may not get their medicine as prescribed.

There were sufficient numbers of staff to keep people safe and meet their needs. The provider supplied one to one care to the person who used the service and employed another staff member to provide additional support when needed. The person told us that the provider was always available to support them and that they never had to wait for support.

Requires Improvement

Is the service effective?

Our findings

Staff understood the needs of the person who used the service and had the skills to provide them with care and support. The provider and the staff member gave us specific information relating to the care of the person who used the service and described how they provided care in line with their needs. We observed how staff supported the person and saw that staff demonstrated knowledge and skill when they interacted with them. However, the provider and staff member were unaware of important legislation and policy in protecting the legal and human rights of people who use services. Both the provider and staff confirmed that they had not completed any training in recent years. The staff member said that their induction involved learning about the storage of hazardous substances and fire regulations. The provider told us that no formal supervision was completed and they were able to discuss any issues informally at regular intervals as the service was small and allowed for this.

The person who used the service told us they made their own decisions and we saw that they were encouraged by staff and the provider to make their own choices. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The provider had not heard of the MCA and was therefore unaware of the legal requirements. However, we saw that the provider and staff member offered choices and promoted independent decision making, in line with the principles of the MCA even though they were unaware of the legal guidelines.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider was not aware of the DoLS. We saw that the person was supported in the least restrictive way possible and was supported to access the community and go on holidays. However, the provider told us that the person was not allowed out of the home grounds alone as this was unsafe. We asked if the person had the mental capacity to make the decision for themselves and the provider told us they did not but no mental capacity assessment had been completed. There was a risk that the person was being unlawfully restricted of their liberty as the provider was unaware and had therefore not followed the principles of the DoLS.

There was a flexible and relaxed approach to meal times. The person who used the service told us they liked the food and were supported to eat and drink adequate amounts. They told us they were offered choice and were actively involved in shopping and planning meals. They said, "I go shopping with [the provider] and I choose what to buy. I like trifle." We saw that snacks and drinks were offered regularly and people had access to the kitchen to help themselves to snacks and drinks. The person said, "I have two cups of tea or as many as I want. I drink lots of water because I get thirsty." The person was supported to eat and drink enough to maintain a balanced diet.

The person was supported to meet their healthcare needs and had access to healthcare professionals when

required. The person told us, "I kept having dizzy dos and I told [the provider]. They took me to the doctor and they gave me something for it." The provider told us and the person confirmed that they had regular access to other professionals including optician and dentist. The person recently had a period of support from a community learning disability nurse to help them understand their health conditions and the support they need. The nurse provided guidance to the provider about how to support the person to manage their health conditions and the provider told us they followed this.

Good

Is the service caring?

Our findings

We saw and the person who used the service told us they were treated with kindness and compassion. We saw that the provider and staff knew the person well and spoke fondly of them. The person said, "If I'm upset I tell [the provider] and they make me feel better." We observed that staff knew how to communicate with the person and spoke to them in a way they could understand. It was clear from our discussions with staff that they had a positive relationship with the person and recognised and valued them as an individual. The provider told us, "[Person who used the service] has achieved a lot since they came here and they are part of the family."

We saw that the person was involved in making decisions about their care and support. They were provided with support on a one to one basis which meant they were given the time and explanations they needed, when they needed it. The person told us, "I choose when I get up, sometimes I get up late and I have a wash and come downstairs." We saw that their routines were flexible and they were offered choices. For example, we saw that the provider asked the person how they would like to spend their evening and their choice was supported. The person told us they once attended a day centre but that they chose not to attend now because it was too noisy. They told us the provider respected their wishes and they now spend their time doing other things they enjoy. The person told us how they were supported to choose and buy the things they liked. The person said, "I chose a new pair of a shoes and a blouse to wear to the pantomime."

The person who used the service told us that their privacy was respected and promoted. The person said, "I've got my own bedroom and I can stop in there if I want to, it's ok with [the provider]." The provider told us that the person often chose to spend time in private and that this was respected. They said, "Whenever they want to they will just go up to their room and that's fine." The person was very proud to show us their bedroom which was decorated to their taste and contained their own belongings and photographs.

We saw that the person was supported to be as independent as possible and was involved in the running of the home. They told us, "We share, they do the hoovering and I do the dishes. I make my own bed." The provider told us that they supported and encouraged the person to do what they could for themselves. For example, they told us person would put their bread in the toaster and be involved in meal preparation as much as they could be.

Good

Is the service responsive?

Our findings

The person received care that was personal to them and met their needs and preferences. The person told us they were supported to follow their interests and access the community. They said, "I go out in the car or I go to bingo, I've got friends there." The provider and staff told us that the person was busy and enjoyed seeing their friends. They told us they were well known in the local community and liked to pursue their hobbies.

The person told us they had enjoyed a number of holidays, supported by the provider. They showed us photographs of their holidays, some of which were displayed in their bedroom and they told us they looked forward to and enjoyed them. They told us, "We're going away for a week when it's my birthday, I like going in the swimming pool." The provider told us they visited the same destination regularly and that the person kept some of their belongings there so that they felt familiar and at ease.

We saw and the person told us their daily routines were varied, dependent on their preferences and there was no expectation that a routine had to be followed. The person said, "When it's a nice day, I go to the park" and "Sometimes I like having a snooze on the sofa." The person told us and the provider confirmed that the person was supported to attend church services of their choice, though they chose not to attend all of the services available. The person said, "I go to Church, I'm a good singer." This empowered the person to have a voice in how their care was provided and enabled them to lead a life that was based on their choices and interests.

The person had a care plan that included life history information, their likes and dislikes. The person told us and we saw that the provider knew the person and their needs well. The provider told us how they supported the person in a specific way so that they were comfortable and so that their independence and dignity was maximised. For example, when having a bath, the provider described how the person preferred to be supported and how they facilitated this.

The person told us that they felt able to share their views with the provider on a daily basis. The service was very small and the person had daily contact with the provider. The person said, "I just ask [the provider] if I'm unhappy." The provider had not received any complaints.

Requires Improvement

Is the service well-led?

Our findings

The provider was not aware of the requirements of their registration with us. We had never received a notification from the service. A notification is information about important events which the provider is required to send us by law. We asked the provider why we had never received a notification and they told us they were unaware of which events they were required to inform us about.

There were no formal quality assurance and governance systems in place. The provider told us that any issues which may arise were dealt with immediately and communicated to the person who uses the service and the staff member. They told us this worked effectively because the service was small and changes could easily be made to improve the quality of the service as the provider delivered the majority of the care.

The provider did not keep complete and accurate records for the person who used the service. They kept records of appointments in a diary and the provider told us there was no reason for them to record how the person had spent their time or how they had presented that day because the provider would immediately act on this. For example, if the person was unwell and needed to see a doctor, this was arranged by the provider. The person told us they saw their doctor regularly. However, if the provider was unavailable or unable to provide support for any reason, there were no records to show what care had been delivered to the person to ensure the person received consistent care. Additionally, there were no records of what medication had been delivered to the person. Risks were not always assessed to ensure that the person was kept safe. The provider told us that they assessed risk daily but did not record this. This meant there was a risk that person could receive unsafe care that was not suitable to meet their needs.

The provider had not kept accurate records in relation to the staff member employed at the service. The provider told us that they had carried out a DBS check for the staff member. The DBS is a national agency that keeps records of criminal convictions. However, the provider was unable to evidence this. They told us they did not request any references for the staff member as they were a member of their family.

The provider and staff lacked knowledge in relation to safeguarding adults' procedures and the Mental Capacity Act 2005. This meant there was risk that concerns may go unreported and the person's human and legal rights may not be respected. For example, the provider told us that the person was unable to leave the grounds of the home for their own safety; however this decision was not recorded.

These issues amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider is registered with us as a single provider and therefore there is no requirement for a registered manager. The service is managed by the provider. The service is small and there was a positive culture that was open and centred around the person who used the service. The person who used the service told us, "I'm at home, this is my family." We observed that there was a homely and relaxed atmosphere and that the service was run like a small family unit. The provider told us that the person was treated as part of the family and was involved in all developments within the service that was run solely for them.

The person who used the service told us that they knew the provider well and would go to them with any issues or concerns. The person said, "I'd just tell [the provider] and they would help me."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems and processes in place in order to assess, monitor and improve the quality and safety of the service. They did not keep complete and accurate records for the person who used the service or the staff employed. They did not assess and monitor risk or ensure they were update with legislation and policy to keep the person safe. These issues amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.