Mrs M Hope and C Hope

Hillcrest Residential Home

Inspection report

14 Northgate Avenue
Bury St Edmunds
Suffolk
IP32 6BB

Tel: 01284760774

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hillcrest Residential Home is a care service for up to 13 older people who may be elderly, have a physical disability or be living with dementia. It does not provide nursing care.

There were nine people living in the service when we inspected on the 13 and 17 March 2017. This was an unannounced inspection.

There was a registered manager in post. 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.

At our comprehensive inspection of 02 October 2014, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which was: Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. At our focussed inspection of 18 June 2015, we found that improvements had been made but needed embedding in the service.

You can read the report from our last comprehensive and focused inspection, by selecting the 'all reports' link for Hillcrest Residential Home on our website at www.cqc.org.uk. This comprehensive inspection was undertaken to check that further improvements to meet legal requirements had been made.

During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Improvements were needed to ensure that medicines were administered safely and in line with best practice.

There were insufficient numbers of staff and improvements were required in the recruitment process to check that staff were suitable to work with vulnerable people. Staffing issues had been identified by the manager and they were trying to address this.

There were some gaps in training records and staff required refresher training to ensure that they were knowledgeable and could support people safely and effectively.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in relation to the Mental Capacity Act 2005 (MCA) were not up to date. Whilst the service had made reference to people's ability to consent within their care records, there were no formal capacity assessments in place to determine people's level of understanding in accordance with the MCA. Staff understanding of what the MCA meant in practice

was limited.

People told us that they had good relationships with the staff that supported them and people were encouraged to be as independent as possible by a staff team who knew them well. People cared were not always able to call for assistance if needed.

People had sufficient amounts to eat and their dietary nutritional needs were met. However, where people's needs changed, these had not always be re-assessed to ensure that the people were having enough fluids to keep them well.

People were encouraged to attend appointments with other health care professionals to maintain their health and well-being.

There were no formal monitoring or audit systems in place to show how the registered manager assessed the quality of the service, identified shortfalls and ensured that these were addressed promptly. This resulted in a lack of oversight of the whole service and areas that required improvement from the registered manager. The service had failed to notify us when a person using the service sustained a serious injury.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were required to ensure that there were enough staff employed at the service.

Medicines were not always administered safely or in line with best practice.

Risk assessments were not always detailed enough.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not make sure that people's capacity to consent to care and treatment was properly assessed and recorded to determine people's level of understanding in accordance with MCA.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. However, not all people were being effectively monitored to ensure they were given enough to drink to support their health and welfare.

People had access to appropriate services which ensured they received on going healthcare support.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their Interactions with people.

People's independence was promoted.

Is the service responsive?

Good

The service was responsive.

Staff knew about people, their individual likes and dislikes and how these needs were met.

People were given the opportunity to participate in activities.

Care plans were up to date and had been reviewed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service provided an open culture and people and their relatives were asked for their views about the service.

Audits were not completed to assess the quality of the service. This meant there was a lack of oversight from the registered manager and shortfalls in the service were not always identified.

Hillcrest Residential Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on the 13 and 17 March 2017 and was undertaken by one inspector.

Prior to the inspection, we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

Before the inspection, we usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems, a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

During our inspection, we looked at the care records of four people, recruitment records of four staff members and records relating to the management of the service and quality monitoring. We spoke with five people living at the service and three relatives. We observed the support provided to those who were unable to talk with us due to their complex needs. We spoke with seven staff including the manager, cook and apprentice and one professional involved with the service.

Requires Improvement

Is the service safe?

Our findings

Improvements were needed to ensure that the medicines administration processes were safe and were following best practice. On the first day of inspection we saw that the medicines for each person had been dispensed into a medicines pot and was being carried around on a tray by the senior staff member on duty. This was unsafe practice as there was a potential risk of the pots being knocked over, medicines being lost or of them being given to the wrong person. The staff member told us that they only did this that morning because they were "busy", however, we saw numerous medicines pots in the office with people's names written on them which indicated this was normal practice. We discussed this with the staff member and the registered manager who agreed that this was not a safe way to administer medicines and that this would be addressed to ensure that medicines were administered safely.

Where as required (PRN) medicines are prescribed, there should be clear guidance to staff on what each medicine is for, when it should be given and how often and any proactive strategies to use prior to using the medicine. This guidance was not in place for all PRN medicines that were being administered. For example, a person had been prescribed lactulose and there was no guidance available on when this medicine may be required or how often it could be taken. The medicines policy did not cover the use of as and when required medicines. This meant that there was a risk that these medicines could be administered when they were not required or wanted.

We checked the medicine administration records (MAR) and saw that that there were some missing signatures. We saw that where one person required cream to be applied, there were 21 occasions where there was no signature to confirm that this medicine had been administered. This meant that we could not be sure that people had received their prescribed medicines as required.

Medicines were not always administered according to the instructions on the MAR. The registered manager told us that they had monitored how the person responded to their medicines and adjusted the amount to ensure that it met the person's needs. For example, where the MAR said, 'Take two daily',the person was actually having one every other day. The registered manager told us that these changes had been agreed by a GP, however they could not find where this had been recorded and the MAR sheet had not been amended. This meant that because the person was not getting their medicines as prescribed, they may not be effective in treating their condition.

The senior staff member on duty had not received any recent medicines training. The registered manager told us that they had received training in their previous employment and that they had shown the staff member how to administer medicines. Staff had not received recent training in medicines administration; however this was planned for that month.

Each bedroom had buzzers so that people could call if they needed help. However, we saw three occasions where buzzers were not within reach of people upstairs in their bedrooms. On the first day of inspection, we saw one person trying to stand up and no evidence of a buzzer within reach to request assistance. The person said, they "needed help." There was no staff member upstairs to provide any assistance. This person

was at risk of falling and their care plan said that they required supervision to prevent falling and that to, reduce the risk, they should be brought down to the lounge. A staff member told us that a sensor mat was used to alert staff if the person required assistance, however, on one occasion we saw this was stored behind a bookcase and on another it was not in the area where the person was sitting. This placed people at risk of being unable to alert a staff member when they required assistance.

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

Staffing rotas were not accurate as not all shifts worked by the registered manager and one other staff member were recorded. We checked the rotas between 22 January and 4 February and found fifteen shifts where staffing levels had been below those required to meet people's needs. The registered manager told us that they covered whenever the service was short of staff; however, this was not always documented on the rota. This meant we could not be sure that the service had been adequately staffed at all times. The manager told us that they had two vacant full time posts and that they were having problems recruiting to these. There were also some instances of sickness in the service which had caused problems with staffing the service to appropriate levels at times. We were concerned about the amount of hours that the registered manager was working in trying to cover the vacant hours and any sickness. We discussed this with the registered manager who said they would continue to try and recruit to the vacant hours.

Despite our findings, relatives told us there were enough staff and we saw that staff were not rushed in their interactions and had time to spend sitting and chatting with people. One relative said, "There is enough staff, they don't appear rushed." Another relative said, "There is not too many people here, so [person] near enough gets supported one to one." One staff member said, "If the service is ever short of staff, the shifts get covered by the three family members." The registered manager and two members of staff working at the service were related. However, one staff member said, "We could do with an extra staff member early morning so there is a staff member to sit in the lounge with the residents who are already up in the morning while others are being supported to get up. There is one staff member who will start early to help out."

Staff told us they had received training in protecting adults from abuse; however we could not see any recent evidence of this. There were some certificates on file from 2015. The registered manager told us that some certificates were missing from staff files and that they would be arranging safeguarding training imminently.

Staff understood the different types of abuse and knew how to recognise them and were able to tell us what action they would take if any form of abuse was suspected. One staff member said, "I did safeguarding training last year. I would tell the manager and if they didn't do anything and it was serious, I would go to the police or to social services." Another staff member commented, "If I suspected abuse, I would see what is happening and if there is a pattern and raise the issue with my manager. I f they didn't respond, I could raise the issue with CQC." Staff told us that they had confidence that any concerns they raised would be taken seriously and action taken by the manager.

Some of the risks to people's personal safety had been assessed and included risks associated with mobility. While some assessments were detailed, others were not and did not always contain enough detail or guidance on the action for staff to take to reduce the risk. For example, where one person was at risk of falls, there was no guidance in place to tell staff how to support the person to reduce the risk of them falling. Because the service had a small staff team who knew people well, the staff team understood the action to take. The manager agreed that some of the information required updating and assured us that the detail would be added.

Risks to people injuring themselves were limited as equipment, including hoists had been serviced and regularly checked so they were fit for purpose and safe to use. Fire fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed.

Records showed that full recruitment checks were not always made on new staff before they were employed by the service. One senior staff member, who had been employed at the service for six months, did not have any references, although they did have a criminal record check in place. . A lack of appropriate checks meant there was a risk that staff could be employed who were not appropriately qualified, competent or experienced to fulfil their role. The Registered Manager told us that the references for this member of staff these had been requested and that they would chase these up urgently.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Improvements were required to ensure that the MCA was appropriately implemented. There was no organisational policy in the service covering the MCA and DoLs (Deprivation of Liberty Safeguards) which was confirmed by the registered manager. The registered manager told us that everyone had capacity to consent to any care that they received and that the service would not be able to meet the needs of anyone who did not have capacity. While we saw that some people had signed to consent to the care that they were receiving, we were not sure that two people had the capacity to make decisions relating to their care due to a change in their needs. This meant that the care the person received may not be appropriate or provided in line with the MCA. This was discussed with the registered manager who told us that they would put a policy in place and ensure that the MCA was appropriately implemented.

Staff had not received any recent training in the MCA and were unsure about what the MCA meant for people. One staff member said, "I haven't had training recently but I would ask the family if someone couldn't make a decision." Another staff member said, "The residents will tell me if they need something."

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent

People were asked for their consent before staff supported them with their care needs. For example, assisting them with their medicines and personal care.

Staff were knowledgeable about their work role, people's individual needs and how they were met. One staff member said, "We need to know people's routines and what they prefer. We know people inside out and this is the advantage of a small home."

Staff told us that they had received training which was relevant and gave them the necessary knowledge for their roles such as first aid, infection control and diabetes, however we did not see evidence of this for all of the staff as some certificates were missing and one staff member said, "I haven't had any training recently." The registered manager confirmed that the staff team required the mandatory training courses to be

refreshed and that they were in the process of arranging this training.

The registered manager was aware of current best practice guidelines in relation to the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work. The registered manager told us that the newest staff member would be completing this. Staff completed an induction which involved shadowing other members of staff. This ensured that new staff knew how to support people according to their needs.

We received mixed feedback regarding the support that staff received. Formal supervision was not always held and although staff meetings took place, these were infrequent with one being held in October 2016 and one in June 2016. Supervision is an opportunity for the staff member and manager to meet and discuss performance and areas for improvement. The registered manager told us that they speak to the staff every day during handover to discuss any issues that arise and that staff have an annual appraisal. One staff member told us, "We do have supervision – it is on-going and an official appraisal every year that goes on file." Another staff member said, "The manager talks to me about everything and I get enough support." However one staff member said, "I haven't had supervision since I have been here."

People were complimentary about the food and said that they had a choice of what to eat. One person said, "The food is quite good and I can choose what I want." And another person said, "Oh yes, the food is nice." One relative said, "[Person] gets fed well." Another relative said, "There is always a roast, they do a lovely Christmas dinner and there is always lots of cold drinks and ice cream in the Summer."

The cook told us that people were asked what food they would like on the menu and that a different menu was used each week. A vegetarian option was available and if people did not like the menu that was available, then they could choose something different. At lunchtime, we saw that the food was freshly cooked and we saw that it was nicely presented. One person commented, "Lunch was very tasty."

People were encouraged to eat independently but where people required assistance, this was provided. For example, one person was finding it difficult to cut up their food and a staff member offered to cut it up and gained their consent before providing the assistance. Where people's food preferences had changed, this was recorded in the care plan.

People's records showed that people's dietary needs were assessed and generally met, however one person's care plan stated, 'Encourage fluids' and we observed on one occasion that there was no fluid within reach of this person when they were sitting in their bedroom. This person had a chest infection and the GP had recommended that fluids were encouraged. There was no re-assessment of this person's needs and there was no record of fluid intake for this person seen or evidence that their fluid intake was being monitored to ensure that it was adequate for their needs. We raised this with a staff member who responded by ensuring that the fluid was within the person's reach.

Where people required their food to be prepared in a certain way, this was documented in the care plan. Some people had not been weighed since December which meant that staff would not be aware of any weight loss or be able to take any action where required. The registered manager was aware that people had not been weighed recently and told us that some staff had fallen behind in keeping records up to date. The registered manager said that she would ensure that people were weighed that week and that this was done regularly going forward.

People's health needs were met and where they required the support of healthcare professionals, this was provided. One relative said, "[Person] had a fall and the GP came out." Another relative said, "They always

get the nurse out if needed." Records showed that people were supported to maintain good health, have access to healthcare services and receive on-going healthcare support. Where changes in people's wellbeing were identified, action was taken to seek guidance and treatment from health professionals.

Good

Is the service caring?

Our findings

People spoken with said that the staff were caring. One person said, "The staff are nice." Another person commented, "The carers are good." A third person said, "I have always enjoyed living here." All of the relatives we spoke with were complimentary about the caring approach of the staff. One relative said, "Staff are very friendly, chatty and it is calm." Another relative said, "I can't say a bad word about any of them [staff]. I am very happy with how [person] is treated." A third relative said, "The caring is the best. They [staff] do look after [person]."

There was a relaxed and friendly atmosphere in the service. We saw that interactions were not rushed and staff spent time sitting and chatting with people and encouraging conversation. Staff communicated in a caring manner and in an effective way by making eye contact, listening to what people said and getting down to their level.

People were supported to maintain their independence by staff. One person's care plan said, "Encourage me in conversation and listen to what I have to say." And, "I would like to maintain my independence as much as possible." One person told us, "I try to get on with it. They [staff] don't always help but I can do it myself." Where one person was being supported to mobilise, they were encouraged to do as much as possible for themselves.

Staff were kind, supported people at their own pace and provided reassurance by explaining what they were doing. For example, when supporting one person to use their walking frame. However, people's privacy was not always respected by staff. There were two occasions where staff did not knock on a person's bedroom door before entering which was not respectful. While staff were able to tell us how they respected people's privacy and dignity, this was not put into practice on these two occasions.

Staff knew people well and their preferences were recorded. One care plan said, "I would like staff to let me touch the bath water before I get in the bath." Another care plan said, "I always like to wear dresses." One relative said, "I think the staff know [person] very well." Staff involved people, where possible, in developing care plans and all of the staff team inputted into care plans to ensure that these were reflective of the person and met their needs. One relative said, "I am not involved in the care plan but they [staff] talk to us about person's care all the time." Another relative said, "Staff do ask us for our views, they are very good like that." People were in the process of having formal care reviews with a social worker.

People told us that they could choose what they wished to do. One person said, "I can choose whatever I want to do." People's bedrooms were personalised and reflected their choice and individuality. People had the opportunity to include personal items of decoration and furnishings to personalise their space.

Visitors could come at any time and we saw people entertaining their visitors who were welcomed by staff. One care plan said, "Make my family feel comfortable when they visit." This meant that the risks of people becoming lonely or isolated were reduced because people's relationships with their family and friends were respected.

Good

Is the service responsive?

Our findings

People were provided with some activities to reduce the risks of boredom and isolation. Activities took place on an ad hoc basis with an art session and church service held monthly. We saw six people taking part in bingo. They were concentrating and enjoying the game, with lots of shouts of "house!" The staff member who was playing the game with them was very encouraging and kept people engaged, checking that they had heard the number that was called out. We also saw people taking part in physical exercises and people were laughing and clearly enjoying themselves. One person proudly showed us the art work that they had completed which was displayed in the dining area. One person said, "There is not much going on but I don't get bored." One relative said, "[Person] has enjoyed playing dominoes and appears very happy." Another relative said, "[Person] does take part in the activities. They do aerobics and I do this with [person]." A third relative said, "There is always something going on."

We discussed activity provision with the registered manager who told us that a mini bus is contracted when people wish to go out for the day; however people didn't want to go out much and preferred to do their own thing and make their own choices daily. Activity records confirmed that activities were mostly home based and included knitting and doing jigsaws. Library books were brought to the service regularly for people to enjoy.

Although there were some group activities arranged, we did not see much quality engagement from staff to prevent the risk of people feeling socially isolated who were in their bedrooms. We discussed this with a staff member who told us that everyone usually spent time in the lounge but some people were not feeling well and said that regular checks were being made on these people to ensure that they were okay.

People had life histories within their records and staff knew about people, their individual likes and dislikes and how these needs were met. Care plans covered areas such as mobility and communication and provided guidance for staff in how people's needs were to be met. One care plan said, "If you would like to know me better, please ask me about anything." There was a list of subjects that the person liked to talk about so that staff could engage in conversation. Care plans had been reviewed, with the last review being in November 2016.

People and their relatives spoke positively about the service. One person was staying for respite and their relative spoke of how they wanted to stay at the service saying, "It is so nice and I like it here." Another relative said, "They [staff] always pick up on things so by the time we raise it, it is already being dealt with." One person said, "I go downstairs and watch the TV and they [staff] make a nice cup of tea." Another person said, "It's alright here. Oh yeah, they look after you."

People's views were gathered through residents meetings although these had not been held regularly, with the last meeting in May 2016. At this meeting, people requested to have a BBQ and the registered manager confirmed that this had taken place. The menu had also been discussed and people had expressed that they were happy with the food options available. The registered manager told us that residents meetings would be introduced again.

The service's complaints policy was out of date and required updating and distributing to those using the service and their relatives. The service had received one formal complaint which the registered manager told us was recorded but was not available on the day of inspection for us to check. Although the policy required updating, relatives knew how to complain and that their concern would be listened to. One relative said, "I didn't find out that my relative had a fall until the following day. I told the [staff]. They were fine with it and have said that they will call in the future."

Requires Improvement

Is the service well-led?

Our findings

The provider was not ensuring that there were robust systems in place to check that the quality of care provided was safe and of a consistently good quality. As mentioned previously in this report, we identified problems with staffing, medicines, recruitment checks, training, the application of the MCA, weight records and a lack of fluid monitoring. While some of these concerns had been identified by the registered manager prior to inspection, they continued to be a concern as action taken had not been effective in addressing the issues. Lack of effective oversight meant people were at risk of receiving care which was not of a good standard.

The registered manager was not up to date with best practice or their responsibilities under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, they were not aware of their responsibilities under Regulation 20: Duty of Candour. The registered manager told us that they read Health and Social care magazines and talked to other care managers to keep up to date with best practice. However, they were not implementing current best practice in the care industry. For example, in the medicines administration process and the application of the MCA. The service was family run and due to the lack of external engagement the service had become isolated from best practice in the industry and this impacted on their ability to continuously improve the service and ensure that the service was up to date.

At our comprehensive inspection of 02 October 2014, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which was: Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. At our focussed inspection of 18 June 2015, we found that improvements had been made but needed embedding in the service. At this inspection, we found that while cleanliness and infection control processes had improved and were embedded; records of cleaning undertaken that were implemented following the inspection were no longer formally recorded. Lessons had not been learned regarding the importance of monitoring and auditing practices within the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:Good Governance
The registered manager did not fully understand their role in ensuring that the service provided care that met the regulatory standards. All care providers have a statutory requirement to notify us about certain changes, events and incidents affecting their service or the people who use it. We had not received any notifications from the service since 2015. We queried this with the registered manager. They acknowledged that there had been occasions when they should have submitted a notification, in particular, an incident where a person using the service sustained a serious injury. We asked that they familiarise themselves with the guidance available for registered providers in relation to statutory notifications.

This was a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

We discussed our findings from the inspection with the registered manager who was open to feedback and recognised that improvements were required. To ensure that the service is up to date and following best practice, we recommend that they explore current guidance from a reputable source, for example, the

National Institute of Clinical Excellence, on the safe management of medicines and also consider guidance relating to the MCA 2005 from a reputable source such as the Department of Health and/or Social Care Institute for Excellence (SCIE).

Despite our findings, staff and relatives told us that they felt that the service was well-led. One staff member said, "We can tell [registered manager] if things are not right. If we need something, it gets sorted out." Another staff member said, "It is definitely well-led. [Registered manager] makes sure that I do my job properly." One relative said, "The service is well-led. They [staff] look after her, they [staff] keep her motivated." Another relative said, "[Registered manager] seems a lovely person.

Staff generally felt that the registered manager listened to their suggestions and acted on their feedback. One staff member said, "[Registered manager] does ask for our opinions and input on the service." Staff generally felt supported. However, one staff member said, "I don't always feel well supported. I just come in and do my job and that is it."

Staff meetings were not held regularly with the last meeting being held in October 2016.The service had a small staff team and the manager was very visible in the service. The manager told us that they worked alongside the staff team and were in the service a minimum of five days a week. This meant that they could speak to staff and people regularly to ensure that they were provided with up to date information to be able to support people effectively.

Relatives told us that the registered manager was approachable. One relative said, "[Registered manager] is lovely. Definitely approachable and I have no concerns." Another relative commented, "[Registered manager] is approachable. It is so nice. Everyone is so nice. I have no concerns."

Annual surveys were completed by people, relatives and staff for feedback on the strengths of the service and areas for improvement, and the results were mostly positive. One survey from a person said, "It's like home. You can do what you want when you like." Another said, "I am well provided for and fell safe." One relative said, "I think Hillcrest do a very good job."

We saw thank you cards that had been received by the service and compliments which included, "I would like to express our gratitude for the consideration you and your staff have shown [person] over the last few years." And, "Thank you for your kindness."

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 18 Registration Regulations 2009 Notifications of other incidents The service had not submitted a statutory notification when serious incidents occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Changes in people's needs had not been taken into account in relation to capacity to consent. There were no policies and procedures regarding the MCA and consent in place. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to ensure the safe and proper administration of medicines. 12(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have an effective quality assurance monitoring process in place. 17 2(a)(f)