M & J Care Homes Limited

The Hollies Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Hollies Care Home is a residential care home providing personal care to people aged 65 and over at the time of the inspection. The home is an adapted house situated in a residential part of Castle Cary and has accommodation arranged over two floors. There are stair lifts to enable people to access the floors. The service can support up to 18 people. At the time of inspection ten people were living at the service.

People's experience of using this service and what we found
People and relatives were mostly happy with the service. One person said, "The staff are pleasant and helpful and kind." However, we found the service did not have robust systems and processes in place to assess risk and ensure people were safe. Fire safety checks had not been completed to ensure people were safe in the event of a fire. This placed people at risk of harm.

People's care needs had not always been appropriately assessed to ensure the service could provide the care they required. Staff told us they used inappropriate moving and handling techniques as they did not have the equipment to assist people. This had placed people at risk of harm.

We imposed urgent conditions to the provider's registration to ensure people were safe. The registered manager shared a memo they sent to staff to cease poor moving and handling practices, arranged for moving and handling training and completed unannounced staff spot checking.
The service shared the procedures on what to do in the event of a fire with staff, arranged for fire safety training and purchased fire evacuation equipment. We contacted the local authority who visited the home with an occupational therapist to assess people's moving and handling needs. We also informed the Fire and Rescue Service for the area of our concerns about fire safety. They arranged to complete a fire safety audit at the service.

Medicines were not stored and managed safely. This put people at risk of not receiving their medicines as prescribed.

We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service did not have a housekeeper in post and there were not enough staff to ensure people's needs were met and that people were kept safe in case of emergency or incidents.

People were not always admitted safely to the service. A person had been admitted into the service without a proper assessment of their needs to ensure they could be cared for safely and effectively. Staff told us they were not aware of the person moving into the service and had no information as to how they should meet the person's care needs.

We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Infection Prevention and Control audits had not been completed regularly and were not up to

date.

The service lacked oversight and governance from the provider and the registered manager. This meant the quality of the service was not monitored. The lack of governance and oversight meant risks were not identified and managed and this placed people at risk of harm.

The registered manager told inspectors they were aware of the shortfalls at the service. However, they had failed to put any systems and processes in place to keep people safe from harm. The registered manager had been in post since March 2021 and told inspectors they planned on improving the service and felt the providers were supportive of this.

Staff and healthcare professionals told us the registered manager was often not available at the service. This meant healthcare professionals were not always able to provide important updates regarding people. Staff roles and responsibilities were not clear. One senior staff member told us they were often left in charge and told us, "I am not paid to run the care home, I am just a senior."

One relative told us they were not informed when their loved one's health deteriorated and did not feel listened to.

Staff knew how to safeguard people and had received up to date training.

Since our inspection the provider has supported the registered manager with spot checks to assess staff competency. The registered manager has re assessed people's care needs and organised training for staff.

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

Rating at last inspection
The last rating for this service was good (published 11 March 2020).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about staffing levels, lack of governance, lack of moving and handling equipment and people's care needs not being met. A decision was made for us to inspect and examine those risks. We inspected and found there were concerns with the management oversight, record keeping and cleanliness. We requested the registered manager to provide us with an action plan detailing how they would improve and mitigate risks to people. Following the action plan deadline date, we visited the service again and widened the scope of the inspection to a focused inspection to include the concerns we found on the first day in the key questions of safe and well-led.

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

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

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

We have identified breaches in relation to the requirements relating to registered managers, safe care and treatment, good governance, staffing and notifications of other incidents, at this inspection.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is inadequate and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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 inspection team consisted of one inspector and one assistant inspector, a pharmacist specialist 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 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 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
This inspection was unannounced.

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 and professionals who work with the service. 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.

During the inspection
We spoke with five people who used the service and five relatives about their experience of the care provided. We spoke with ten members of staff including the providers, registered manager, senior care workers, care workers and the chef.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People had been placed at risk of avoidable harm in the event of a fire. Safety checks had not been completed, including regular testing of the fire alarm system, fire exits and emergency lighting. The service did not have an up to date fire risk assessment in place and did not have equipment to evacuate people in an emergency.
- Staff had not had adequate training and drills in fire safety. According to the records provided, five staff had not completed the fire safety training and two staff we spoke with were unable to tell us what they would do in the event of a fire. One staff member said, "I honestly have not thought about it. We would do our best to keep people safe. We have not had a fire drill in two years, and I've completed no fire training. There are people who require 2:1, we would struggle to move them and everyone else. We would put ourselves and residents at risk."
- Moving and handling practices at the service placed people at risk of harm. People's moving and handling needs had not been assessed so staff could safely use what equipment there was to assist people with their mobility. Staff told us they did not have the equipment to support people safely and had raised their concerns to the providers and registered manager. One staff member said, "We have to basically manual handle them to help them out, the ones you are not supposed to do, the ones under the arms. We have asked for electrical stand aids and proper hoists but haven't received them." Another staff member said; "[person] can't stand to use the stand and turn, we have to lift [person], one arm under each shoulder, that's how I hurt my shoulder."
- External referrals to healthcare professionals to keep people safe had not been made appropriately. Staff told us, and the registered manager confirmed, not all people who were reportedly requiring extra support with their mobility had been referred to the occupational therapist. This had placed people at risk of harm.
- The environment was unsafe and placed people at risk of harm. The door leading to the garden was left open, exposing a lip to be stepped over to access the outside. No signs had been placed to easily identify this. The accessible route to the garden was littered with hazards including broken furniture, rubbish and a ladder. This meant people were at risk of trips and falls and due to low staffing levels, these areas were often unsupervised meaning people could fall without staff knowledge to assist.
- The service did not learn from concerns, accidents, incidents and adverse events. The registered manager told us a lessons learned process was not currently in place and this was something they planned to introduce.

The provider had failed to assess, monitor and mitigate risks to the health and safety of people and had placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff to provide timely and safe care, or to respond to emergencies or incidents. This was reflected on the rota and on the day of inspection two care staff and one chef were on duty. Ten people required support, of whom four required two staff to support them with their care needs. In the event of an emergency such as a fire, there were not enough staff to support people and keep them safe. One person using the service said, "One of the problems they do have is not enough staff, yes, I would say I am affected a little as it is a risk."

● At least five staff had not completed up to date safety-related training. This meant staff were not always provided with the up to date skills and knowledge to carry out their duties, which placed people at risk of harm.

● Staff performance was not robustly monitored. This meant poor performance or evidence of unsuitability may not be recognised or responded to, and people were likely to be harmed as a result. One staff member said, "No, I have not had any supervision or monitoring of what I am doing but for all [registered manager] knows, I could be doing anything. I do not think [they] supervises any of the staff. No one checks our competencies."

The provider failed to ensure there were sufficient numbers of suitably skilled and competent staff to meet people's care needs and to ensure that people were safe in case of an emergency or incident. This placed people at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they reviewed staffing and had live adverts where they were currently recruiting.

Using medicines safely

● Medicines were not stored and managed safely. On the day of inspection, the medicines room was left unlocked with the medicine trolley, keys and boxed medication not yet booked in left on the side, accessible to anyone who walked in. There was a security risk that anyone could access prescribed medication, placing people at risk of harm.

● Medicines were not being stored correctly to ensure they were effective, which had placed people at risk of harm. Room temperature checks were not recorded to ensure medicines were stored at the correct temperature. Medicines with reduced expiry dates after opening were not removed from use in a timely manner and were still available to be administered.

● Hand-written medication administration records (MAR) were not completed in accordance with the service policy or best practice guidance, meaning people were at risk of not receiving their medicines as prescribed. No signatures were present on the charts to indicate who had taken responsibility for creating them. Medication had not always been booked in and balances recorded on the MAR.

● There was no information either within medication administration records or in the individual care plans to support staff to decide when to administer medicines prescribed to be used "when required". This placed people at risk of harm from not receiving medicines as required.

● MAR were not always fully completed to show why people might have missed doses. This had not been identified by the provider as they did not complete quality monitoring including audits and medicine stock checks. This meant the provider could not be assured people were receiving their medicines as prescribed and placed people at risk of harm.

● Controlled drugs had not been managed safely. Signatures were missing from MAR and the controlled register. This had not been identified by the provider as they did not complete audits and medicine stock checks. The provider could not be assured people were receiving their medicines as prescribed, placing people at risk of harm.

● Staff received training in safe handling of medicines; however, the provider did not complete medicine competency checks to ensure staff continued to administer medicines safely. One staff member said, "No one checks our competencies, we used to have one by [name of pharmacy] and do checks and ensure staff were competent but since then nothing so no system in place."

We found no evidence that people had come to harm; however, medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home was not clean. This included communal areas found with cobwebs, excessive dust and dead bugs. Carpets had not been hoovered or floors cleaned. This increased the risk of the spreading of infection including COVID-19.

● The service did not have a housekeeper in post. Staff were expected to clean but told us they did not have time. Cleaning was not observed during the day off inspection, this included frequent touch points. This had placed people at risk of harm due to the increased risk of spreading infection.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. On the day of the inspection the inspector and assistant inspector were not asked for a negative COVID-19 test, nor temperature checked or reminded to use PPE. However, three relatives told us, "I do the test and wear a mask, "[they] provided me with a big box of lateral flow tests, you test and sit in your car and wait. We're given apron, gloves and masks" and "We wear masks, sign in, do a lateral flow test."

● We were not assured that the provider was admitting people safely to the service. The service had not followed government guidance when admitting a person into the home. This includes regular COVID-19 testing of the person to protect them and others. This had placed people at risk of harm from the spread of infection.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Regular infection prevention and control (IPC) audits had not been completed. The last IPC audit was completed June 2021. Spot checks had been completed for May and June, but there were no records for July and August. This means the registered manager could not be assured that the service was doing everything reasonably practical to mitigate the risk of the spread of infections.

● We were not assured that the provider was accessing testing for people using the service. We were not provided with any records to demonstrate people were taking routine regular testing. This meant the service was unable to locate any new source of infection and had placed people at risk of harm.

● We were somewhat assured that the provider was accessing testing for staff. Polymerase chain reaction (PCR) results had been sent for six staff. Staff told us they were lateral flow device (LFD) testing daily. Contemporaneous records were not provided to demonstrate this.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. Individual COVID-19 risk assessments and care plans had not been completed. This meant clinical extremely vulnerable people had not been identified for shielding measures to be implemented if required. Most people stayed in their room by choice and low occupancy meant those who did come out of their rooms were able to at a safe distance from others.

We found no evidence that people had come to harm; however, infection control processes were not robust and did not follow government guidance. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was using Personal Protective Equipment (PPE) effectively and safely.

People and relatives told us staff wore their masks and we observed staff wore appropriate PPE on the day of inspection. Staff told us they had plentiful access to PPE and the registered manager said they had ordered new PPE stations to aid with the access to staff through the service.

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

Systems and processes to safeguard people from the risk of abuse

- Three people we spoke to told us they felt safe. Comments included: "I do feel safe and happy", "I feel safe here and I like it" and "I feel quite safe."
- Staff we spoke with knew how to identify signs of abuse and how to report their concerns.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The service was not well-led. The provider did not have systems and processes in place such as audits to monitor fire safety, safe administration of medicines and to check care plans were up to date to be assured people were receiving person-centred care with good outcomes. Other audits such as daily spot checks and infection prevention and control monitoring had not been completed since June and the last maintenance audit had been completed in July. This meant the provider could not be assured people were being provided a quality safe service which placed people at risk of harm.
- A relative told us the home had failed to identify their loved one's declining health, which had led to the person needing to go into hospital. They said, "The home did not take action and they did not tell me of the changes in their health." The person's doctor also had concerns which resulted in the hospital admission. This meant lack of oversight and governance had led to a person being harmed.
- Staff told us they did not feel listened to, respected, valued or supported. Staff said that when they raised their concerns to the registered manager and provider, they felt their concerns were not listened to. This had resulted in people not receiving care appropriate for their needs and had placed them at risk of harm. Comments included, "The manager seems to listen, but he is not 'present'", "[the registered manager] promises lots but doesn't deliver", "Our manager is not too involved in what is happening and it is very sad, because [we] are dedicated to our work but are unseen and unheard and undervalued" and "[staff meetings] we get a chance to air views, but it is not followed through and it just makes you think, if the owners and manager don't care then why should we?"
- M & J Care website stated, "aims to provide the highest quality of care for an individual that enables them to enjoy and fully explore their interests, hobbies and things that make them happy." However, low staffing numbers meant there were not always enough staff to provide activities for people, meaning people lacked stimulation. The service did not have a dedicated an activities co-ordinator as specified in their statement of purpose. People told us, "There are not a lot of activities", "Nothing very special is ever going on" and "[There's] not a lot to do."

Systems were either not in place or robust enough to demonstrate the quality and safety of services was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they liked the registered manager and felt listened to. One person said, "I like [registered

manager] and get on very well with him, I can ask things and he says he will do them." Another person said that although they did like the registered manager, they found them to be "a bit laid back and does not seem to bother sometimes and lets other things get in the way".

● Four relatives told us they were happy with the general email communication they received from the registered manager. They felt the registered manager was open and honest with them. One relative said, "Manager is a lovely caring man."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● The registered manager was aware of their regulatory responsibilities but failed to carry them out. The registered manager had previously been registered with CQC for a different location since 2016. For this, the registered manager had attended and passed a fit person interview where they demonstrated they had the appropriate knowledge of applicable legislation and understood their role as a registered manager. The registered manager told us "When I start [at this service] March/April [2021] I kind of identified a lot of shortfalls in every single area." However, the registered manager had not created any plan to work towards improving the areas of concern. This had contributed to breaches in regulations found during the inspection and had placed people at risk of harm.

● The registered manager did not demonstrate the competency and skills required to manage the regulated activity or have sufficient oversight of the service to ensure people received the care and support they needed that promoted their wellbeing and protected them from harm. The registered manager did not have robust systems and processes in place to monitor the quality of the service and identify areas for improvement. The registered manager had not completed actions from the targeted inspection 26 July 2021 action plan where it was identified people were being placed at risk of harm.

● Staff told us they had meetings and felt able to speak to the registered manager but did not feel their concerns were acted upon. One staff member said, "We've told [registered manager] and [they] say 'yeah, yeah, we'll do it' but that is it. We've nagged [them] so much and either [they] have not got it, [they] forget or does not bother and [they] are never here to do it."

● Healthcare professionals were concerned staff did not have the skills to recognise when a person's health was declining. Healthcare professionals we spoke with were concerned that the registered manager was not at the service for them to speak with when they had concerns about people and staff capacity to provide safe care and treatment to them.

●. The registered manager had not ensured risks to people had been appropriately assessed. This included risks to people in relation to COVID-19.

There had been a failure to manage the service in accordance with the regulations and people had been placed at risk of harm. This is a breach of regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) 2014

● The provider had not sought feedback from people using the service and relatives since 2019. We asked the registered manager about this who told they "I was going to seek feedback but, feedback has not been requested due to only five people living in the service at the time, so I thought I'd wait until January 2022 when we have more residents." This meant people and their families did not have the opportunity to feed back their views on the quality of the service and meant areas of improvement had not been identified.

● Staff had not received supervisions or received honest feedback about how they were performing. This meant the registered manager had not been able to identify areas of improvement to ensure people received safe person-centred care.

Systems were either not in place or robust enough to demonstrate the quality and safety of services was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service failed to notify CQC of notifiable incidents as part of their regulatory requirements. They had not notified CQC that a person had fallen and broken their neck of femur (hip). They also failed to report to CQC that a person had acquired a grade three pressure sore. This meant external scrutiny was not possible to ensure people were not being neglected or receiving care or treatment that would place them at risk of harm.

The provider had failed to ensure notifiable incidents had been reported to CQC. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, monitor and mitigate risks to the health and safety of people and had placed people at risk of harm.

The enforcement action we took:

We imposed urgent conditions to the providers registration to ensure people were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate the quality and safety of services was effectively managed.

The enforcement action we took:

Notice of decision served to cancel provider registration for this location under Section 28 of the Health and Social Care Act 2008.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers There had been a failure to manage the service in accordance with the regulations.

The enforcement action we took:

Notice of decision served to the registered manager to cancel their registration under Section 28 of the Health and Social Care Act 2008.