Country Care Home Limited

Hill House Care Home

Inspection report

Hill House
Little Somerford
Chippenham
Wiltshire
SN15 5BH

Tel: 01666822363
Website: www.countrycarehomes.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Hill House Care Home provides accommodation and nursing care for up to 35 people. At the time of our inspection there were 19 people living at the home and three people staying on temporary respite care.

We inspected Hill House Care Home on 18 and 19 October 2017, this inspection was unannounced. The service was previously inspected in October 2015 and received an overall rating of Good. In February 2017 the service increased the number of people they could support to 35 with the addition of a new contemporary building. The old building and the new are joined by a covered outside walkway. In addition the provider added the provision of nursing care to their registration. Work was underway to extend the new building which would provide a further 25 rooms. This will increase the service to 60 beds in total.

During this inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A recommendation was also made in response to medicines management in the service. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Due to the number of concerns we wrote to the provider requesting an action plan to immediately address these shortfalls and keep people safe. The provider responded to this letter within the timeframe and we are currently considering what action to take.

There was a registered manager in post when we inspected the service. 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.

Risks in the service had not been well managed. Risk assessments were not always updated to review safety measures. People did not always receive the care and support they needed to prevent risks in areas such as mobility and pressure area care. Fire records to make sure that people could be evacuated safely were not

up to date and staff were not adequately trained to make sure they could respond effectively in the event of a fire.

Staffing levels in the home were not sufficient when taking into account the layout between two separate buildings and the number of floors. The registered manager did not calculate the staffing levels in accordance with people's needs, but instead was told the numbers they could use by senior management. Staff had previously raised concerns around shortages, which had not been investigated.

Safe recruitment practices had not always been followed or the necessary checks completed to ensure new employees were safe to work with vulnerable adults.

Staff were not trained sufficiently in all areas to make sure they were effective in their roles. There was a lack of regular supervision to support staff to undertake their roles safely.

People's choices were not always promoted or respected. This included decisions on where people preferred to spend their time and around meal choices.

We found concerns around staff understanding and recording of people's mental capacity in the service. The service had accepted decisions made by relatives who did not have the legal authority to make decisions on behalf of people. Restrictions had been imposed on people without following the appropriate procedures.

Care records were not completed in sufficient detail to support staff to provide person-centred care. There was inconsistent recording which did not provide a clear picture of what people's needs were. There was a lack of evidence to demonstrate that people had received a formal review of their care or been involved in a review process.

People's complaints were not taken seriously or used as an opportunity to improve the service. Complaints had not been handled according to the provider's policy.

The management and leadership within the home had not been effective and a breakdown of communication within the management team had impacted the delivery of care that people received.

There was insufficient quality monitoring in place. We were not confident the provider or management had oversight of the service. Accidents and incidents were not being monitored to reduce the risk of re-occurrence or share any learning points with the staff team.

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.

Risks were not being identified or managed in order to make sure people were safe. Fire records had not been updated and staff were not adequately trained to respond in the event of a fire.

Safe recruitment checks had not always been carried out prior to employing staff.

There were insufficient levels of skilled and experienced staff deployed across the service to meet people's needs.

Medicines recording for 'medicines when required' and topical medicines were not consistently completed.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received up to date training in key areas including safeguarding, mental capacity and infection control.

Staff did not receive regular support and supervision.

There was a lack of understanding in ensuring that where people lacked capacity the appropriate support was provided following the legal processes.

There was a lack of choice at mealtimes and people waited for long periods to receive a meal.

Is the service caring?

Requires Improvement

The service was not always caring.

People's choices were not always promoted or followed in relation to their care and support.

Staff did not always respect people's privacy or dignity.

We saw that when staff supported people, this was conducted in

a kind manner and people were mostly positive about the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records lacked detail and were inconsistent which made it hard to establish people's current level of need. The plans were not being reviewed regularly and updated when people's needs changed.

Complaints and feedback had not been encouraged and were not investigated in accordance with the provider's policy.

Activities were not always tailored to meet people's interests. Suggestions form people for different activities were not taken seriously.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of provider and management oversight of this home. A breakdown of communication in the management of the home had impacted on the delivery of the service to people.

There were no quality monitoring systems in place to identify and monitor the quality and effectiveness of the care that people received.

Hill House 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.

The inspection took place on 18 and 19 October 2017 and was unannounced. On day one the inspection was carried out by two inspectors and a pharmacy inspector, on day two there were three inspectors.

Before the inspection the provider completed 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. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

During the inspection we spoke to nine people living at the home and two relatives. We spoke with 12 members of staff, the registered manager, operations director and one of the directors of the company. We also spoke with one health care professional.

We looked at the care and support records for 11 people. We also looked at records relating to the management of the service including the staffing rota, provider's policies, incident and accident records and recruitment and training records. We observed care and support provided to people in the communal areas of the service.

Inadequate

Is the service safe?

Our findings

Risks in the service had not always been safely assessed, managed or information reviewed and updated where required in order to keep people safe from potential harm. For example we saw that a fire folder was in place in each building which contained details of which rooms people were in and the support they needed to evacuate in an emergency. This information would be used to inform staff and fire fighters if they needed to assist people to safety in the event of a fire. However we saw that the information recorded had not been kept up to date. Two people in the older building had passed away and one person had moved to the new building. This meant that time could have been lost in an emergency looking for people who were no longer at the service.

A fire drill had taken place for staff in February 2016 and it was documented that staff had not known what to do and could not locate the fire detector. It stated that the detector needed to be fixed as had not been facing the right way, however there was no information recorded if this had been done and if staff had received further training around this in another fire drill. After our inspection further evidence was received which demonstrated that the detector concerns had been resolved. We saw in the registered manager's 24 hour report of the home that a comment had been made stating that the kitchen fryer had been left on again for the fourth time. There was no further information on if any action had been taken to prevent this reoccurrence or why this was still happening. We saw one staff supervision documented that the staff wanted training on the fire procedures in the new building as had not yet had this. Another staff member also disclosed that they had not received any fire safety training since being in post. We have made a referral to the Dorset and Wiltshire Fire Safety team regarding these concerns.

One person had a repositioning chart in place as they were assessed to be at very high risk of developing pressure ulcers and needed support to change their position regularly. The chart in place did not state how often this person needed to change their position. We asked staff how often this person needed to change position. One staff was unable to tell us and another staff said two to three hourly. We saw in the person's care plan it recorded that they needed to reposition two to three hourly. However the repositioning chart showed gaps of four hour periods where this person had not been supported to change their position. This meant staff were not following this person's care plan and this person was at risk from a potential pressure ulcer.

One person's room on the top floor of the new building has restricted access due to the corridor doors when open covered half of this person's entrance to their bedroom. This made it hard for the person to come in and out of their bedroom and had not been considered in the new building design. We raised this concern with the management team. They were unaware that this design was causing a restriction for this person.

There was confusion over whether people had bedrails in place. We were told by staff that in the new building three people had bedrails in place which were currently being used. We saw one person had a risk assessment for bedrails in place but this had no dates on and had not been reviewed. We reviewed the maintenance file and saw that bedrail checks had last been completed in 2013 and since then no bedrails had been used. We saw one person had experienced a fall out of their bed and the staff on duty had decided

to put up bed rails in response to this fall. There was no bed rail assessment, consent or mental capacity assessment completed around this decision. On the accident form staff had recorded 'Bed rail put in place as a precaution to a fall.' In the daily notes it was documented '[X] very restless, being checked every 15 minutes. Has not tried to jump over the bed rails again.' At 5.30am staff had further recorded 'Climbing over bed rail, monitor and decide on safest option.' This meant that decisions to use bed rails were being made by staff as a reactive measure, without considering the further risks to people these could cause.

Water outlets for empty rooms were recorded as being flushed on a weekly basis to ensure legionella bacteria did not develop. We saw that weekly checks had been completed up until 28 September 2017 and then there was nothing further recorded. The registered manager was unable to account for why the checks had stopped and could not produce any further evidence of these missing weekly checks when asked. This information could not be obtained at the time of the inspection but was later located and sent after this time. The operations manager informed us that they used a company who regularly tested the water and produced email correspondence to evidence this. We saw that it was stated in these emails that the home had tested positive for legionella bacteria and precautionary measures and action to take were listed. The home had not yet been retested to ensure this was now clear and the registered manager was unable to evidence if these steps had been followed.

Maintenance records were in place and recorded that items including call bell alarms, wheelchairs and walking frames were being checked every three months. However there was no information about which one's had been checked, who they belonged to, or where these were located. It had been dated and signed with no further information documented.

A downstairs bathroom needed a lot of maintenance and repair to be made safe, however this room was still being used by people living in the home. The previous bath hoist had been removed and the service was awaiting a new one. This had left a large hole in the flooring which had not been covered to keep clean or safe but instead a shower chair had been placed over it and the hole was still visible. There was no warning to people not to move the chair or to take care when using this bathroom. In this bathroom four commodes and a shower chair were being stored which reduced accessibility and did not make this a safe or useable space for people as a bathroom.

The bathroom door was marked and paintwork was scratched and in need of redecoration. A board had been removed exposing pipes and the sealant around the sink and toilet needed to be replaced. Two tiles by the sink were cracked and had not been removed. These could be lifted up and had sharp edges. The provider's risk assessment process had not picked these safety concerns up when assessing the safety of this bathroom for people to use. We raised our concerns with the management of the service who informed us the bathroom needed to be addressed and the flooring replaced. This bathroom was not currently safe for people to use but action had not been taken in this interim period to prevent any potential harm.

We observed one example of unsafe practice when a staff member was assisting a person in a wheelchair to the toilet. The staff member left this person in the corridor whilst they went to check the toilet and did not put any brakes on the wheelchair to ensure the person remained safe whilst they were left unattended.

Accidents had not been well managed in the service to ensure that any incidents were reviewed and measures put in place to prevent reoccurrence and keep people safe. We saw one person had experienced seven falls in the space of two months with six of these falls occurring in one month. There were two occasions when the person fell twice on the same day. Although this person had a falls chart in place there was no detail of any analysis that had been completed into why this person may be falling or any measures put in place or action taken to reduce the falls. We saw that this person required the assistance of two staff

to make transfers from their bed, chair and to the toilet yet five of these falls had still happened during mobilising with two staff supporting. No investigation into this had taken place.

We saw that on one occasion this person had fallen during a transfer and it was recorded that only one staff member had been supporting despite the person's care plan stating they always needed two staff. This meant this person had not been provided with safe care and during this unsafe practice the person had sustained a fall, resulting in bruising. We saw another fall was recorded as happening because the person missed the chair due to a lack of concentration from the person; however there was no investigation as to how this could have happened with two staff present and supporting. This person had not been kept safe and appropriate measures had not been taken during the support given or after as a result of a fall occurring.

We saw that this person had also experienced an accident and obtained a bruise when a chair they were sat on broke. During our inspection we saw in the new building two chairs had been stacked and left in a corridor with a piece of paper left on them that stated 'Don't use, not safe.' These chairs had not been safely stored away to ensure that people would not use them and be at risk of further harm. We fed these concerns back to the management to address.

One person, who was at risk of choking due to swallowing difficulties, had an eating and drinking care plan in place. This stated that this person was on a soft diet as recommended by Speech and language therapists (Speech and language therapists (SALT) provide treatment, support and care for people who have difficulties with communication, or with eating, drinking and swallowing). Full details about the consistency this person's soft diet should be blended to had not been recorded in the care plan. We saw that this person's care plan also said they should be monitored by staff from a distance during all meals; however we later observed that they were left with biscuits in their room during this inspection.

This was a breach of Regulation 12 (2) (a) (b) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe living at Hill House commenting "I feel safe, no worries whatsoever" and "I have a pretty reasonable room with a view, I feel safer here." One staff member said "I would report anything to my line manager and the registered manger. I'm here for people." Not all staff had received up to date training in safeguarding adults and one staff told us "I have not done safeguarding training, I don't know what to look for but I would report things to the manager." Other staff we spoke with knew and understood what was meant by safeguarding; however they were not clear on where else they could take their concerns externally to the service.

There were not enough staff available to meet people's needs. One person told us, "I never know what time I am going to get up. They tell me I have to wait." The registered manager told us one nurse would be on shift and four care staff. This dropped by one care staff at night. One building had two floors and the new building was over three floors which meant that staff were spread out. Some people's needs in the nursing part of the building meant that they needed two carers to support them. With only two carers in the whole of the building this meant that there were two floors unattended whilst care was being delivered.

The registered manager was not using a dependency tool to ensure that the levels of support people needed could be adequately met by the staffing levels in place. The registered manager told us that it had been a "real challenge" managing the service over two buildings. They told us that they felt undermined with no autonomy to make decisions and that the operations director and owner told them how many staff they could have on a shift. The registered manager had started a 'daily managers' report' for the staff to complete

every 24 hours. We found that these contained comments written by nursing staff such as, 'carers under pressure especially when short of staff' and 'residents need toileting after meals.' These daily reports were being stored in the registered manager's office and there was no evidence that any actions had been taken in response to the content of these reports. They had not been signed off as read or actioned by any of the management team.

The service operated a wireless call system, with a removable pendant in which a person could carry with them when moving around the home. During our inspection we heard people's calls being answered in a timely manner, however staff were not often visible around the floor and the staffing levels were seen to have an impact on the activities and engagement opportunities offered for people. One staff told us "There are not enough experienced carers and they struggle with the dynamics of having the new nurses as the leads." Other staff commented "There's never enough staff, it has been different with the new build, staffing has increased, but I do feel for them when all the bells are going off". "We need to get some sort of normality between the two builds, some staff find it tiring but are getting more confident now" and "Staffing is improved, we are thin on the ground today, there are two of us so one will be on ground floor and the person upstairs is quite independent so we just keep popping up to check."

People using the service commented "On the whole they are good, night staff are particularly good, but there's not consistent staff. When I ring my bell they come as quick as they can" and "I don't know where my call bell is, I need one of those pendant bells to wear. Staff come quickly if I need them, there always seems to be someone about." The two relatives we spoke with did not raise any concerns about their relative's safety.

We saw in the minutes of a team meeting in August 2017 staff had raised concerns that they were short staffed, to which the registered manager responded 'No'. One staff had commented that only one carer was helping frequently at lunch time, which they felt, was a risk to people in the home. Another member of staff was recorded as saying it took an hour to support one person with two members of staff, and the registered manager replied it only takes 30 minutes. There was not any further discussion, review of staffing levels or observations completed in response to these concerns raised by staff. We raised with the registered manager that during lunch we had observed there were not enough staff present and were told this was when staff took their breaks. The management team agreed they needed to review when staff took their breaks as this was being done over the lunchtime period when people needed support.

This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that safe recruitment practices had not always been followed or the necessary checks completed to ensure new employees were safe to work with venerable adults. One staff member had started work in December 2016 but not received their Disclosure and Barring service (DBS) checks until February 2017 (DBS is a criminal records check). No risk assessment had been put in place to ensure that this staff did not work alone until this clearance check had been confirmed. We spoke with this staff member who told us they had only shadowed for a week before working alone. We saw that two further staff files had no recording that a DBS had been applied for or yet received. We found that there were no staff identification photos on any of the staff files that we viewed.

Another staff member was awaiting the return of their DBS. We saw that they had started their employment but was shadowing another member of staff until their DBS check had been done. However when we checked this staff member's recruitment file we found there were no references in place. The registered manager told us they had not received references back for this staff but had started them regardless of this.

The registered manager further said that this staff had a relative already working in the service so they were happy to accept them on this basis. We checked the provider selection and recruitment of staff policy which stated 'Appropriate job references will be taken up for all prime candidates by the proprietor and subsequent job offers will depend upon satisfactory clearance or responses.' The provider's policy had not been followed and people were receiving support from staff who had not been through the appropriate checks to ensure they were safe to work with vulnerable adults.

This was a breach of Regulation 19 (2) Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we reviewed the arrangements for managing medicines. Staff used medication administration records (MARs) to record when a medicine had been given. We observed medicines administration for three residents and they were given in a safe and caring way. We looked at 14 people's MARs which were all completed accurately. Some people had medicines prescribed to be taken when required. Guidance was available for staff to explain when these medicines could be given to these people. However this was not complete for four people, who did not have information available for one of their 'when required' medicines with their MAR chart.

Charts to record the application of external preparations such as creams or ointments were not being used consistently throughout the home. This could lead to confusion for staff as to how best to record the application of these medicines. It was possible for people to look after their own medicines if they wished although no-one was doing this for all their medicines at the time of the inspection. Two residents were self-administering one of their medicines and it had been checked to make sure this was safe for them.

Staff could respond quickly to people's minor symptoms by offering non-prescription medicines. This was covered by the homes policy, and a record was kept when any medicine was supplied. There were suitable arrangements for the ordering and disposal of medicines and records were completed appropriately. Medicines were stored safely, including those requiring extra security. However, we saw that staff had not recorded one medicine that required additional record keeping, when it had been received recently.

We recommend that the service reviews the recording of some aspects of medicines management, referring to current guidance.

The new building was found to be clean and odour free. However in the older building we observed that one communal shower room had no hand wash, paper towels or a waste paper bin in place for people to use. When we raised this with the registered manager they responded that no one apart from the registered manager really used this bathroom. Cleaning schedules were in place and staff signed to say that people's bedrooms and communal areas had been cleaned. We saw deeper cleans were also recorded where staff would move furniture and carpet clean if needed. Staff commented "We do regular deep cleans as it's easier to keep on top of it" and "I clean frames and handles to prevent cross contamination, wherever I think people might touch."

We saw that there was an issue with people's clothes not being able to be identified by staff. A box in the laundry room contained misplaced items and there were more clothes hanging on the back of the laundry room door. Staff told us that a lot of clothes were not labelled and they could not identify which items belonged to whom. This meant that people living in the home had not had some of their clothes returned to them after they had been sent for washing.

Requires Improvement

Is the service effective?

Our findings

Staff had not been supported to have the training they needed to meet people's needs and ensure their safety. A training manager had been employed with the service to address the large gaps across staff training and commented "There are big gaps in up to date staff training. With all the changes this year this has got lost. We realise there is a deficit and this year is a transition period, we are having regular training meetings with senior management so decisions can be taken there and then." We saw that out of 42 staff only eight were up to date with their safeguarding. This meant that 34 staff had not received their safeguarding training. The training manager told us that training had been offered in July but staff were busy taking leave and some had to be taken out of training because they were needed to work where there were shortfalls in care delivery. The training manager informed us that manual handling training had been one of their biggest challenges and only five care staff were trained and 15 still needed this training.

Training had been put on for staff in areas including promoting continence with 12 staff booked in, however only six staff attended this. For infection control training 12 staff were again booked to attend and only four attended this. The training manager told us "There's been a lapse in the culture of training." No staff in the home apart from the registered manager had received up to date training on mental capacity and the nurses and care staff administering medicines had not been receiving medicine competencies to ensure their practice was safe. The training manager said these had used to happen but stopped some time last year and they were starting this again now. The training manager further commented "We are aware of what needs to be done, it's not as easy as it would seem, it's finding who can offer what we need, so we are integrating what we can in-between, anything to get staff knowledge up in the meantime. More than half of the staff are new."

The training manager had devised a matrix tool to record which staff needed what training and had put new staff forward for higher level health and social care training. One staff told us "I have done health and safety and first aid, training is mostly face to face. My induction was really good, I shadowed another staff but I haven't done the care certificate. I don't have any mental capacity training". One health and social care professional told us "I have confidence in the staff, generally their knowledge is good. The nurse is always well informed."

We saw a record of induction had been put in place for staff starting from January 2017 which recorded information about the provider's history, confidentiality, dealing with complaints, staff meetings, and personal introductions to staff and people during a tour of the home. Most staff spoke positively about their induction with one staff commenting "I shadowed shifts initially and always felt supported during my induction. I had a check list of competencies." However we saw in the team meeting in August staff had raised concerns around the induction process stating they felt the induction was too short and needed to be more than four hours.

Not all staff had not received regular supervisions (one to one meetings) with their line manager. The registered manager informed us that supervisions were meant to be every three months with an annual appraisal. We could not find any recorded evidence of supervisions in the staff files that we looked at. The

registered manager found one person's supervision from May 2017 but could not locate any other supervision records to show that these had taken place. One staff told us "I have these (supervisions) all the time, and I don't wait for this to raise things or speak my mind." Another staff member told us "We have supervision informally, and appraisal annually. The rest of the staff we spoke with were unable to tell us when they had last had a supervision or how often this was meant to take place.

This was a breach of Regulation 18 (1) (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found concerns around the staff understanding and recording of people's mental capacity in the service. We found evidence of some mental capacity assessments that had been completed, however they did not document how the decision had been made that a person lacked capacity and how that person was involved in this process. For example one person had a mental capacity assessment in place to receive care from staff at Hill House. However there was no information about how this person had been supported to try and retain the information or if they had contributed to this process. Another person had a mental capacity assessment in place for 'having a bath instead of a shower even though this person would only have showers at home'. This person had full capacity, which demonstrated a lack of knowledge in understanding this was about choice not capacity and did not need an assessment in place.

We saw that two people had a Do Not Attempt Resuscitation (DNAR) form in place which stated they had capacity (The DNAR is a document issued and signed by a doctor, which tells your medical team not to attempt cardiopulmonary resuscitation). We saw that the care plans contradicted the information in the DNAR and recorded each person was unable to make informed decisions or retain information. We raised this with the registered manager to review people's DNAR with the GP.

We saw that where three people lacked capacity to give their consent, decisions had been made for them by relatives who did not have the legal authority to consent on their behalf. The service had accepted these decisions without ensuring that the relatives had a lasting power of attorney (LPA) in place (LPA is a legal document that lets people appoint someone to make decisions on their behalf). For example one person's family had consented for them to have the flu vaccination. The registered manager was unable to evidence that this person's relative had the legal authority to make this decision. Another person's relatives had written a living will for the person stating what treatment they wanted them to receive. The service had accepted this and incorporated it into the person's care plan; however they did not have legal authority to make these decisions on behalf of the person.

We saw that people in the new building who lacked capacity were unable to move around the building or leave without the support of staff. People could not access the lift without a key code. We asked the registered manager why this was in place and were informed that one person had used the lift to go up to the top floor during one night. The action taken had then been to prevent everyone in this building from moving around instead of considering how the person could be supported at an individual level. We saw only one person had a mental capacity assessment in place for this restriction, however no information was recorded around if the person understood this restriction, or had been helped to try and retain the key code to the lifts and front door.

We further found that the service had not applied for Deprivation of Liberty Safeguards (DoLS) for anyone living in the home (DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.) The service had not ensured that where people had been deprived

of their liberty this had been done following the correct legal processes.

This was a breach of Regulation 11 (1) (2) Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in October 2015 we found that the service was not promoting people's choices around meal times. At this inspection we found this had not improved. People living in the home were told the menu a week in advance so if they did not like the one option an alternative could be prepared. We asked how people were supported if they had forgotten what the choice was or wanted something different on the day and staff said an alternative would be offered. We observed on both days of our inspection there was only one option displayed. The staff said this was currently under review and they were looking to change the menus in the future to offer people choices. We saw one person's care plan stated they should be offered choices at every meal but the current menu would not have supported this.

The menu in the older building only displayed the menu until the first day of our inspection. We saw on the second day this had not been changed. In the new dining room the blackboard had also not be changed and continued to display the meal from the previous day. This meant people did not know what the menu choice was for that day until it was served.

We observed the mealtime experiences for people in the home and saw that people had to wait half an hour from the time they were assisted to sit in the main dining room until their meal was served. On one table everyone apart from one person had finished their meal. A staff member came over to cut up this person's food and the other three people at the table were watching. This person then did not eat any more of their meal and was aware of people watching which did not make it a dignified experience for them. When the pudding was served to people it was put down in front of them without a choice being offered or being asked if they wished to have pudding.

On the second day of our inspection there was pork on the menu, and staff had told us the day before two people did not like pork. We observed that one of these people had to wait for 40 minutes whilst an omelette was prepared instead of the pork dish. The person they were seated with had finished their meal before this person's arrived. There had been no earlier preparation to ensure that this person was given their alternative meal at the same time as everyone else despite knowing their dislikes in advance. This person's choices had not been respected in a person centred manner.

People had mixed experiences about the food that was on offer commenting "The food is very good, I like traditional food", "The tea is not warm, it comes over from the new building", "Sometimes the food isn't as good as you would do it yourself", "The food is not good considering what we are paying" and "The food on the whole is good, they know my likes and dislikes, you get a choice at supper, not at lunch, but if don't like it they make an alternative. I have tea or coffee and biscuits and I get a lot of fruit, I love all the fruit." One relative told us "I have had issues with the food but when I flagged it was sorted, food wasn't always warm, but is now. Staff know what my relative likes and dislikes and will try new food for her."

People, who chose not to go over to the new building for their meals, had their food brought over. This was originally planned to be done in a hot trolley to ensure it was kept warm, however staff told us this had not worked out as pushing the heavy hot trolleys up the ramp between the two buildings had not been feasible. Instead meals were plated up and carried over individually by staff. We saw that one person's meal was left on the second floor of the new building. It had a cover on it but was at the nurse's station accessible to anyone walking past. We asked a staff member who it was for and they did not know but were trying to find out. Five minutes later this staff member returned and stated it had been left on the side whilst personal

care was being given. This person's meal continued to be left on the side and during this time it was not kept hot. The provider could not be confident this person's meal was served at the correct temperature.

We saw that any allergies or meal requirements were recorded by the chef. Staff made up trays with tea or coffee on in the mornings and afternoons with biscuits or cakes and took these to people in both buildings. We saw that these trays were pre made up with either tea or coffee and asked how people were given a choice of which they preferred. We were shown a sheet which recorded everyone living in the home and if they had tea or coffee in the afternoon. However this meant that people were not asked at the time what they would like to drink but instead had been asked once and that was now recorded as their constant preference. We spoke with one person who told us they were always given tea but actually liked coffee too. This meant that people's choices were not been promoted in this instance.

This was a breach of Regulation 9 (1) (b) (c) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was providing 24 hour nursing care and people had weekly access to a GP if they needed this service. One health and social care professional told us "On the whole they are good at contacting health professionals. Some staff here are very good." We saw that where professionals had visited people their visits were recorded in people's care plans.

The service was spread over two buildings, and work was continuing on the new build to further increase the number of beds. Access between the two buildings was through a perspex covered walkway but the sides were open to the elements. Relatives commented "The new build has had a positive impact; we originally chose Hill House as it was small but it brought in registered nurses and my relative is moving towards needing that. The transition has been managed well. It's cold moving between the two buildings" and "It feels like this (the older building) is a satellite building now, very quiet, before there was more activity, you could hear things and music going on. Having nurses on board has made a difference though and the disruption has been well managed." One person commented "I find it cold, walking across to the new building."

Requires Improvement

Is the service caring?

Our findings

We found that people's choices were not always promoted or followed in relation to their care and support. For example the choice of having a bath over a shower or wash was not always offered in line with people's preferences in their care plan. We saw that three people's care plans documented that they all preferred to have a bath, however they had only been supported with one shower during a period of 18 days in October 2017 and no bath that month. We spoke to one of them who told us they "Loved a bath."

On one occasion during our inspection a staff member walk into a lounge and commented on how quiet it was and went to put on some music saying "You all like classical don't you." No choice was offered to people and they were not asked if they even wanted any music to be put on.

Some people in the older building told us they were given the choice of going over to the new building for meals and to spend their day commenting "Sometimes I have my meals downstairs or in the new building, I can chat to other people" and "The new build facilities seem good, sometimes I eat over there or in my room, staff help me go over." However other people were not so positive about the new build saying "We would always rather not go over to the new building and have our meal downstairs, but we have to ask specially", "I don't like the new building at all it's horrible, I go over for lunch. I have to wait and ask staff to let me in or out of the new building, I haven't been given the code, it's a keypad on the wall. We wait for a while and sometimes it's cold waiting and with winter coming it will be worse" and "I have been over to the new build, it's nice but it's different, a different kind of life, I prefer it over here."

We observed that people tended to be supported to move between the two buildings in groups rather than on an individual basis. We heard one staff ask another member of staff "[X] (staff member) is going to bring everyone over now to the new building. The staff replied "Who is coming over" and was told all the people would be brought over. The new building had a keypad entry to gain access but we saw people had to wait for staff to open the door or staff would take them over. We did not see evidence of people knowing and using the code themselves.

We observed on occasions that staff did not always respect people's privacy or dignity. For example one staff entered a person's bedroom without knocking first and seeking permission in case the person did not want to be disturbed. At other times staff were seen to be patronising to people in their verbal communication saying "Pin back your ears", "What darling" and "What would you like sweetness" instead of using people's preferred names. We did not see any information in people's care plans that they were happy to be spoken to in this manner, and care plans recorded requests for people if they wished to be called anything aside from their name.

Relatives we spoke with however felt their relatives were treated with respect and commented "Staff are very respectful and very fond of my relative, I can't fault them, they are lovely" and "Staff are very good and respectful. I have seen them hoist [X], they are very caring and talk to her throughout." One person told us "Staff are respectful to me." One person commented "Staff treat us well and with respect." Other comments from people included "Sometimes agency staff come and they can be from all over the world, they are all

very polite and caring, no-one fools about" and "I'm quite an independent chap and I keep myself to myself and staff respect that."

People we spoke with were mostly positive about the care provided by staff commenting "I am content here, this is my third home and I feel much happier here", "Staff are very good, the staff do change a bit, but if you want something they help you", "It's very pleasant, it's not home. Staff are good, some aren't as gentle as others but on the whole they run a good ship" and "The girls know how I like my wardrobe organised and are very good. I have everything I want but it's not home. Staff are lovely." One health and social care professional told us "It's a good feel I get when I come in here. I think this is a good home."

We saw that when staff supported people, this was conducted in a kind manner, speaking with people as they passed them. We observed one person being supported to eat their meal in their bedroom and the staff member spoke with them during this and checked that they were enjoying their meal. This staff then went off to find a pudding that they thought the person would enjoy as they had not been very well recently and had struggled to eat some foods. One staff told us "It's a very friendly place, we have a garden party in summer and that's lovely. They go to a lot of effort." Another staff commented "I like working here; they (other staff) seem up to speed in how they treat the residents." Relatives we spoke with felt their loved ones were well cared for commenting "The care she's been given is exceptional, they do so much more with residents" and "I'm happy with what we have for my relative, happier than ever, I couldn't wish for her to be in a better place now. The staff are the best thing, the regular staff, I can't praise highly enough."

Requires Improvement

Is the service responsive?

Our findings

The support plans we viewed contained information on people's life history, interests and likes and dislikes. However we found that information recorded often lacked detail and was inconsistent. For example one person's care plan recorded that they had checks throughout the night. However when we spoke with staff about where these checks were recorded they told us they did not check this person during the night as there was no need to do so. This was not in line with what their care plan stated and had not been updated.

We found one person's care plan recording around their mobility was inconsistent which made it hard to establish their current level of need. The falls risk assessment stated this person had not fallen before they came to live at the home, however the preadmission information recorded that they fell and went into hospital and this was the reason they moved into the home. This person had experienced four falls since April 2017 resulting in minor injuries of skin tears and bruising and was using a walking frame when mobilising. However their daily living care plan recorded that they mobilised with the aid of a walking stick and when it was reviewed in October 2017, it was documented that there was 'no changes' to this despite the person now using a walking frame.

We found further inconsistencies in care plans for personal hygiene. One person's daily living care plan stated that they 'manage their own personal care daily with assistance to wash back and feet. 'Further on in their personal hygiene care plan it states that this person needed assistance from 'one carer for their personal care needs at all times.'

Where a person's care plan contained specific details around a care regime, we found that this was not always reflected in practice. For example one person had a detailed care plan for skin care which involved prescribed cream being applied daily to their legs and arms. In the daily notes it stated that the person's legs were having cream applied but during October 2017 their arms had only had cream applied twice out of 18 days. When we spoke to staff about this person they were not able to tell us what areas the cream should be applied.

There was mixed levels of recording in place for monitoring people's wound care and treatment. One person had an injury to their toe and photos had been taken and notes of the professionals involved and management plan. However another person who had been admitted to the home with a pressure ulcer had no dates recorded or wound plan in place to show how this had been monitored and managed or if it was still a concern. Another person had fallen in August 2017 and it was recorded that they had sustained a bruise to their upper arm and blood was found. The action taken was recorded as putting a wound chart and body map in place. However the wound chart could not be located in this person's care plan and the body map stated no injury and had been left blank despite the person having had a bruise. The recording was inconsistent and made it hard to track the exact injuries this person had experienced in order to ensure they were being appropriately cared for.

One person had a body map which recorded they had 'red heels'. Their pressure area risk assessment documented that this person was at very high risk of developing pressure ulcers. We were not able to see

any further recording about the redness of this person's skin or how this person was being supported. This meant it was unknown if the appropriate action had been taken to prevent or reduce the risk of the development of further skin damage for this person.

We saw that people living in the home had been scored on their dependency levels in areas of mobility and personal care support. A total score was recorded however there was no information on what this score meant for the person, if their needs were high and how their care would be given in line with this score.

The registered manager told us that no one in the home was at risk of dehydration or malnutrition; however we saw that three people were having their daily intake recorded on food and fluid monitoring charts. We saw that there was no recommended amount recorded on the fluid monitoring charts and the total had not been added up to ensure people were receiving enough. Where staff had recorded food it did not state the size of the portion and gaps were often observed in the charts. The monitoring charts were not being used as an effective tool and this meant if there were concerns they would not be identified in a timely manner in order for action to be taken. One person's care plan stated they had started to have their meals in their room in June 2017 as had been unwell, however we saw this person on both days in the new building's dining room. This person's care plan had not been updated to reflect their current situation.

Although we saw that people had communication care plans in place which detailed how to effectively communicate with them if there were specific needs, there was a lack of pictorial or easy read content for people who may need information in this way. We saw that there were no pictorial aids used to assist people in making choices around their preferred menu options or other care decisions.

We could not see evidence in people's care plans that they had been invited to attend regular care reviews with the registered manager, staff and their family if they wished them to be present. The registered manager told us that these were not currently being done but needed to look at planning these in.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints had not been encouraged or managed appropriately within the service. A complaints policy was in place. We reviewed the complaints procedure for people who lived at the service which stated that 'complaints can vary from the trivial to the serious.' We queried the appropriateness of the word 'trivial' with the registered manager in making it clear to people that they should be supported to raise any concern without fear that they will not be taken seriously.

The service had received two complaints this year. One was from a person who had received visitors in her night clothes due to staff being unable to support them to get up. This person had stated this was due to staff shortages. This complaint had not been recorded on a complaints form as per the complaints policy. There was no investigation attached to demonstrate what actions had been taken to determine the events that led to this complaint being made. We found a written response from the registered manager apologising. The complaints policy states that all complaints will be resolved within seven working days. The letter of response from the registered manager was written 10 days after the complaint had been made. There was no evidence to demonstrate this complaint had been shared with staff.

Another complaint had been received from a person stating that their mail had been found by accident in the building by a carer. The person had written 'it may seem trivial but to me it's not.' We observed on both days of the inspection that people's mail was left unattended in the main hallway. On both days it was there when we left the service in the evenings. In response to this complaint the registered manager had recorded

in the complaints log 'I have spoken to all staff and put a notice up in the staff room that all mail is delivered daily.' However this was not being followed and learning from this complaint had not been implemented into the service.
This was a breach of Regulation 16 (1) (2) Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were happy to raise any concerns and knew how to do this. Comments included "I like to go to the top so I would speak to the sister (clinical lead)" and "I know the manager, she wanders through and if there is anything I write to her and tell her, she wrote back and addressed my concerns in a letter." One relative said "I don't have any concerns; any I have had are raised."

There was one activities staff member employed at the service four days per week. The service had employed two staff but one had recently left. The registered manager told us that they hoped to recruit into this post swiftly. There was a plan for activities between the hours of 9.30am and 2.50pm but nothing after this time. There was provision for a group activity in the morning and afternoon and sometime set aside for personal interactions on a one to one basis.

We observed positive social interactions between people and the activity staff member that were inclusive. One person told the activity worker "We are glad to see you; we know we will get good quality entertainment when you are here." The activity staff told us the service was a member of the National Activity Providers Association (NAPA) and that they used this membership to read resources and help them think of activities.

On the first day of our inspection there was a residents' meeting. We were invited to attend. The registered manager chaired the meeting and the operations director was also present. There was an agenda which was discussed. People asked for more entertainment and the registered manager replied that there was a "Robust entertainment programme with no room for error." They went on to add that "Hours were allocated so that everyone gets the same amount of one to one time." This response to activity provision did not demonstrate a person-centred approach to meeting people's individual social needs which would vary day to day. The registered manager had also not taken seriously concerns raised by people or completed thorough investigations into the nature of the complaints.

We observed six people sitting in the new building lounge area engaged in an activity they had come up with between themselves. There were no staff present and the planned activity of a quiz had finished by 2.30pm with no other activities scheduled. One person told us "There is nothing for us to do. If we don't use our brains they rot and some of us are very capable." Another person said "The activities are poor, we try and amuse ourselves." The lounge area looked out over a rural landscape, one person told us "We look out at a lovely landscape but nothing happens." On the second day of our inspection one person in their bedroom told us they were staying in their room because "There is nothing happening today."

Other comments from people included "If they are doing something that appeals to me then I will go", "There seems to be a lot going on but when you get to my age you don't always want to do a lot, we have films and talks, it could be better. I like to watch if I don't join in", "There isn't many activities in this building, they are all in the new building, there isn't the space" and "I like to read or do puzzles, not really join activities I'm a loner. I have a meal with another resident, we are good friends and chat and when the weather is nice we can sit outside."

Inadequate

Is the service well-led?

Our findings

The registered manager had remained in post since our last inspection. However at this inspection it became clear that the service was no longer being well managed and the leadership and governance of the home was ineffective. There had been a breakdown of communication within the management team and this had impacted on the delivery of service that people received. Some staff we spoke with referred to tensions within the management team with one staff commenting on the "Reactive' relationship between the management and the clash of management styles." Another staff member said "The managers are open and I feel listened to, but things are not put into place quickly enough."

We spoke with senior management about these concerns and they were open in discussing that there had been struggles in the last year. The provider however was unaware that the concerns had impacted so heavily on the daily running of the service. The operations director told us they had needed to step back from the service to enable the registered manager to develop, however the registered manager in turn felt that they were not being supported appropriately.

The provider had undertaken a large project to build new accommodation on this site increasing the number of beds to 35. The provider had also changed their registration in February 2017 to provide nursing care at this location. Building work was continuing with plans to further increase the location size. However the service was not effectively supporting the 22 people who already lived at the service had and were struggling to recruit staff in all job areas. The registered manager had little knowledge of people's nursing needs and these were overseen by a clinical lead. However the clinical lead and registered manager had also struggled to build a relationship which meant that there was a lack of supervision of people's needs in the nursing part of the building. The clinical lead was leaving the service and a new lead had been recruited. During our inspection it became apparent that the registered manager lacked oversight of any person's care and support who resided in the new nursing building.

Concerns were raised to us by staff about how the dining room and kitchen would cater for the planned increase in numbers. The management spoke about having two sittings for mealtimes; however the kitchen staff told us lunch took until 2pm to finish with only 22 people to currently cater for, so they could not envision how this would work successfully. The current dining room did not have the space to accommodate increased numbers of people and the further building work did not include any more dining space. The provider and senior management told us this was something they needed to think about further.

Concerns had been raised with the provider at the time of registering the new building about there being no link between the two buildings and how meals would be served to people if they stayed in the older building. The provider at this time had provided assurances that they would maintain the current dining room and a hot trolley would be used to transport food over and maintain the temperature of people's meals. At this inspection we found that the provider had failed to follow this registration agreement and the hot trolley was no longer being used. Instead staff were manually carrying individual meals over to the older building.

The provider did not have effective systems in place to monitor the quality of care and support that people received. The registered manager could not produce documented evidence of how they were currently monitoring the quality of service people received and we were unable to seek assurance from the audits that had been completed. For example audit forms to monitor accidents and incidents only listed each incident. There was no investigation, analysis of cause or points of learning that had been shared after these events. There had been no consideration given to identifying trends or patterns in order for the service to implement any future preventative measures.

The registered manager was not able to demonstrate that they were sharing any learning points from incidents with the staff team. We found two accident forms which recorded that one person had their hand trapped in a bed rail and another person had their hand trapped in the lift. Neither of these accidents had been investigated to prevent a reoccurrence, or to inform staff's future practice. The registered manager told us they had verbally told the staff team preventative measures; however there was no documentation to support this. We looked at the generic risk assessments for the building and saw that these had not been had not been reviewed since 2016. The registered manager told us they had completed reviews in 2017 but were unable to locate or show us the updated versions during this inspection.

We found that a care systems audit had been completed. This had identified that some care plans needed updating however, there was no action plan to identify how these shortfalls were going to be addressed or timescales to complete this by. There were no on-going records of what if any actions had been taken to meet this shortfall. An individual monitoring chart audit had been completed once this year. It identified shortfalls but no action plan had been put in place or any indication that the shortfalls had been addressed. We found that the registered manager had written this report and signed it off with 'and so on and so on, blaa blaa blaa'. This demonstrated a clear lack of management approach and governance in ensuring the service was monitored and people received appropriate care and support.

This was a breach of Regulation 17 (2)(a)(b)(f) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the number of concerns we wrote to the provider requesting an action plan to immediately address these shortfalls and keep people safe. The provider responded to this letter within the timeframe and we are currently considering what action to take.

Services are required by law to send us statutory notifications about incidents and events that have occurred at the service and which may need further investigation. In August 2017 we found that the provider had failed to notify us of an alleged abuse incident. We were informed by the Local Authority Safeguarding team. We contacted the provider to query why this had not been notified and were informed this had been an oversight. The notification was sent shortly after this time.

The provider had displayed their ratings from the last inspection clearly at this location and on the provider's website so people could be informed of this information.

We saw that resident meetings were being held and we observed one of these take place during our inspection. One person told us "There is a resident's meeting and this is regular." However relative meetings or feedback opportunities were not being facilitated, with relatives commenting "We don't have relatives meetings now, we did have a few but it fizzled out. The home do ring and communicate anything to us about my relative. I have not been asked to give feedback" and "Communication is good, I haven't been to a relatives meeting and I was asked to give feedback once a long time ago." The registered manager told us they had removed the suggestions box from the front reception as they had only received "Silly suggestions"

mainly from staff. This showed that feedback was not taken seriously or valued as an opportunity to address concerns and improve the service.

People spoke positively about the registered manager commenting "The manager made herself known; she comes into the rooms and is available if you want to talk to her which is good. I would recommend this home", "I see her about, she comes and chats with me" and "The manager is very nice, I am very satisfied with it all here, it's the caring staff that count." Relatives also told us "The registered manager's door is always open, we don't have set times when things are reviewed but I'm happy to bring things to their attention. The manager delivers on anything I ask or finds out" and "It's very friendly, since it's enlarged the management has improved, they are working more efficiently and had to up their game, I feel comfortable with the set up here, they are always ready to listen." One staff member commented "The managers are very caring towards staff and there is an open door policy with the registered manager." Other staff told us they felt supported by the registered manager and they were approachable and available.

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 9 HSCA RA Regulations 2014 Person-centred care People were not supported in a dignified manner during mealtimes. Choice was not always given or preferences supported. Regulation 9 (1)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment had not always been obtained following the appropriate procedures to ensure people were not unduly restricted. Regulation 11 (1) (2) .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not effectively assessed, managed or reviewed in order to keep them safe. Regulation 12 (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People's complaints had not been encouraged or managed appropriately within the service. These were not shared with staff to implement in future learning.Regulation 16 (1) (2).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Information in people's support plans and monitoring records was often inconsistent and lacked detail making it hard to ascertain people's current needs. Regulation 17 (2)(c) The leadership and management in the service was ineffective which had impacted on the quality and delivery of care people received. No quality monitoring had been completed of the service.Regulation 17 (2)(a)(b)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices had not always been followed or the necessary checks completed to ensure new employees were safe to work with venerable adults. Regulation 19 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People's care and support needs had not been considered when calculating the staffing levels to ensure there was enough staff. Regulation 18 (1). Staff had not been supported to keep their knowledge up to date and inform their practice to appropriately support people. Staff had not been supported to attend regular supervision. Regulation 18 (2)(a).