Leonard Cheshire Disability

Hydon Hill - Care Home with Nursing Physical Disabilities

Inspection report

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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

About the service
Hydon Hill is registered to provide accommodation and personal care for up to 46 people who may have a nursing need, a disability or may have an acquired brain injury. There were 40 people living at the service at the time of our inspection.

People's experience of using this service and what we found
There were not enough staff deployed at the service which left people at risk. Risks associated with people's care were not always being managed in a safe way. Incidents of safeguarding were not always being investigated appropriately. Although staff received training and supervision, this was not effective in ensuring good practice within the service.

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 and in their best interests. People did not always have access to meaningful activities and people in their rooms were at risk of social isolation. Pre-assessments of care and care plans did not always have accurate information about people's care and staff did not always understand people's needs.

People did not always have choices around their care delivery and at times were not treated with dignity and respect. Quality assurance was not always effective. Where shortfalls in care had been identified with staff this had not been addressed robustly. The leadership needed to be more effective in ensuring staff were delivering appropriate care. The provider had failed to maintain robust oversight of the service. As a result, the level of care had deteriorated from the last inspection.

People and relatives told us that staff were kind and caring and we did see some examples of this. There were some people who were supported and encouraged to remain as independent as possible and were able to access the community. Relatives and visitors were welcomed as often as they wanted. People and relatives knew how to complain and were confident that complaints would be listened to and addressed.

People had access to health care professionals to support them with their care. The lay out of the service helped to support people that had difficulties with their mobility.

Previous Inspection
The last rating for this service was Good (report published 14 September 2017).

Why we inspected
The inspection took place earlier than planned as we had received concerns about the quality of care being provided. We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Caring Responsive and Well Led sections of this full report.

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

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Hydon Hill - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Our inspection was completed by two inspectors, a specialist nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Hydon Hill is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We inspected the service on the 14 October 2019.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. The registered manager completed a Provider Information Return. This is information providers are required to send us with key information about their

service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with 10 people who used the service and three relatives. We spoke with the registered manager and two deputy managers. We also spoke with seven members of staff including nurses and care workers. We observed care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also spoke with another member of staff after the inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
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At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People told us there were not enough staff. One person said, "There is not enough staff. They are very stressed."
- During the inspection the deployment of staff left people at risk. There were 15 care staff on duty during the day. However, 13 staff all went off on their break at 12.00 leaving two care staff to provide support to people. During the staff break these two staff were bringing people into the dining room and leaving them without staff support whilst they went and assisted other people to the dining room.
- At night one nurse was on duty to support 40 people. A nurse that had worked night duty told us this left them feeling, "Vulnerable." Another nurse told us the medicine round took over two hours to complete and, "Staff know that when I am doing medicines I am pre-occupied and not to interrupt me." The registered manager told us, "I don't think one nurse at night is enough. I don't have enough ability to bring another nurse in because of the budget. I think one nurse taking sole responsibility is not right. I would love to put more [care staff] on at night." A deputy manager told us that one nurse at night was, "Unsafe."
- The two nurses on duty during the day did not have time to complete the necessary paperwork needed. We found several instances of risk assessments and care plans not being up to date as the nurse had not had the time to do this. The registered manager said, "It's very busy for nurses, ideally I would have one more during the day. The paperwork and the quality is falling behind." A nurse told us they considered it would be beneficial to have some, "Admin time" per month, to give protected time to, "Get things done" such as care plans, as there was limited time on shift.
- A deputy manager told us they were unable to recruit a second activities coordinator due to resourcing. There had also been a reduction in the amount of support from volunteers for people since the last inspection. Due to there only being one activities coordinator only six people could participate each day on the chosen in-house activity. There was no activity coordinator working at the weekend. A deputy manager told us, "There is no budget for activities staff at the weekends."
- The care staff numbers reduced by two in the afternoon. We were told by the registered manager that this was based on the needs of people and that personal care reduced in the afternoon. However, on the day of the inspection they also told us they felt they needed more care staff during the day. They said, "The staff would get to spend more time with residents. I would like two to three more carers. The work is very task focused." It had not been considered by the provider that care staff could have assisted with activities in the afternoon including spending some time with people that were cared for in their rooms.
- Staff told us that at times they needed more staff to assist them. One told us, "Maybe we could do with more staff to support people to eat. Maybe one more person in activities." A deputy manager told us, "We could do with more assistance with eating [supporting people with their meal]." We noted during lunch time people were having to wait long periods of time before they were assisted with their meal by staff.

●After the inspection we asked the provider and the registered manager to review their nurse levels at night and to confirm the rationale for why only one nurse is required and what actions were being taken to assure yourselves that this is the correct staff level. They provided us with a tool to show how the staff levels had been assessed. The regulation about staffing states that there must be enough staff to meet people's needs at all times, given our observations and the feedback from people and staff this is not always happening. A person told us, "There are two [nurses on duty] during the day but only one at night. It isn't enough. There are 40 of us here and if one of us has a problem, it ties them [the nurse] up and the rest of us might have to wait for hours." They told us there were nurses that lived on site that could be called upon should an emergency occur.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people. However, we found that staff were not always asked for a full employment history. The registered manager advised us they would ensure that this was undertaken from now on.

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

● Relatives did not always feel that the risks associated with their loved one's care were being managed in a safe way. One relative said, "There is a problem with the alarm (call bell). On many occasions it is not left with her [their family member] but displaced. Once we found it in front of the TV where she obviously cannot reach. We are concern for her safety.''

● Risk associated with people's care was not always managed in safe way. One person had been admitted to the service with a pressure sore. It stated in the care plan that the person needed their hydration to be monitored and for their skin integrity to be reviewed monthly however this was not being done.

● There were other people whose skin integrity needed to be reviewed monthly and this was not always taking place. In addition to this on another person's care plan their nutritional and hydration care plan needed to be reviewed monthly as they were at medium risk. This had not been undertaken since July 2019.

● Where people were having their food and fluid recorded there were no target amounts to indicate to staff what the expected intake should be or when to raise a concern or seek medical advice. There was no evidence that staff were totalling the amounts that people were having each day. Where food was being recorded there was no information on what the measurements of food were being eaten. For example, where it stated 'Half eaten' there was no information of what this meant.

● We saw a risk assessment which identified that the person was at risk of falling from their bed. It also stated that the person was at risk of climbing over bedrails if installed. However, the person still had bedrails fitted despite this risk. The bed was not at its lowest setting and there was no safety mat in place which may have been a safer and a less restrictive measure.

● People that were cared for in bed and were at risk of developing pressure sores were not always being repositioned to reduce this risk. For example, in one care plan it stated that the person was at, "Very high risk" in relation to their skin integrity and that staff were to, "Monitor." There was no other information to indicate what staff needed to do to mitigate this risk and there was no record that the person was being repositioned in bed.

● There were areas for action arising from the previous fire risk assessment that had not yet been addressed. In a fire risk assessment from 2018 it stated that some bedroom doors would not be effective as fire doors due to a gap at the bottom. It stated all doors needed to be surveyed and any with a gap of eight millimetres

plus to be fitted with a strip. One of the deputy managers confirmed this had still not been addressed.
● Medical equipment was not always being stored in the most effective way to reduce any risk of items becoming unsterile. For example, the laundry cupboard was being used to store catheter tubes and bags. There were tubes that were not in packaging and were being looped over the wooden shelves.
● The kitchen staff did not always have accurate dietary information about people. There was an agency chef in the kitchen on the day of the inspection. They were not aware that there was a list of people and their dietary needs stored in the kitchen office. They were instead relying upon the kitchen assistant to provide them with information. When we checked the list, this had not been updated since 23 September 2019 and did not include people most recently admitted to the home. The kitchen assistant did not know that the information was not up to date.
● Accidents and incidents did not always have detailed information recorded on the actions taken to reduce further occurrence. For example, one person was found on the floor in their room. The actions taken stated, "[Person] to be closely monitored." It did not state how often staff should observe the person in their room. Another person had called out to staff from their room as they were uncomfortable. It was identified by staff that their air mattress was flat as the power had been switched off. There was no evidence of any investigation into this or recorded actions on how this could be avoided in the future.

Failure to provide people's care in a safe way was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person's had a Personal Emergency Evacuation Plan (PEEP) which outlined how the person could be removed or kept safe in the event of an emergency, such as fire or flood and staff were aware of these. There was a service contingency plan so that in the event of an emergency people could be evacuated to neighbouring services. All staff had received fire safety training.
● People and relatives fed back that the service was clean. One person said, "Cleanliness is ok as far as I know. The cleaner comes most days in the week."
● There was appropriate hand gels, gloves and aprons around for staff and visitors to use. We saw staff wearing gloves where appropriate and the service was being cleaned throughout the day.

Systems and processes to safeguard people from the risk of abuse
● People told us that they felt safe at the service. One person said, "They lock the doors, we've got an emergency bell if we need it." Another said, "Everyone who enters the building has to sign in. They keep it safe that way." Despite this we found that people were not always being protected from the risk of abuse.
● Safeguarding incidents were not always being reported or investigated appropriately by the registered manager. We noted from the incident reports there were instances of alleged abuse. There was no evidence that these had been reported to the Local Authority safeguarding team. For example, one form stated that staff had left a person in an unsafe position after they had provided care. The incident form stated that staff had left the person with no seat belt, no head rest and left with very, "Poor posture." This had not been investigated or referred to the Local Authority.
● On the complaints analysis we noted that a person had complained that a member of staff had been rude to them during personal care and another member of staff had been, "Rough" with them whilst supporting them to move. The report stated that this had been, "Partially" upheld. This had not been referred to the Local Authority.
● Although staff had received training in safeguarding and were able to tell us what they would do if they suspected abuse this was not being put into practice.

As people were not always being protected from abuse and improper treatment this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were managed in a safe way and people told us that they received their medicines when needed.

● People's medicines were recorded in the Medicine Administration Records (MARS) and were reflected people's current medical treatment. There was evidence that 'the use when required' (PRN) medications were being given appropriately for example when people were in pain.

● The medicine room was securely locked, and the fridge temperature was checked daily to ensure it was at a safe temperature.

● Medicine competency checks took place to ensure that staff were appropriately administering medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Where decisions were being made for people there was not always evidence that their capacity had been assessed. For example, the deputy manager told us about one person who lacked capacity to make decisions. We saw they had bedrails in place that are considered potential restraints. They should only be used when absolutely needed to keep a person safe in their bed. There was no assessment of the person's capacity to agree to the bed rails and no evidence of any best interests discussion to determine that this was the least restrictive option.
● Other capacity assessments were undertaken for people for example in relation to having care. However, the two signatories on the best interest forms were both from staff that worked at the service. There was no evidence of family involvement or other health or social care professionals. Where the person had no family involved in their care there was no evidence that an Independent Mental Capacity Advocate (IMCA) was consulted to provide a report about the person's situation and views.
● Staff received training around MCA and DoLS however there was a lack of understanding of the principals involved. One member of staff told us of a situation where a person refused to go to hospital. They told us they made the decision for the person to be admitted as they believed it was in the person's 'best interest.' One of the main principles of MCA is that, "You don't treat a person as lacking the capacity to make a decision just because they make an unwise decision." It was not clear that the member of staff had considered this. The member of staff was not sure whether the person had capacity or not.
● We saw from the notes of a staff meeting that a decision had been made to leave a person (that was not independently mobile) on their bed until day staff came on duty. This was to prevent the person using the

hot water urn as they had previously burned themselves when making a drink. Staff had not considered that this was restraining the person. There was no evidence that a capacity assessment had taken place in relation to whether the person was able to consent to being kept in bed.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

● People and relatives were not always confident that all staff were trained effectively to support them. They told us they had concerns with the lack of information that agency staff had that related to their needs. One person said, "Staff here are trained very well. It makes me less anxious if the agency staff were trained by our staff here." Another said, 'It's a minority of agency [staff] that aren't so good."

● There was no system in place to ensure that agency staff were provided with a summary of people's care when they worked at the service. We saw from an incident form that agency staff left a person at risk as they were not familiar with how the person required their support.

● Although training, including clinical training, was provided to staff this was not effective in ensuring that staff understood what they needed to do. During the inspection we found shortfalls in practices around safeguarding, MCA and the management of risks.

● On the "Service Improvement Database" it was noted there were a list of competencies that needed to be assessed for each nurse by the duty manager, these included catheter care. At the time of the inspection only the medicines management competencies had been assessed for five of the nurses. This was despite the Local Authority raising this as a concern when they visited in 2018. This was also raised on an internal audit in July 2019.

● Although supervisions were taking place these were not effective in ensuring that any shortfalls identified were followed up. We found that clinical supervisions were not always being undertaken by a person that had a clinical background.

As staff were not appropriately trained and supervised in their role this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● There was a lack of detailed assessments taking place prior to people using the service. This meant that the service could not be certain that they were able to meet people's needs.

● One person was admitted back to the service after spending a period of time in their own home. The deputy manager told us that the reason the person had to come back was because the person's bed that was specialised for them was broken. We were told that the person also had long term leg ulcers. None of this information was on the persons' pre-admission assessment. There was also information missing relating to what support they needed with their psychological needs, cognitive abilities and what support they wanted with past times and daily living.

● Another person had been admitted to the service and had since left as their needs could not be met. The person had complex nursing needs however the pre-assessment was undertaken by the registered manager who did not have a nursing background. The assessment recorded limited information about the person's medical background and areas left blank on the form included hobbies, interests, ambitions and aspirations other than to, "Manage their illness."

As care was not planned in a detailed assessment prior to care being delivered this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they enjoyed the food at the service. One person said, "Food is tasty, I cannot complain. My favourite meal is roast dinner, I can have it once a week.'' Another said, "Food is nice. I can choose between two meal options.''

● We observed throughout the day people were offered snacks in between meals. During lunch people were offered a selection of hot meals and alternatives offered if people wanted something different. However, we noted that for people that were on restrictive diets they were not routinely offered two choices of meals. For example, those people on a pureed meal. A member of staff told us, "We do these meals in advance. We normally choose the meat version unless they are vegetarian." They did say that they could offer the person an alternative if they did not like what had been offered to them.

● People were supported to the dining room from 12.00 however there were people that were still waiting for their meal at 13.00. We heard one person calling out and banging their cutlery on the table as they wanted their meal to be served. We have commented under the Safe domain that staff stated that more of them were required to support people with their meals.

● People had access to drinks through the day and there were drinks stations at the service for people to help themselves if they wanted. We saw people using these.

We recommend that the provider ensures people have choices of meals and that people are not kept waiting long periods of time to have their meal provided.

Adapting service, design, decoration to meet people's needs

● The corridors were wide to allow easy access for people that were wheelchair users. There were outside areas that we saw people accessing during the day.

● Special beds and pressure relieving mattresses were in place for those who needed them.

● There were rooms with ensuites and people were able to have personal effects including furniture in their bedrooms.

● There was a shop in the service where people could purchase toiletries and snacks if they wanted.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People told us they had access to health care support. One person said, "If you want to see a doctor you just have to ask."

● Staff worked with health care professionals in support of people's care. We saw evidence of involvement from the GP, dentist, Tissue Viability Nurse (TVN), epilepsy specialist nurse and nutritionist. There was also an in-house physiotherapist that people had access to.

● Care records showed that people had regular annual eye checks and regular involvement of the chiropodist. Staff followed the guidance provided by the health care professionals.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People told us that staff were kind and caring towards them. One person said, "I love it in here. People are nice." Another person said, "I really like it here. Neither me or my family would want me anywhere else. I am settled here." However other people told us that the caring nature of staff was dependant on who was providing the care. People said they felt rushed with their care which was a concern. We saw this was also raised through an internal audit in July 2019.
- People did not always have the choice around their care for instance when they were able to have a bath or a shower or if they wanted male of female staff. We also identified that there was a bathing rota in place. The management team confirmed that this was in place to manage staff's duties each day. One person told us, "I can't choose to have female HCA [health care assistant] to do my intimate hygiene but if it is a male then they mostly help the female staff.''
- During lunch we saw a member of staff standing whilst supporting a person to eat which was not dignified. We saw this had also been raised by the provider when they audited the service in August 2019.
- People's clothes and bedding were not separated into lights and darks when washed. We saw that as a result white clothes and sheets were grey.

As people were not always able to make choices around their care and were not always treated in a caring and respectful way this is a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People did feedback that there were staff that were attentive to their needs. One person said, "The carers understand me. One of the agency [staff] is very good at calming me down. Just her hand on my arm is all I need." Another person said, "Staff are very kind."
- We observed individual caring interactions between people and staff. Staff greeted people when they walked down the corridors. During an activity one member of staff encouraged and listened to people when participating in the game being played.
- When personal care was being provided this was done behind closed doors. Staff knocked on people's doors and waited for them to respond before they walked in. One person said, "Staff ask for my permission and knock on the door.''
- Family and friends were welcomed to the service whenever they wanted. One person said, "We can have visitors whenever we like. I have a group of friends who come in and we use the lounge." Another told us,

"My family visit me. They can come any time they like."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. People's needs were not always met.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- There were mixed responses from people in relation to activities. One person said, "There's lots to do." Another said, "There are a lot of museum trips. I'm going to the V and A." However, another person, who was cared for in their room, told us, "I get a little bored." Another said, "It would be nice if they [staff] come and talk to me but they have so much work to do, always in a rush." A third said, "I don't have social contacts in here."
- "The management team told us that in-house activities were limited to six people a day due to the available staff to support them with this. We saw a card game being played during the morning which was attended by five people. There was no evidence that people that were in their rooms were offered any activities. We saw from a staff meeting in September that activities were being rotated and that people needed to be reminded that if they were turned away it was for their safety as there was not room for everyone to attend.
- At the previous inspection there were a number of oversees volunteers that supported with activities. We were told by the management team that the volunteers had decreased. One deputy manager told us, "We do have other volunteers, mostly for befriending. They run the shop and do a quiz in the evening on a Wednesday."
- Care plans contained some information on the likes and interests that people had but this was not detailed. Staff did not always support the person to follow their interests. For example, one care plan stated, "I like to watch Elvis films…. Please assist me to watch the films I want by putting the DVD in the player and setting it up for me if I ask." There was no record over the period of September 2019 of this taking place or any record of the person having any social interaction or engagement. One relative told us, "She [their family member] is left in bed all the time. I am not sure if staff are aware of her care plan."
- There was not always sufficient guidance in the care plans around the specific needs of people. This meant that there was a risk that staff would not deliver the most appropriate care. For example, we were told by a deputy manager that one person had behaviours that challenged. Their care plan did not contain clear guidance for staff about how to support the person in a consistent way. The, "Behaviour and risk" care plan stated, "I sometimes get verbally and physically abusive. I suffer with mood swings." This was followed by, "How to prevent this happening: Please treat me with the respect I deserve. Please don't treat me like a child. Please ensure…..." The end of the sentence was missing and there was no further information on there to guide staff.
- Daily notes were task-focused and just recorded the care provided. The notes lacked person centred

information such as what the person ate, how they felt throughout the day and what conversation topics were spoken about. This information can help provide responsive and personalised care to a person.
● People at the service were supposed to be allocated a member of staff called a, "Key worker." Their function was to take a social interest in the person developing opportunities and activities for them. However, a deputy manager told us that the keyworker system was not working effectively due to time pressures.
● End of life care was not always being planned around people's wishes. There was insufficient evidence that discussions took place with people including people's spirituality, religion, what family they wanted around them and where they wanted to be at the end of their life A deputy manager told us, "Its likely those things haven't been discussed."

Failure to plan care and treatment around people's needs and to provide meaningful activities was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were aspects to the planning of care that were effective. There were people that told us they enjoyed participating in external activities and found this fulfilling. Comments included, "I go sailing. Another resident or two come with me. Staff take me to days out, museums, galleries", "We enjoy the weekly quiz and enjoy outings to Hampton Court and boat trips on the Solent and the Wey." The person told us that events were organised at Christmas and they had the opportunity to go Christmas shopping.
● We saw there was guidance in care plans that were detailed around the person's needs. This included information about how the person mobilised and how staff needed to support them with this. There was also details on how staff needed to support people with their personal care.

Improving care quality in response to complaints or concerns
● People and relatives told us they would know how to complain if needed. One person said, "I complained about a carer. My complaint was considered, and she is not coming any longer." Another person said, "When we have concerns, we go to the assistant manager. She is proactive, kind and always available, her door is open. She listens to us."
● Complaints and concerns were reviewed by the registered manager. They were investigated, and people and their relatives were satisfied with the response. For example, one person complained about the noise coming from another person's room. The registered manager investigated this and resolved this to both people's satisfaction.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Each care plan detailed how best to communicate with the person. Information was available in larger print and where necessary, interpreting services were available for people whose first language was not English. Electronic equipment and communication books were in place where needed.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Since the last inspection there had been a change to the management of the service. There were mixed responses from people and relatives about how accessible the registered manager was. One person said, "I know the manager, she is nice.'' Another said, "She keeps her door closed. All the other managers we have had have left theirs open." A relative said, "She [the registered manager] is not available." Another told us, "Sadly, there is no homely touch and trust any longer, it has been lost.''
- We observed the registered manager kept their door shut to their office during the inspection. They told us, "I do sit in here and shut the door as I have lots and lots of deadlines. The noise out there is distracting." When asked how staff responded to them closing their door they said, "Some staff are aware [of the pressures] but others say, 'We don't see the manager." A member of staff told us, "[The manager] will put a note on her door saying, 'Do not disturb', There is a lot of pressure to get things done."
- People fed back that they did not always feel communicated with. One person said, "One time someone died, and the carers were told, 'Don't tell the residents.' They thought we would be upset but we were more upset not to be told." On the day of the inspection the physiotherapist had cancelled their sessions due to training. However, this had not been communicated to people. One person told us, "Communication could be better." People told us that they were not told why the sessions had been cancelled.
- Where shortfalls had been identified by the management team these had not always been addressed. For example, we identified that during the day the majority of care staff took their break leaving only two care staff to support 40 people. This was known to the management team, yet no action had been taken until we inspected. The registered manager told us, "We tried to change it but it's what they (staff) want. Ideally, I would like it staggered." They then added that although they did not agree with the way staff took their break they said, "It hasn't proven a problem." By the end of the inspection the registered manager had advised staff that breaks would now be staggered.
- Where audits identified shortfalls or gaps, these were not always addressed. For example, during a care plan audit in March 2019 it has been identified on one care plan that that there was, "No information on who manages finances." On this inspection we saw this has not been addressed. There was a note in the care plan under, "Managing money and finances" stating, "No information is available at this time." The rest of the information had been left blank.
- At a 'Heads of Department' meeting in April 2019 it stated that, "[Person] needs a routine for his sensory room as his shouting hasn't been acceptable." We found on this inspection that this had not been sufficiently addressed. The evidence from the person's care plan was that a routine had not been put in

place.
● It was identified on an audit undertaken in July 2019 by a, 'Resident representative' that people were missing being able to do cooking sessions. It was also felt that people found it difficult to approach the manager if they had a concern and that the manager was not visible around the home. There was no evidence to indicate how both of these concerns had been addressed.
● A provider audit took place in July and August 2019. There were multiple actions as a result of the audit and the service was internally rated as, "Requires Improvement." The audit did not identify some of the concerns we found on the day including the inconsistency with the MCA capacity assessments, the requirement to have more detailed pre-admission assessments and the majority of staff taking their breaks all together. Their audit stated there were no concerns with these areas.
● The management team told us that there was a lot of pressure to ensure that all paper care plans were transferred onto their new electronic systems which they believed was having an impact on the other work they had to undertake.

As quality checks and leadership was not always robust or effective at improving the service, this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were elements of the quality assurance that were effective. We saw a note on the residents meeting minutes that a person has requested gluten free bread and pasta and dairy free milk. The kitchen had these items in place.
● There were regular staff meetings where training, policies and recruitment of staff were regularly discussed. Staff fed back that they did feel supported by the management team. One told us, "I think (registered manager) is doing a really good job." Another said, "I think she is really really great." The registered manager was also complimentary about the support they received from their line manager. They said, "My boss is great. I love the home but I'm battling against things."
● After the inspection the registered manager sent us an action plan of things that they were addressing since the inspection. This included ensuring that food and fluid charts were now in place, recruitment files were being reviewed, skin integrity assessments were being updated, the work on the fire doors was resolved and care plans were being reviewed and updated.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Whilst on the inspection we identified several incidents of safeguarding that had not been notified to the CQC.
● One incident form stated that a person had been left in an unsafe position in their wheelchair leaving them at risk of injury. This was due to the neglect of staff supporting them however this had not been reported to the CQC as a notifiable incident.
● Another person had suffered two burns on their leg and received treatment in hospital. The injury had not been identified for two days after the incident occurred. Again, this was a notifiable incident that had not been sent to the CQC.
● A third person scratched another person with a fork. This was not notified as a safeguarding incident to the CQC.

As notifiable incidents were not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

Continuous learning and improving care; Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Nursing staff had reflective practice discussions to look at ways of improving the quality of care. For example, in relation to wound care management, medicines and daily health monitoring.
● The provider and registered manager worked with external organisations that regularly supported the service. The registered manager told us, "As we are voluntary we have a large internal volunteer base. Hydon Hill also has partnerships with corporate volunteers who will come to Hydon Hill to carry out a project either within the building or outside and this is for the benefit of the residents. The courtyard gardens were recently redone [funded by Company name] which has enabled the residents to enjoy the courtyard and benefit from the space"
● Relatives told us that they were also contacted if there had been any concern in the way care had been delivered to their family member.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that where appropriate notifications were sent to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people were always provided with care that was specific to their needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were always involved in their care and that they were treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people's consent had been sought before care was delivered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

Treatment of disease, disorder or injury	improper treatment The provider had not ensured that people were always protected against the risk of abuse

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of staff deployed and that they were suitably trained and supervised.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that people were always provided with safe care and treatment

The enforcement action we took:

We issued the provider and the registered manager with a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured that there was robust oversight of the service

The enforcement action we took:

We issued the provider and the registered manager with a warning notice