Garforth Care Homes Ltd

The Hollies

Inspection report

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Garforth
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Date of inspection visit:
16 June 2021

Date of publication:
07 October 2021

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 is a residential care home providing personal care to people aged 65 and over, some of whom are living with dementia. At the time of the inspection there was 28 people using the service. The service can support up to 28 people.

People's experience of using this service and what we found
We found the staffing levels were not adequate. There were limited activities organised for people however, the service is in the process of recruiting an activity co-ordinator.

The service reported a high number of unwitnessed falls over the previous 12 months. We were not assured that systems were always in place to take action to reduce these. Equipment such as stair safety gates and handrails had been fitted to improve safety in the environment.
There was a lack of effective governance systems. We found some policies were out of date or had no review date, the registered manager stated this would be actioned.
We found risks were not always managed in the least restrictive way. We recommend the provider works within the principles of the Mental Capacity Act 2005 (MCA) to determine whether alternatives could have been considered rather than using restrictive practices.
During our inspection we found issues with medicines storage and administration. We were not assured the service reviewed medicines and records were not always complete. People at the service felt supported to take their medicines, one person told us, "I feel supported to take my tablets on time."
People told us they felt safe living at The Hollies. The provider had effective safeguarding systems in place. Staff demonstrated a good understanding of how to raise safeguarding concerns.
People and staff provided us with positive comments about the management team "if I need help, I know I can ask". Staff said they felt supported. We found the management team had taken steps to improve the service.
The service had established good working relationships with health professionals, one health professional told us "the staff are always friendly and approachable".

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 inspection was not rated and there were no breaches (published 27 November 2020). At the last comprehensive inspection the service was rated requires improvement overall published 28 January 2020.

Why we inspected
This was a planned inspection and was prompted in part by notification of a specific incident. Following which a person using the service sustained a serious injury. The information CQC received about the incident indicated concerns about the management of falls from stairs. This inspection examined those risks.

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.

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

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

We have found evidence the provider needs to make improvements. Please see the Safe and Well led sections of this full report.

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 management of risks, medicine management, governance and staffing at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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 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

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

Service and service type
The Hollies 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 had a manager registered with the Care Quality Commission. 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
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. We visited the office location on 16 June.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, local safeguarding team and Healthwatch. 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 observed the delivery of care and support in communal areas to help us understand the experience of people who were unable to talk with us. We spoke with staff including the nominated individual and registered manager. We reviewed a range of records during and after our visit to the home. This included five people's care records and three people's medication records.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

We spoke with various professionals over the telephone including two health professionals who regularly visit the service, and we spoke with six members of staff who work at The Hollies. We also spoke with five people who used the service and five relatives about their experience of the care provided.

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 inspected but not rated. At this inspection we have rated safe as requires improvement: 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
•Risks were not always managed in the least restrictive way. For example, people's rooms had been locked during the day following incidents of other people going into their bedrooms. We recommend the provider works within the principles of the MCA to determine whether alternatives could have been considered rather than using restrictive practices.
•Risks were not managed to ensure peoples safety. For example, there were a high number of unwitnessed falls. We were not assured that systems were always in place to take action to reduce these.
•We found risks were not always identified or actions in place to reduce risks. We found an incident form without any action or follow up documented.
• One relative felt staff did not respond to risk appropriately. They said, "There has been times my [family member] has fallen and I think [the person] should have been assessed by the doctor but this didn't happen."

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Checks to monitor the safety and quality of the environment were in place. This included checks on fire safety and equipment. We found the latest fire risk assessment had some actions that had not been addressed since March 2020. We referred our concerns about this to the local fire safety team, who have assured us they will liaise with the service regarding this.

Staffing and recruitment
•The service did not have enough staff to care for people safely. We found the communal lounges unsupervised for periods of time. This put people at risk of harm, such as falls or physical altercations between people.

•Staff told us staffing levels were unsafe, one staff said, "There are times when no staff are on the floor so anything could happen".
•The registered manager told us they used a dependency tool to identify how many staff were required for every shift. However, we found this to be ineffective as it did not take into account those people that required two staff for support with personal care.
• We reviewed the staffing levels at night and identified there were only two staff on the night shift. Following the inspection, the registered manager provided us with a copy of the disaster response plan for the night shift, this included what to do in various possible emergencies including who to contact however we were

not assured this could be deployed to ensure peoples safety.
•There was not enough staff to engage people in meaningful activities, we observed people sleeping in the lounge through the day. A Health professional told us, "The residents are always sat doing nothing, they need stimulation."

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The provider had robust recruitment checks in place to ensure staff were suitable to work in a care setting.

Using medicines safely
• Medicines were not managed safely. The provider stated medicines were reviewed weekly however during the inspection we found medicine reviews were not adequate.
• We found medicines records incomplete or with unclear directions.
•Records of medicines stored in the service were not accurate. This included controlled drugs. We raised this with the registered manager and evidence was shown following the inspection that action had been taken to address these issues.
•We found medicines were not always stored in line with best practice.
•The medicines policy was not up to date.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they were happy with the support they received to take their medicines.

Lessons learnt when things go wrong
•Accidents and incidents were recorded and reviewed to identify trends or patterns. However, these had not been fully effective and had not always led to reductions in falls for people.
• We were not always assured that lessons had been learnt from re occurring incidents. For example, one person had three unwitnessed falls in May 2021. Actions recorded to mitigate the risk did not ensure all measures were explored for example, sensors for staff to monitor when the person is mobilising therefore the risk had not been managed. We report on this further in the well led domain of this report.
• Equipment such as stair safety gates and handrails had been fitted to improve safety in the environment.

Preventing and controlling infection
• We were not assured that the provider was meeting social distancing rules, during the inspection we observed staff not social distancing.
• We were not assured cleaning records were up to date.
• We were not assured the provider was using PPE effectively and safely, during the inspection we observed staff with face masks worn incorrectly. This was addressed with the registered manager at the time of the inspection who assured us they would discuss with staff.
• We were not assured the provider was promoting safety through the layout and hygiene practices of the premises.
• We were not assured the provider's infection prevention and control policy was up to date. During the inspection we found old guidance in use.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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

Systems and processes to safeguard people from the risk of abuse
• The provider had effective safeguarding systems in place. Staff had a good understanding of what to do to make sure people were protected from abuse. They had received appropriate and effective training in this topic.
• Staff knew how they could whistle blow. Whistleblowing is where people can disclose concerns, they have about any part of the service where they feel dangerous, illegal or improper activity is happening. There was a policy with specific emails and numbers staff could call.
• Health professionals we spoke with stated the service communicated concerns.
• People who used the service told us they felt safe. We asked one person if they felt safe and they told us "Yes, very much so."

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 inspected but not rated. At this inspection we have rated Well-Led as requires improvement 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

• We found records were not always accurate. For example, one person was to be checked by staff every 30 minutes, but this was not documented in the person's care notes. We raised this during the inspection and the registered manager agreed to take action.

• There was no clear analysis of trends in incidents over a period of time, to include details of when and where they happened and any injuries sustained, to subsequently reduce any apparent risks. We discussed this with the registered manager who addressed this immediately, providing us with supporting evidence following the inspection.

• Staff said they were able to raise concerns with management. However, they did not always feel sufficient actions had been taken. For example, concerns raised about staffing levels.

• We found some policies were out of date or had no review date, the registered manager stated this would be actioned.

• Audits were carried out, with a rota in place throughout the year to ensure all areas were monitored in the home. There was a service action plan to ensure the home improved. However, our findings regarding medicines, risk management, infection prevention and control and gaps in records had not been identified through these audits.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The management team were clear in their responsibilities to act on concerns raised and provided effective responses to complaints.

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

• There was an open and positive culture. Staff told us they felt part of a team and were supported by the management team.

• People and relatives told us they felt well supported by the staff team. One relative told us "Everybody knows him, I'm made to feel part of it nothing is too much trouble."

• Relatives had provided positive feedback about the service and the outcomes it had achieved with people.

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

characteristics; Continuous learning and improving care
• Daily meetings were held with staff to ensure they were updated with any new changes within the home.
• People told us communication with staff was good. Surveys were carried out to ask people and their relatives for their views on the service so they could continually improve.

Working in partnership with others
• The home had established good working relationships with health professionals and received compliments from visiting professionals.

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 Regulation 12 (2)(b). Risks were not always identified or actions in place to reduce risks effectively for people who used the service Regulation 12 (2)(g). The provider failed to ensure the proper and safe management of medicines Regulation 12 (2)(h). The provider failed to prevent and control the spread of potential infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and quality assurance processes were not always effective in mitigating risks. Regulation 17 (1)(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff to ensure people's needs were met. Regulation 18 (1).