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

Overall summary

Hydon Hill Nursing Home provides nursing and personal care for up to 46 people. There were 36 people living at the home at the time of the inspection. They had a range of complex health care needs which included people who have multiple sclerosis, acquired brain injuries stroke, and injuries sustained as result of an accident. Most people required help and support from two members of staff in relation to their mobility and personal care needs.

Hydon Hill Nursing Home is owned by and run by Leonard Cheshire Disability which is a charity that states it provides care and support to people with physical disabilities helping them to fulfil their potential and live the lives they choose.

Hydon Hill is a purpose built single storey accommodation set in extensive grounds and surrounding woodland. The accommodation had been

Summary of findings

adapted to meet people's individual and complex needs. It was accessible to wheelchairs throughout. There was a large activity room and a physiotherapy room which people were able to use throughout the day. Due to its remote location, accommodation in chalets set in the grounds was available for staff and volunteers if they wished.

There is a registered manager at the home. 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.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 9 and 10 November 2015.

People's safety was compromised in a number of areas. Care plans did not all reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as diabetes or those who required catheter care did not have sufficient guidance in place for staff to deliver safe care. Not everyone had risk assessments that guided staff to promote people's comfort, nutrition, and the prevention of pressure damage. There was no guidance to ensure equipment used to prevent pressure damage was set correctly. This had resulted in potential risks to people's safety and well-being.

People and staff did not feel valued by the organisation. They did not feel they were involved or informed about the day to day running of the home.

There were not enough staff on duty to meet people's needs in a person-centred way. This meant care was task orientated and reflected the number of staff on duty rather than people's individual needs.

Quality assurance systems were in place. Areas for improvement had been identified and an action plan was in place to address these, however, the provider had not ensured action was taken when needed to meet regulatory requirements.

Staff knew people well, they were kind and treated people with compassion and patience. However there were occasions where people were not treated with dignity and respect. People were not always attended to in a timely way and their personal preferences, lifestyle and care choices were not always met.

Arrangements for the training, supervision and appraisal of staff were in place. However, staff had not received clinical training updates or ongoing professional development through regular supervisions.

People were supported to have enough to eat and drink however their nutritional assessments and care plans did not contain sufficient information to provide guidance to staff. Food was freshly cooked each day and people were provided with choices. The cook and staff had a good understanding of people's dietary needs.

Mental capacity assessments were not in place and did not meet with the principles of the Mental Capacity Act 2005, as they are required to do so. There was information to show people's consent had been sought in relation to some decisions however there was no information to show people had capacity to consent.

People spoke well about the support they received from staff. Staff interactions demonstrated they had built good relationships with people and staff were passionate about ensuring people lived a life which helped them achieve their potential.

The overall rating for this provider 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.

We found a number of 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 this report.

Summary of findings

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

Hydon Hill was not safe.

Risks were not always safely managed. Not all risks had been identified and others did not have sufficient guidance in their care plans to inform staff how to look after people.

There was not enough staff to meet people's needs. Assessment of people's needs had not taken place to determine staffing levels.

People's medicines were managed safely.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse.

Staff recruitment practices were safe.

Is the service effective?

Requires improvement

Hydon Hill was not consistently effective.

Mental capacity assessments did not meet with the principles of the Mental Capacity Act 2005.

There was an ongoing training and supervision programme in place however staff had not received any recent clinical training updates or ongoing professional development through regular supervisions.

People were supported to maintain a healthy diet. They were provided with appropriate assistance and support and staff understood people's nutritional needs. However, records did not provide clear guidance to ensure people's nutritional needs were met.

People were supported to have access to healthcare services this included the GP, dietician and chiropodist.

Is the service caring?

Requires improvement

Hydon Hill was not consistently caring.

Staff knew people well and treated them with kindness and patience. However there were occasions where people were not treated dignity and respect in ensuring their personal preferences, lifestyle and care choices were consistently met.

Staff understood people's needs and preferences.

People were involved in making decisions about what they did each day.

Is the service responsive?

Requires improvement

Hydon Hill was not consistently responsive.

Summary of findings

Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

The delivery of care was not always person focused.

People told us that they were able to make everyday choices. There was a range of activities for people to participate in as groups or individually.

However, there was no guidance for staff to support and encourage people who were less able to participate or communicate.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be investigated and resolved.

Is the service well-led?

Inadequate

Hydon Hill was not well led.

Although areas for improvement had been identified the provider had failed to ensure action was taken when needed to meet regulatory requirements.

Staff did not feel valued by the organisation. Although people spoke positively of the care they told us they did not feel valued or involved in the day to day running of the home.

The registered manager was aware of these concerns and was taking action to address them.

Hydon Hill - Care Home with Nursing Physical Disabilities

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 was an unannounced inspection on 9 and 10 November 2015. It was undertaken by two inspectors, an inspection manager 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.

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 reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records staff files including staff recruitment, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits, policies and procedures along with information in regards to the upkeep of the premises.

We looked at five care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with 14 people who lived at the home, five relatives, and nine staff members including nurses, care staff, activity staff, physiotherapy staff, the registered manager and a senior manager from the provider. Following the inspection we received written testimonials from relatives and a health a visiting professional.

We met with people who lived at Hydon Hill, we observed the care which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime meals. As some people had difficulties in verbal communication the inspection team spent time observing people in communal areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People told us they were happy and felt safe living at Hydon Hill. However, they also told us there were not enough staff and sometimes their care was rushed. One person said that they felt that having so many agency staff "Created the potential for inconsistent care." Someone else said they never felt that their safety was in jeopardy. We found however there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

People, visitors and staff told us there were not enough staff on duty to meet people's care and support needs. There were two nurses all day and one at night. There were twelve care staff in the morning; this was reduced to nine in the afternoon. At night there were four care staff. In addition there were housekeeping staff, the cook and a kitchen assistant, two physiotherapists, activities staff, drivers and a team of volunteers who supported people for example at mealtimes, with activities and going out. We observed staff were constantly busy throughout our inspection. People told us they were not always attended to in a timely way. During the inspection two people told us they had got up late because there were not enough staff to attend to them at their preferred time. Staff told us they were aware some people would like to be up before breakfast but there was not enough staff to do this. One staff member said, "Sometimes we don't get people up until lunchtime," This was not always people's individual preference.

People told us they did not always have baths or showers when they wished. One person said, "They were short staffed so I didn't get my shower." Another person told us, "I haven't had a shower for 10 days. There's just not enough staff." During the inspection we were told a recent trip out for people had been cancelled due to lack of staff.

We heard people's call bells were ringing constantly through the day. After ringing for a period of time the call bells would escalate to an emergency bell. Staff told us call bells constantly escalated as staff were busy and unable to answer them promptly. One staff member said, "When people call we will go and show our face, turn the buzzer off and tell them we will be back." People confirmed this happened. One person said, "If staff can't attend to me straight away they keep popping in and apologising." On a number of occasions we observed staff telling people, "I'm sorry, I can't do it now, I'll come back to you."

Staff told us although people had to wait they believed their care needs were met. Staff told us, "We won't neglect people's care, other things may go like paperwork but people get their care." We heard staff being told to leave paperwork and attend to people throughout the inspection. When the nurses were administering medicines they wore a tabard which informed people what they were doing and were not to be disturbed unless it was an emergency. We saw the nurses were constantly interrupted by people, they told us this was because other staff were busy and not easily accessible.

There was no evidence that people's needs were taken into account when determining staffing levels. People had complex care needs and they all required two members of staff to assist them with all personal hygiene needs and assistance with mobilising. There was a dependency tool in people's individual care plans but this had not generally been completed and there was no analysis of people's dependency across the home. Staffing levels were based on how many people lived at the home and did not reflect people's individual needs. The staffing levels were not flexible and had not been reviewed to ensure staff could meet people's needs.

We found the provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were sufficient numbers of staff deployed. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Once people were up they were supported at mealtimes and with activities by volunteers at the home. One staff member said, "Without the volunteers there is no Hydon Hill. Staffing levels are ridiculous."

There was a current reliance on agency staff at the home however; there was an active recruitment programme in place. In an attempt to maximise continuity of care for people, as far as possible, regular agency staff were used. Most people required the support of two care staff therefore agency staff were supported by staff who regularly worked at the home and knew people well. One staff member said, "Most agency staff know people well now."

We found that people with specific health problems did not have sufficient guidance in their care plans for staff to deliver safe care. This included wound care, catheter care, diabetes and support for people who were prone to

seizures. There were seizure charts in place where staff recorded the type, duration and length of a seizure. However, there was no guidance in place for staff to inform them of any possible triggers and no guidance to ensure the person received appropriate care during a seizure. We saw one person's care plan for diabetes. This informed staff the person required regular insulin and blood tests and these were undertaken by the nurses. However, there was no guidance to help staff identify if this person may be unwell due to their diabetes for example signs their blood sugar may be low. Staff told us this person was unable to identify when their blood sugar was low.

Risk assessments did not include guidance for care staff to provide safe care. For example, good skin care involves good management of incontinence and regular change of position. There was no information in care plans about altering people's position, there was no information about air relieving pressure mattresses and what setting they should be and no evidence pressure mattress setting checks took place. Risk assessments had not been reviewed, we saw one risk assessment that should have been reviewed monthly was last reviewed in August 2015.

Some people were at risk of choking however risk assessments were not in place. Examples included one person who had an eating and drinking care plan which stated they could eat 'normal food.' However, further information stated the person was at risk of choking and had been referred to a speech and language therapist for assessment. However, there was no guidance in place to ensure this person was able to eat and drink safely and protect them from harm.

Some people who had fallen or were at risk of falling did not have a falls risk assessment in place. Accidents and incidents had been documented with the immediate actions taken. However there was a lack of follow up or actions taken as a result of accidents and incidents. For people who had fallen and had been unwitnessed by staff there was no record of an investigation or a plan to prevent further falls. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect people from harm. Therefore there was no learning evidenced from accidents and incidents.

There were some personal emergency evacuation plans (PEEPs) however they were not in place for everybody. These are to ensure staff and emergency services are aware of people's individual needs and the assistance required in event of an emergency evacuation. This meant people were at risk of harm as essential information relating to their requirements in event of an emergency was not available.

Although risks were not always safely managed the impact on people was reduced because regular and agency staff knew people well and understand the risks associated with their care.

Not all risks had been identified and others did not have sufficient guidance in care plans. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding training and had a good understanding of their responsibilities in relation to safeguarding people in order to protect them from the risk of abuse. They were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. Staff told us they would report to the most senior person on duty at the time. If this was not appropriate they would report to the relevant external organisations. They told us they would always report concerns to make sure people were safe. There was a safeguarding policy in place which was accessible to staff. This had relevant contact numbers to external organisations for staff guidance.

Medicines were stored, administered, recorded and disposed of safely. We observed medicines being given safely and correctly as prescribed. Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. There was PRN protocols in place which provided guidance about why the person may require the medicine and when it should be given. Prior to administering PRN medicines the nurse asked people if they required the medicine. The nurses spent time with people when administering their medicines, they explained what the medicines were for and gave them in a way people liked. For example one person liked to take their medicines with a cup of hot chocolate which was provided. Some medicines were required to be checked by two members of staff, we observed this practice was being followed. We observed one staff member checked the medicine being dispensed and given. This staff member, who was not responsible for administering medicines,

Inadequate

Is the service safe?

asked the nurse about the medicine and the dose. This demonstrated the member of staff understood their responsibility in ensuring people received the correct medicines as prescribed.

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the home. This included an employment history, references, and disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults. Nursing and Midwifery Council PIN checks for registered nurses had been recorded and demonstrated they had the appropriate qualifications for their job. There were a number of volunteers at the home and they underwent similar recruitment checks. This included two references and a DBS check. On occasions volunteers may start work at the home prior to receiving their DBS checks however, they would not attend to or spend any time alone with people until satisfactory checks had been received.

Records showed regular servicing and health and safety checks had taken place. This included gas and electrical services, emergency lighting and fire safety checks. The home was staffed 24 hours a day.

Requires improvement

Is the service effective?

Our findings

People told us they were satisfied with the food. They said there was a choice of menu and it was possible to order other items not on the menu. One person said, said "The food is very good, the chef is brilliant."

Staff had some understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training records showed 60% of staff had received MCA training and 50% DoLS training. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. We saw a number of applications for DoLS had been made. This indicated people did not have full capacity however there was limited information available to staff.

One person had a mental capacity assessment completed. This showed they did not have full capacity however, there was no information in their care plan to inform staff the person lacked capacity, what decisions they were able to make and where they needed support. The mental capacity assessment was not filed with the person's daily care plans so staff may not be aware of it. We received conflicting information from staff about other people's capacity. We were told by one member of staff about a person who was deemed to have full capacity but another staff member told us they had fluctuating capacity. There was no information in any other care plans viewed about people's mental capacity, if people were able to make decisions or where they required support to help them make decisions. Where DoLS applications had been made there was no information in people's care plans to inform staff and no guidance about how to support people. Some people used bed rails, and lap belts whilst in their wheelchairs. Consent forms had been completed for some of these decisions, some had been signed by the person and others recorded as verbal consent given. However, there were no mental capacity assessments to demonstrate these people were able to give their consent which meant inappropriate decisions could be made.

The provider had failed to follow the principles of the Mental Capacity Act 2005. Mental capacity assessments were not in place. There was no information about how decisions were made or how people's freedom may be restricted. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular training. This included safeguarding, infection control and moving and handling and the training they received enabled them to provide appropriate support to people. Records showed that training was ongoing and further training was booked for staff. However, the training policy identified some training required updates for example safeguarding and manual handling theory and practical should be updated each year. From the records we saw 48.65% of staff had completed manual handling practical and 59.65% manual handling theory. Although staff demonstrated a good understanding of supporting people to mobilise safely the provider could not be sure they were following current best practice.

We were told staff received induction training when they started work based on the Care Certificate. The Care Certificate is a set of 15 standards that health and social care workers follow. The Care Certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. However for a new member of staff there was no evidence of any induction having taken place. We were told induction information was retained by staff, but there was no record of what had been completed or any supervision to assess the staff competency or demonstrate their current knowledge. Therefore no-one knew whether they had been deemed competent to deliver the care required.

The nurses told us they received training updates in relation to their clinical skills however we did not see any evidence of recent clinical training. Nurses told us they were able to update their clinical knowledge through the support of external professionals who visited the home for example the tissue viability nurse. The nurses were aware of their own skill levels. They told us people were assessed

Requires improvement

Is the service effective?

before they moved into the home and if staff did not have the appropriate skills to look after the person then they would not be admitted. The nurses also told us if they identified a need for clinical training they could ask the registered manager and were confident this would be arranged.

There was a supervision programme in place and we were told staff should receive supervision every three months. However staff told us they had not received regular supervision for "some time." They told us this was because of time constraints due to lack of staff. Staff files did not contain any evidence of supervisions despite there being a section for them. There was no evidence of clinical supervisions for the nurses. There was no evidence of recent appraisals for those that had worked at the home for more than one year. From the evidence we saw the last appraisals were for 2011. This meant the provider had not ensured staff received appropriate support, supervision and appraisal to ensure their competence was maintained. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Volunteers at the service received an induction period and a training programme. This included an induction to the service, health and safety for example supporting people in wheelchairs, key policies, safeguarding, whistleblowing and information about communication and disability rights.

People had nutritional assessments and eating and drinking care plans in place. However, these did not always provide up to date or accurate information. The care plans included a pictorial guide on how people needed to be supported at mealtimes. For example whether they required a pureed diet and what support they needed. However care plans did not always reflect people's current needs. For example one person's care plan and pictorial guide stated they could make their own meals choice, manage their meals with supervision and were able to drink 'normal' fluids. However, a review in January 2015 stated this person now required increased support to make meal choices and drink fluids. The nutritional assessment of May 2015 stated they now required thickened fluids. Another person had an unexplained weight loss. Their eating and drinking care plan informed staff how to support this person at mealtimes, however this plan was due to be reviewed in January 2015 but this had not taken place. There was a food chart in place but there was no guidance in the care plan to inform staff this was required. The food chart did not include everything the person had eaten. For example entries stated the person had gone out for lunch but there was no information about what they had eaten. Nutritional assessments informed staff how often people should be weighed. This was based on their assessed risk however people had not always been weighed as stated on the assessments. These issues meant that the provider could not be sure people were receiving adequate nutrition and hydration as there assessed needs were not always up to date and people were not weighed as stated in their care plans.

Although staff were able to tell us about people, their current dietary needs and how they were supported there was a reliance on agency staff at the home. These records did not provide clear guidance for staff to ensure consistency or demonstrate evidence that people's nutritional needs were met. This is an area that needs to be improved.

Food was freshly cooked each day following people's meal choices in the morning. The cook and staff had a good understanding of people's dietary needs in relation to specialised diets for example diabetic or pureed. The food was served by a catering assistant who had a very good understanding of people as individuals including their likes, dislikes and dietary needs. When meals were served this was documented by the catering assistant to ensure everybody had received a meal.

People chose where to eat their meals. We observed that lunchtime was an enjoyable experience for people. There were enough staff and volunteers in the dining room and those that needed support had one to one provided. This was calm, patient and at people's own pace. The atmosphere was pleasant and we observed good interaction between people, staff and volunteers. People who chose to eat in their rooms received the appropriate support.

Staff supported people to maintain good health and access healthcare services. Records showed external healthcare professionals were involved in people's care; these included the GP, tissue viability nurse, dentist, dietician, optician and chiropodist. There was a physiotherapist at the home who people had access to. Physiotherapy could be provided to people in their own rooms or in the physiotherapy room at the home. People told us they were able to access the physiotherapy room when they wished.

Requires improvement

Is the service effective?

The registered manager had identified the home required some re-decoration and updating. We were told the flooring in the communal areas had recently been changed from carpet to vinyl flooring. This made it more accessible to people in wheelchairs. There were plans to repaint the communal areas in the near future and the registered manager told us how people had been involved in choosing the colours. People had a wide range of complex needs and as a result were reliant upon the support of staff for their personal care needs. They were also dependant on wheelchairs for their mobility and to maintain their independence. We saw people had individual wheelchairs specific to their needs to ensure they maintained maximum independence. The home was purpose built with wide corridors and doorways making it accessible to people throughout. Where people required the use of a hoist to transfer, for example, from their bed to wheelchair overhead tracking hoist had been installed in their bedrooms. This meant the equipment was always available for people and was suitable for their individual needs. There were a range of accessible toilets and bathrooms which people were supported to use depending on their preference of baths or showers. There was level access throughout the home and grounds and people had freedom to access all areas. Due to the location of the home with no nearby shops or facilities and no public transport people were reliant on staff and volunteers for trips out.

Requires improvement

Is the service caring?

Our findings

People were positive about the care they received and told us they were happy living at Hydon Hill. One person told us, "I'm very very happy here." Another person said it was, "A wonderful place to live." A number of people told us they were, "The person they are today," because of the care and support at the home. People also told us staff were, "Respectful, friendly and professional." Staff said, ""It's all about the residents. It's about what they want to do. It's their home and we ensure they are happy."

Whilst we observed staff engaging with people in a kind and caring way people were not always treated with the respect and dignity they deserved. Staff did not always have enough time to attend to people's needs when they required it. People told us their preferences for personal care were not always followed. One person, who was dependant on staff for all their needs, told us. "I had a shower two days ago, but it had been ten days since my last one." Another person said, "I often go without my shower, staff are busy." People told us they had received an assisted wash but much preferred a shower. Three people told us they would like to get up before they had breakfast but this did not always happen. One person said, "I like breakfast in the dining room but I had to have breakfast in bed this morning because staff were too busy." This meant that people had not had an opportunity to enjoy their morning as they were waiting for staff.

People told us staff shortages and the continual use of agency staff impacted on their dignity. Whilst people understood the need for agency staff they told us this had a negative impact on their care. One person said, "It's another stranger, another person you have to talk through your care." People told us they had to wait for staff to attend to them and were not always able to have the care or support when they wanted it. One person told us they had experienced an episode of incontinence and had to wait for over an hour for staff to attend to them. They told us, "Staff kept popping in to apologise, I know they're busy but I really shouldn't have been left that long."

We observed other aspects around the home which demonstrated people were not always treated in a dignified way. At lunchtime we observed people eating in the dining room. The table height was adjustable and we observed people eating at tables which were clearly too high for them. Staff did not offer to adjust the tables or ask people if they would like to sit at a different table. We asked two people if they were happy with the table height. One person told us they were satisfied the other person said they would have liked it to be lowered but they were never given the option. This did not promote people's independence or autonomy.

A number of staff lived in accommodation in the grounds of the home. We observed some mattresses which had been discarded by staff were left outside. These were visible to people as they went into the grounds. This demonstrated staff did not always respect people's home and environment.

Care plans were not always stored securely. We observed them left on desks in the office which was open and accessible to people. There was wording within the care plans which was not respectful to people. For example one person had experienced an episode of incontinence and daily notes stated the person had, "Peed the bed."

People were not treated with dignity and respect in ensuring their personal preferences, lifestyle and care choices were consistently met. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns we observed staff supporting people with kindness and compassion.

We observed staff attending to people, taking their time and working at people's own pace and enabling them to do what they chose throughout the day. Staff chatted with people whilst providing support. In the communal and dining areas we heard staff talking to people, engaging people as individuals and groups and generally enjoying themselves with people. People told us, "The staff are our friends."

It was clear staff knew people well and treated everyone as an individual. They spoke to them with kindness and patience they were able to tell us about people's personal histories, care needs, likes, dislikes, individual choices and preferences. They told us, and we observed, how they communicated with people who were less able to express themselves verbally. This included observing how people responded to questions and gestures.

Requires improvement

Is the service caring?

All of the staff spoken with were equally committed to providing a good care and a good home for people to live in. One staff member said, “I love the job, love the residents, that’s who we are here for.”

Requires improvement

Is the service responsive?

Our findings

People told us they enjoyed the activities available at Hydon Hill. One person said, "Activities are good, this is one of the reasons I like living here." People told us they valued the use of the physiotherapy room and they felt this had helped them to regain their independence and strength. One person told us, "Hydon Hill has made me what I am today." Staff told us, "People here love life." However, care plans were not in place for every assessed need and were not always updated when people's care needs changed. They lacked details of how to manage and provide person specific care for individual needs. Although reviews took place information was not always used to update people's care plans.

Some people's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. However, care plans did not always include the guidance staff needed to support people in relation to their identified risk or to reflect their assessed need. Examples included a care plan for one person who had a urethral catheter in place. The care plan informed staff how to look after the catheter on a day to day basis but there was no clinical information to guide the nurses. There was a log to show when the catheter had been changed which included details of the equipment used and a list on the wall informed staff when the catheter was next due to be changed. However, there was no guidance for staff about what action to take if for example the catheter was not draining. Some people were prone to seizures and seizure monitoring charts were in place. However, there were no care plans in place to inform staff what may trigger a seizure and what actions they should take at the immediate time of the seizure. Information in assessments and daily notes showed some people may display behaviour that challenged others.

There was no guidance in place for staff and no evidence that people's complex emotional needs had been assessed. There were behaviour charts in place for one person and staff had recorded when this person had 'shouted' at night. The daily notes for another person stated the person was 'rude' but there was no further information to ensure staff supported these people appropriately or try to establish reasons for their behaviour.

Where people were prescribed topical medicines such as creams the MAR charts were completed to demonstrate the medicine had been applied. There were no care plans or body maps to inform staff where this medicine needed to be applied. Staff told us they were informed in handover who needed what cream. There was no written guidance in place to ensure consistency.

Care plans were not personalised and did not contain detailed guidance for staff to support people. One person who had recently moved into the home, there was a pre-admission assessment which showed the person was unable to walk unaided and was forgetful at times. The pre-assessment also informed staff this person was continent. Information contained in the daily notes showed this person had complex emotional and physical needs. There was information in the daily notes which demonstrated this person's needs were not being met. For example although the pre-admission assessment stated this person was continent they had been fitted with a convene which is a urinary device to support continence. There was no evidence the person's need had changed from their pre-admission assessment in relation to continence. However, we saw this person frequently required the support of staff to use the toilet and daily notes demonstrated they could become distressed when they were required to wait for staff. There was no information about this person's preferences or how they would like their care delivered. Their daily notes included comments such as, "Wouldn't go to bed," and "Told it was late." There was no care plan or other information to guide staff about what time this person would like to go to bed. This person's care was not responsive to their individual needs, but for the convenience of staff.

Some people needed specific support when sitting or lying in bed to ensure they were comfortable and well supported. There were photographs in people's care plans which provided good visual guidance for staff to follow. However, there was no written information to guide staff to ensure people received consistent care. The physiotherapist told us when people required specific positioning this would be discussed with staff and recorded in the communication diary.

Staff told us if they didn't know people's needs they would read the care plan. However, care plans contained conflicting information. One person told us they liked to have breakfast in the dining room but were unable to because of staffing shortages. However, their daily routine stated they liked to wake at 10.30am and have breakfast

Requires improvement

Is the service responsive?

'first thing.' However, there was no information about what time this was. This information had not been reviewed since August 2015 so staff could not be sure this reflected the person's current wishes.

There was some information about people's past interests and hobbies however there was limited information about how staff could support people to continue with these interests. Assessments included interests people may wish to develop. We saw these had been completed when people moved into the home but had not been reviewed. There was also information about how people could be supported by volunteers for example going shopping or trips out. Again, these were not reviewed. Whilst there was a wide range of activities available there was no information in care plans about activities people participated in and whether they enjoyed them. There was no guidance for staff to support and encourage people who were less able to participate or communicate. Activity staff told us currently they did not have the resources to provide individual activities to people who remained in their rooms. People also told us that due to staffing levels there was very limited activity provision at the weekends.

People who lived at the home had complex physical and emotional needs. Although staff knew people well and could tell us how they looked after them people did not always receive the care they wished for or required. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a wide range of activities available to people and activity staff were enthusiastic and encouraged people to participate. There was an activity room and this included a small kitchen, a computer room which included computers that had been adapted for people's individual needs. People were supported to take part in a various activities and we were told people enjoyed word games and quizzes. People from Hydon Hill took part in quiz competitions with another care home. People were also able to go out on trips. Activity staff told us this was discussed with people, ideas were given and people chose what they would like to do. A recent addition had been a trip to a vineyard which staff told us had been a success. One person had recently been to a show that interested them with the support of staff. Currently staff and people were planning Christmas activities including shopping trips. People were supported by activity staff and volunteers and people were supported as individuals within larger groups. We were shown examples of work people had done with the support of staff. One person was interested in graffiti and was being supported to fulfil this.

Some people were able to arrange their own activities. One person told us how they and a friend had been to a recent concert with the support of a volunteer from the home. People we spoke with, including those who remained in their rooms told us they were not bored and had plenty to do. We observed people had specialised equipment for example to help them turn on the television and audio books. We saw staff supporting people in their rooms to remain occupied for example one staff member said to a person, "Shall I turn the radio on, it's time for (radio programme)." We observed other staff asking people if they wanted their television's turned on or off. Another person told us they enjoyed reading and had plenty of books.

People had access to the physiotherapy room five days a week. They told us they were able to develop their own programme with the physiotherapist. This was confirmed by the physiotherapist who told us they assessed people when they moved into the home. People told us how the regular exercises had increased their independence and mobility. One person told us when they moved into the home they had required support of staff to turn pages of newspapers or magazines and they were now able to do this independently. Another person told us how with the support of staff they had rebuilt themselves both "physically and emotionally."

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

People told us if they had any concerns or complaints they would discuss them with the registered manager or other staff. When previous complaints had been raised we saw actions had been taken to address and resolve them.

Inadequate

Is the service well-led?

Our findings

People told us they were happy living at the home. They said they felt well supported by the care staff. Care staff were passionate about providing a home that people wanted to live in. However, some people and staff expressed concerns with the management of the home. Most staff expressed dissatisfaction with senior managers at provider level.

We found Hydon Hill was not well-led.

When the registered manager started work at Hydon Hill in January 2015 she had identified many areas that required improvement. This included environmental issues in regards to the maintenance of the home, staffing levels and care documentation. There was an action plan and we observed work had taken place to start addressing these issues. For example the flooring had been replaced in the communal walkways and some bedrooms had been redecorated. Before our inspection we had been informed of a large amount of rubbish in the car park. We were aware that work had started to clear this and although there was a considerable amount that still needed to be cleared we were informed by a visiting environmental health officer that this had improved vastly. The registered manager was aware and the process of clearing continued. We saw further refurbishment of the home was planned for the weeks following our inspection. There was an active and ongoing recruitment drive in order to employ more staff.

Although areas for improvement had been identified leadership of the service and the provider had failed to ensure action was taken when needed. Care plans, risk assessment and nutritional assessments did not reflect people's needs and there was limited evidence of any actions being taken to address this. A care plan audit by the provider in April 2015 had identified these shortfalls but there had been no further provider audit to assess whether action had been taken to address these. The management had failed to ensure these were embedded as best practice in all applicable areas.

Although there was a recruitment drive the provider had not identified people's safety was potentially at risk from inadequate staffing levels. They had not identified that inadequate staffing levels had also impacted on the shortfalls we found in people's care records. Records we saw showed that some staff had not updated their safeguarding training since 2001. We received information from the provider following the inspection which demonstrated that all staff had received safeguarding training since this time, although some updates were required. However, this information was not available to us at the time of the inspection. The lack of supervision and oversight of training meant the provider had not identified whether staff needed further training or support to meet people's needs.

Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems to identify trends and mitigate risks. Learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews.

The service failed to ensure continuous improvement and development of the service and to demonstrate learning from incidents and accidents. The quality assurance framework was ineffective because the provider failed to have effective systems and processes to ensure they were able, at all times, to meet requirements in other parts of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a negative culture at the home and this was impacting on the welfare of people. There were inconsistencies within the staff team in relation to support. All staff told us they felt supported by the nurses, they told us they could speak to them and discuss any concerns. Some staff felt supported by the registered manager and management team but others did not. One staff member said, "I don't feel supported by the manager, she isn't approachable, I don't feel valued or appreciated." However, another staff member told us, "I feel supported by the manager, she gave us a lot of hope. I appreciate and respect her, she inspires." Staff told us about conflict within the staff team, whilst others felt supported by all their colleagues. One staff member said, "We're a good team, we all get on and work well together." Another told us, "Staff are not working well as a team. People are rigid and will not support others or work across teams and zones, management are not dealing with staff issues."

Inadequate

Is the service well-led?

People and staff did not feel supported from senior management with the Leonard Cheshire organisation. Comments included, “We’re not valued.” “They don’t know about the problems we have here.” (This was in relation to difficulties recruiting staff). People and staff told us about an incident where disciplinary action had been taken. One person said, “They came down on that heavily, but not when something goes well. We don’t get the same level of praise as we do criticism.” People and staff also told us they did not feel involved with decisions that were made about the day to day running of the home.

People we spoke with told us they were concerned about the staff morale. They told us recent changes and incidents at the home had impacted on staff. This was information people could only have acquired from staff. Whilst there was an open and friendly relationship between people and staff this indicated to us the culture of the home was negatively affecting people who lived there. For example people told us they were concerned about how much work staff were expected to do and as a result staff may leave the service. This was acknowledged by some staff who told us they were aware the way some staff were feeling was being shared with people. This staff member said, “They (staff) need to remember this is our job, it’s what we do, any problems shouldn’t be affecting the residents.”

The registered manager told us she was aware of these concerns and was trying to address them. She had arranged meetings with staff and with people to share the action plan to help people understand the issues and how they were being addressed. This included staff recruitment and refurbishment of the home. People were now involved in interviewing prospective new staff and there were joint meetings with people and heads of departments.

We saw the registered manager was known to staff and people. One person told us, “She is very visible.” We observed people approaching her, discussing concerns and engaging in day to day conversation. The registered manager acknowledged that changes were required but also understood this may take some time.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had failed to follow the principles of the Mental Capacity Act 2005. Mental capacity assessments were not in place. There was no information about how decisions were made or how people's freedom may be restricted.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Not all risks had been identified and others did not have sufficient guidance in care plans.** **Regulation 12 (2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff had not received appropriate support or supervision.** **Regulation 18(2)(a).**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive the care they wished for or required.** **Regulation 9(1)(a)(b)(c)(3)(a)(b)(h)(i)**

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.** **Regulation 10(1)(2)(a)(b)**

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to ensure there were appropriate systems or processes to assess, monitor and improve the quality and safety of services.** **Regulation 17 (1)(2)(a)(b)(c)(d)(f)**

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

We found the registered provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were sufficient numbers of staff deployed.

Regulation 18(1)

The enforcement action we took:
Warning notice