Tamaris Healthcare (England) Limited

Hillside Lodge Care Home

Inspection report

Braeside
Berwick Upon Tweed
Northumberland
TD15 2BY

Tel: 01289307500
Website: www.fshc.co.uk

Date of inspection visit:
30 March 2016

Date of publication:
11 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 March 2016 and was unannounced. A previous inspection undertaken in September 2014 found the home to be fully compliant with legal requirements.

Hillside Lodge Care Home is located in a residential area of Tweedmouth near Berwick, Northumberland. It is registered to provide accommodation for up to 50 people. At the time of the inspection there were 42 people using the service, some of whom were living with dementia.

The previous registered manager had recently retired and had deregistered with the CQC. A new manager was in post and had applied to become the registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff were aware of the need to safeguard people from abuse and had a good understanding of potential abusive situations. They had received training in relation to this area and were able to describe the action they would take if they had any concerns. There had been no recent safeguarding issues at the home. The home had worked with key agencies around previous safeguarding events.

Risk assessments were in place both in relation to the wider operation of the home and linked to the individual needs of people using the service. Regular checks were made on fire and safety systems to ensure they worked effectively. Equipment was checked to ensure it was safe to use.

People told us they did not have to wait long for support and help. We observed call bells did not ring for long periods. The manager told us she had recently increased staffing numbers to provide additional support. However, the recruitment of qualified nurses had proved difficult. There was regular use of agency nursing staff, although this was usually staff familiar with people living at the home, and the clinical lead was working excessive hours to ensure nursing requirements were fully covered. Suitable recruitment and vetting procedures were in place.

We found medicines were appropriately managed, administered and stored safely. The clinical lead carried out regular checks on the storage of medicines. Some topical cream records held in people's rooms had been removed and destroyed meaning accurate records were not available to ensure they had been applied as prescribed.
A number of areas of the home were not clean. Bathrooms, showers and sluice areas were in need of effective cleaning and in some cases refurbishment. The laundry area was also in need of effective cleaning. The manager had noted the need for these improvements and highlighted it as priority work to be undertaken.

Staff told us they had access to a range of training and updating. Records showed completion of online training was high. Additional training was available to further enhance staff skills. Staff told us, and records confirmed regular supervision and annual appraisals took place.

People told us meals at the home were good and they enjoyed them. Alternatives to the planned menu were available. Staff supported people with their meals appropriately and in a dignified manner. Kitchen staff demonstrated a good knowledge of people's individual dietary requirements. Diet preference/ requirement sheets were available and updated regularly. Where people were on food and fluid charts, to help monitor their intake, these were completed well and up to date. People's weight was monitored on a weekly basis.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. Where necessary applications had been made to restrict people's freedom under the MCA. Staff understood the concept of acting in people's best interests and the need to ensure people made decisions about their care. Records showed people had provided their consent or that best interests decision had been made. The provider had notified the CQC about the outcome of DoLS applications as they are legally obliged to do so.

People and their relatives told us they were happy with the care provided. We observed staff treated people patiently, appropriately and with good humour. Staff were able to demonstrate an understanding of people's particular needs. People's health and wellbeing were monitored, with ready access to general practitioners and other health professionals. Staff were able to explain how they maintained people's dignity during the provision of personal care and demonstrated supporting people with dignity and respect throughout the inspection.

Care plans reflected people's individual needs and were reviewed to reflect changes in people's care. Care plans also reflected advice from visiting professionals such as the behaviour analysis and intervention team (BAIT). A range of activities were offered for people to participate in. People said they enjoyed the activities and could suggest activities for the home. There was a live musical performance on the day of our inspection.

There had been no formal complaints within the previous six months. Information about how to raise a complaint was available around the home. People said they knew how to make a complaint and they would speak with the manager if they had any concerns.

The provider had a system of electronic audits and checks. These dealt with individual's care and welfare along with broad reviews of the home and the environment. There was also an electronic system for people, relatives, professionals and staff to record their views of the home and the management. The overwhelming response had been positive during the previous month. The manager said any concerns were logged and action taken to address them.

Staff told us the manager was new but felt she was supportive and approachable. Comments suggested they were happy working at the home. Regular staff meetings took place and workers said they were able to raise issues for discussion.

Records relating to the cleanliness of the home were not always completed and this meant we could not be sure cleaning schedules had been followed. Records relating to the application of topical medicines had not been retained as they are legally required to be.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to Safe care and treatment, Staffing and Good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The clinical lead at the home was working excessive hours to ensure that nursing tasks at the home were covered and complete. There was regular use of agency staff. Bathrooms, showers, sluices and toilet areas required additional cleaning and refurbishment to bring then up to an acceptable standard.

People and their relatives told us they felt their family members were safe living at the home and staff had undertaken training in safeguarding vulnerable adults.

Risk assessments had been undertaken in relation to people's individual needs and the wider environment of the home. Medicines were managed safely and kept securely, although topical medicine records had been erroneously disposed of.

Is the service effective?

Good

The service was effective.

There was evidence applications had been made to the local authority to in relation to the Deprivation of Liberty Safeguards (DoLS). Staff understood about supporting people to make decisions and best interests processes were used where people lacked capacity to make decisions.

Staff told us, and records confirmed a range of training had been provided. Training records showed a high completion level of online training. Regular supervision and annual appraisals were undertaken. People's wellbeing was effectively monitored with access to a range of health and social care professionals.

A range of food and drink was available at the home and specialist diets were supported. People told us they were happy with the meals provided. Monitoring of fluid and food intake was up to date.

Is the service caring?

Good

The service was caring.

Relationships between people and staff were friendly and supportive.

People and their relatives told us they were happy with the care they received and felt they were well supported by staff. They said they had been involved in determining the care they received. They were kept up to date on any issues or changes.

We observed staff supporting people with dignity and respect in a range of care situations. People were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs had been undertaken and care plans reflected these individual needs. Plans were reviewed and updated as people's requirements changed and incorporated advice and guidance from health professionals.

There were activities for people to participate in. People said they enjoyed the activities, with both group and individual time made available. We witnessed people enjoying a live music event. People told us they could make choices about how they spent their days or the care they received.

The provider had a complaints policy in place and people were aware of how to raise any complaints or concerns. There had been no recent formal complaints.

Is the service well-led?

Requires Improvement

Not all aspect of the service were well led.

Records relating to the cleaning of the home were not always complete and up to date and topical medicine records had been disposed of.

The provider had introduced a range of electronic auditing systems to ensure the quality and standard of care was maintained or improved. Comments on the service from people, professionals and relatives were overwhelmingly positive.

Staff were positive about the support they received from the new manager and felt the home was changing slowly for the better.

Hillside Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 30 March 2016 and was unannounced.

The inspection team consisted of an adult social care inspector, a specialist advisor (SPA), with expertise in the care of elderly people with nursing needs, and an expert by experience (EXE). A SPA is a professional with a back ground and experience of working in services related to the type of locations we were inspecting. An ExE is a person who has personal experience of using or caring for someone who uses this type of 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. Prior to our inspection, we reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority safeguarding adults team and the local clinical commissioning group. We used the information they provided to help plan the inspection.

We spoke with six people who used the service to obtain their views on the care and support they received. We also spoke with two relatives who were visiting the home on the day of our inspection. We talked with the regional manager, the manager who was applying to become the registered manager of the home, the clinical lead, six care workers, the activities organiser, a member of the domestic team, the maintenance worker and the cook. We also spoke with a general practitioner who was visiting the home on the day of the inspection and contacted the community matron following our visit.

We observed care and support being delivered in communal areas, including lounges and dining rooms, looked in the kitchen areas, the laundry, treatment rooms, bath/shower rooms and toilet areas. We checked people's individual accommodation. We reviewed a range of documents and records including; five care

records for people who used the service, eight medicine administration records; three records of staff employed at the home, duty rotas, complaints records, accidents and incident records, minutes of meetings, a range of other quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

During our inspection we noted there were transient malodours in parts of the home and in some individual rooms, although the general ambiance of the home improved as the day progressed. Bathrooms, shower rooms and toilets were not always clean. Some floor areas were in needs of cleaning, some taps were encrusted with lime scale, drains in both sinks and baths had hair in them, tiled areas had grouting that was discoloured and tiles were cracked in one sink area. A range of redundant equipment was stored in some of bath and shower rooms. Light pull cords in some toilets and washing facilities did not have wipeable covers on, meaning the cords were soiled and stained and could not be effectively cleaned. The general decoration of bath and shower areas was in need of updating with vinyl and tiled floor area stained in places.

Sluice areas in the home were also not well maintained. Drying racks for urine bottles and bedpans had paint that was badly cracked and rusted. Bedpans and basins used in personal care were not always well cleaned, despite home having a number of working sluice machines. We found one sluice machine, which staff said had not been used for a number of months still encrusted with dried faeces when we looked inside it. Taps and sink areas in sluices were not always well cleaned. Some waste bins in sluices and one in the kitchen area were broken and could not be foot operated, meaning staff had to touch the bins by hand to dispose of rubbish or soiled items. Some bins did not have plastic waste bags fitted properly, allowing them to fall down and potentially spill rubbish or soiled items on the floor. This meant there was a risk on cross contamination and infection because washing facilities and sluices were not always maintained in a clean and tidy way and some equipment was not fully cleaned.

In the laundry area we noted the area behind the washing machines and driers was excessively dirty with dust and powder residue. Clothes that had been washed were hung to dry above the washing machines, meaning they were at risk of being contaminated as washing machines were loaded with dirty clothing or bedding.

Domestic staff used colour coded mop buckets and equipment to clean designated areas around the home. However, some mop buckets were stained and encrusted with lime scale. Domestic staff told us there were enough domestic staff hours scheduled to carry out the required cleaning tasks and they had access to appropriate types and levels of equipment.

We spoke with the manager regarding the general cleanliness of the home and in particular the sluice and bath areas. She told us the cleanliness of the bathrooms and the sluices was something that she had identified early when she came into post. She said she had already spoken to the regional manager about a programme of full refurbishment of these areas. She also told us she had personally tried to clean some of the areas with a stiff brush and cleaning solutions but this had had limited effect and that redecoration was the long term solution. She also said she was already in the process of sourcing new drying racks for bedpans in the sluice areas. The regional manager told us that as part of his audit of the home he had also identified the laundry area as in need of urgent cleaning and this had been arranged through the provider's maintenance contractors.

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

The manager told us there were 38 staff employed overall at the home. She said that on the morning of the inspection there was one nurse and seven care workers on shift. Night shifts consisted of one nurse and four care workers. Staff told us these staffing levels had only recently been increased by the new manager and the seventh care worker on day shifts only worked for the morning period. The manager confirmed the additional staff worked until 2.00pm, but said she wanted to extend this to a full day as more staff were recruited.

People told us there were enough staff to look after them and they responded to their personal needs in good time. They told us they had regular access to baths and showers. We noted throughout the day that call bells did not ring for long periods. The manager told us the home had two full time nurses currently employed, one of whom was the clinical lead for the home. A third permanent member of nursing staff was being inducted on the day of our inspection. She told us there was regular use of agency or bank nursing staff, but such staff tended to be the same individuals and so knew the home and the people living there. This was confirmed by the community matron.

We looked at staff duty rotas. We noted the clinical lead was regularly working five 12 hour shifts each week, meaning they were working 60 hours a week. On some weeks they also worked a number of supernumerary hours, meaning they worked in excess of 60 hours. Rotas showed that on one week they had worked two night shifts and four days shifts, meaning they had worked 72 hours in total. We spoke to the clinical lead about the hours they worked. They told us they would rather work additional hours than bring in agency staff. They also told us they often worked additional hours at the end of the shift to ensure they had completed all their tasks and could leave the home knowing that the service was left safe.

The clinical lead told us there was only one nurse on shift at any one time, and staff rotas confirmed this. They said having one nurse on shift was difficult as they had to complete the medicines for all the people living at the home, along with other nursing duties and clinical lead requirements. Additionally nursing staff were now required to complete daily audits as part of the new overall audit process. This meant nursing staff were required to administer medicines to all 43 people who were living at the home. We observed that the clinical lead spent considerable time dealing with medicines on the day of the inspection, particularly ensuring that people who were sometimes confused had the right approach and time to understand what was being requested of them. This meant the clinical lead was regularly working excessive and tiring hours on shift which may lead to issues around safety of judgement. This also meant that some people may not get their medicines in a timely manner, because there was only one nurse administering the medicines on each shift.

We spoke with the manager and regional manager about the workload of the clinical lead at the home. The manager said it was the clinical lead's choice to work the additional hours and she was quite happy to bring in additional agency hours. She also told us that recruiting nursing staff in such a rural area could be an issue, although they hoped to be bringing in at least one additional nursing staff member in the coming weeks. The regional manager acknowledged that better management of the clinical lead's time needed to be affected and he would look at this. He also told us that it was the intention to train senior care workers to administer medicines of some people to free up nursing time. However, this training had not been completed and senior care workers had not yet taken over this duty.

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

The provider had in place a safeguarding policy and information was displayed around the home about safeguarding and how people and staff could report any safeguarding concerns. Staff had a good understanding of safeguarding issues and said they would report any issues or concerns to the manager or clinical lead. The manager told us there had been no recent safeguarding incidents at the home. The CQC had been notified of previous safeguarding incidents or concerns and these had been dealt with appropriately. Information about the provider's whistleblowing policy and process was also available throughout the home. People told us they felt safe living at the home. This meant the provider had appropriate systems in place for reporting and managing safeguarding concerns at the home.

Risk assessments were in place, both for the general running of the home and as part of people's care records. Regular checks were made by the home's maintenance workers on fire safety equipment, water systems and other equipment throughout the home. At the time of the inspection an outside contractor was visiting the home to check and service lifting equipment used in the home. People's care records contained individual risk assessments related to their health and well-being, such as risks associated with moving and handling, choking, falls and nutritional intake. People also had Personal Emergency Evacuation Plans (PEEP) detailing the level of support or assistance they would require in the event of a fire or other emergency at the home. This meant appropriate systems were in place to identify and minimise risks within the service.

Medicines within the home were generally managed safely and effectively. Medicines were stored safely and cabinets and medicines trolleys were clean and tidily maintained. Medicines for each individual were easily identifiable and recorded. Medicine administration records (MARs) were well kept and up to date with no gaps in signatures. We noted some people had "as required" care plans, although the actual medicine was not recorded on the MAR. "As required" medicines are those given only when needed, such as for pain relief. The clinical lead told us local GP surgeries had previous had a blanket policy regarding homely remedies and "as required" medicines but she was currently in the process of updating all the MARs to ensure any "as required" or homely medicines were individually noted and agreed with the person's GP. Homely remedies are Items that can be bought from a chemist, such as cough linctus. Controlled medicines were stored safely and records were up to date. Controlled medicines are those where there are special laws related to their use and safe storage. When controlled medicines were given two members of staff signed to confirm the dosage. The clinical lead told us care staff had been specially trained to support this system because there was only one nurse on duty. Records related to the provision of topical medicines were not available for review. Topical medicines are those used on the skin, such a cream and lotions. This meant the majority of medicines were managed safely and effectively, although we could not be clear about how people were supported with topical medicines because records could not be reviewed.

Good

Is the service effective?

Our findings

Staff told us they had access to a range of training and development opportunities. They told us the majority of training was completed on line although some face to face training was also provided. Some staff told us they found it difficult to find time to do on line training in work hours and so did it in their own time when at home. The manager told us that if staff came into the home to complete training when off shift they would be paid for these hours. The manager showed us a printed report detailing the percentage completion of training for staff employed at the home. We saw that all the areas highlighted at mandatory training were above the 90% completion rate. The manager told us all new staff would be undertaking an induction programme based on the national care certificate. However, she said staff would only complete a proportion of the full range of available modules.

At the time of our inspection a new member of staff was participating in an induction day. We saw they spent time shadowing other members of staff. We also saw the maintenance worker was showing and explaining to the staff member the fire systems in place at the home and how the various extinguishers operated. Staff told us they had regular supervision and annual appraisals and records confirmed this. A small number of supervision documentation were not dated or signed by the staff member to say they agreed with the recorded comments. The manager told us that supervision of staff was divided between herself and the clinical lead. This meant systems were in place to ensure there were regular training and development opportunities for staff and regular supervisions and appraisal meetings.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw documentation related to DoLS was contained within people's care records and that the manager kept an oversight document to track applications and expiry dates.

Where people had capacity to make their own decisions about the care they received then this was documented. Where people did not have capacity to make their own decisions then staff had followed the MCA and best interests decisions were noted. This included where people were supported to be safe through the use bedrails. There was evidence of appropriate processes being followed where people had DNACPR (Do not attempt cardiopulmonary resuscitation) notifications in place. Staff understood about supporting people to make personal choices where ever possible. This meant appropriate action had been taken by the home to ensure proper and legal processes were followed in relation the MCA and DoLS.

People told us they enjoyed the food at the home. We spent time observing how people were supported over meal times and saw this was done appropriately and with dignity and respect. Where people required additional equipment to support them with their meals and drinks, such a specialist cutlery or plate guards, this was available, although we noted some people seemed to have difficulty identifying pale food items on white crockery. The manager told us coloured crockery was available and its use would be reviewed. Where people required specialist diets these were provided. For example, the cook told us one person new to the home required a gluten free diet. They showed us how they had obtained special products to cater for this particular need. Each person also had a dietary preference sheet to identify their likes and dislikes, as well and any special requirements. Where there were concerns about people's food or fluid intake then a record was kept to monitor their consumption. We saw these were up to date. The cook said food was generally fortified through such actions as adding cream to mashed potatoes. Where people required additional fortified diet further supplements were provided, such as milkshakes in the afternoon. People's weight was regularly monitored and no one at the home was noted to be losing significant weight. This meant people were supported to sustain an adequate dietary and fluid intake whilst living at the home.

People were supported to maintain good health and wellbeing whilst living at the home. There was evidence in people's care records which showed they were supported and encouraged to attend outpatient or hospital appointments. Where necessary people had been visited and assessed by health professionals, such as occupational therapists or speech and language therapists. The community matron told us she visited the home on a regular basis and staff would always contact her for advice if they were unsure about how to deal with people's conditions. During our inspection a general practitioner visited the home to examine and review a number of people. He told us he regularly visited the home to provide assessments and support. This meant people living at the home were supported to access appropriate health and social care services to maintain their wellbeing.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments included, "I think the staff all very good"; "It's ok here but not like home but it is ok, I like it here" and "I am very happy here, the staff were very good and I am happy with the all the care provided."

We spent time observing the interaction between people and the staff. We saw there appeared to be good relationship and staff treated people with kindness and consideration. Staff spoke to people in a kind and sympathetic manner and also engaged in jokes with people. Staff members, other than care workers, also engaged positively with people. Members of the domestic staff team chatted with people whilst they were cleaning their rooms and enquired if people were alright. A domestic spontaneously danced with a person as they were listening to music from an event elsewhere in the home. Staff told us they got to know people as they helped and supported them and got to know their families. They said having this understanding of people and their families helped them to care for them because they knew more about them as a person. This meant the relationships at the home were caring and supportive.

People were supported to follow their particular religious beliefs and there was a multi denominational service held at the home. We saw in one person's care plan that attending church had been something they had participated in before moving to the home. Their personal plan stated staff should support the person to attend the religious service at the home, to help maintain this interest. The activities worker told us about another person who could not always attend services. She said she supported the person through the use of a tablet computer device, where they could watch religious services in videos or listen to hymns. This meant staff understood about supporting people's diverse needs and interests.

People and their relatives told us they were involved in developing their or their relative's care packages. One person told us how she had been asked about her preferences when she started living at the home. The clinical lead told us they regularly discussed any issues or concerns with people and their families and had built good relationships to maintain their involvement. Staff were observed to actively encourage people to make choices and decisions, where they could. People told us they could put forward ideas for activities at the home and these would be supported. The activities co-ordinator told us how it had been raised in a 'residents'/ relatives' meeting that people would like to have ice creams during the summer and so an ice cream van called at the home weekly during the summer months. She also told us people had requested benches at the front of the home were moved to the rear garden, as this was a better place to sit and enjoy the fresh air and that this had been done. Relatives told us they were kept informed and any changes to their relation's care needs. This meant people and relatives were supported to actively participate in determining the delivery of their care.

Staff talked knowledgably about supporting people's privacy and dignity during the delivery of personal care. We observed that when people were being assisted with personal tasks, staff ensured doors were closed and moved in and out of rooms in a discrete manner. People looked well cared for, were dressed appropriately and wore suitable footwear. Men had been shaved and everyone's hair was tidy. People were wearing glasses, if required, and had been supported to wear their dentures, where necessary. At meal times

staff approached people and asked if they would like their clothing to be covered during the meal to protect against spillages. This showed staff understood about supporting people to maintain their dignity during the delivery of care and respecting people as individuals.

People were supported to maintain their independence. They were able to stroll around the home as they wished and could spend time in lounge areas or in their own rooms. When we began the inspection we met a small group of people sat chatting on one of the lounge areas. We asked them what they were going to do for the rest of the day and they told us they were still discussing this and deciding how they wanted to spend their time. This meant people were supported and encouraged to maintain their independence as far as possible.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs. Comments included, "Staff here are very good, my room door is always open and when the staff go by they always pop in to say hello, talk to me and always ask me if I needed anything" and "The staff were very good and I am happy with all the care provided. The staff come whenever I call them from my room." We observed that call bells at the home did not ring for long periods before staff attended and supported people. At one point during the day of the inspection, an emergency buzzer was pressed, indicating someone required urgent assistance or a staff member required additional assistance whilst supporting someone. We saw a range of staff members responded immediately to this call and attended the location of the call buzzer to offer assistance.

The cook told us about one person who could be quite restless and often found it difficult to sit in the dining room with other people. They explained they would support the person to have their meals after other people had eaten and ensured that a meal and a drink were available immediately, to reduce the possibility of the person being distracted. The cook said that on days where the person found it difficult to sit and eat they would provide the person with finger foods, such as sandwiches, which they could eat whilst they walked around the home, meaning they could still access food and drinks without the need to sit in the dining area. This meant staff were understanding of people's needs and responded to people's day to day needs.

Care plans were observed to be comprehensive and related appropriately to the individual needs of the person. Care records were person centred and contained assessments of their needs, including specific assessments of areas such as mobility needs, skin integrity needs and nutritional requirements. People's care records contained a front sheet highlighted as "clinical hotspots." This was an immediate visual prompt for staff as to particular areas people may be at high risk in. This meant appropriate assessment and reviews of people need were undertaken and any risks highlighted.

People's records contained detailed care plans related to their individual needs. Care plans covered areas such as mobility, skin integrity, support with medicines and support with pain relief. Care plans contained actions that staff should take to support people with these identified needs. Where necessary, advice had been sought from health professionals and this had been incorporated in care plans. For example, one person sometimes displayed behaviour which could be described as challenging. We saw advice had been sought from the behaviour analysis and intervention team (BAIT). A specific care plan had been developed identifying ways staff should approach and support the person if their responses became challenging.

Care staff told us they informed the nurse in charge of any concerns they might have regarding people's skin condition, continence or nutritional intake. They said the nurse would review the person quickly and discuss any treatment or intervention required, such as starting a food and fluid chart or turning/moving someone with the potential for skin damage. This meant plans were in place to ensure people received the correct care and treatment and these were reviewed and updated when necessary.

We spoke to staff about people who lived at the home and found they had a good understanding of them as

individuals and their particular needs. They were able to describe the range of support people needed and also their particular likes and dislikes. The activities organiser told us about one person who liked cats. They were unable to have a cat at the home, but as part of individual time they spent with the person they would use the tablet computer and watch cat videos posted on the internet, which they really enjoyed.

The activities worker provided a range of activities and events for people who lived at the home. During the afternoon of the inspection day a singer had visited the home to provide live music. We observed people were singing along during the performance, smiling, tapping their feet or hands and generally seemed to be enjoying the event. People told us a range of events and activities were on offer. The activities worker told us there were group activities, such as carpet bowls, quizzes or similar events. They also said that during the summer, trips out to local places of interest were organised. They said they also ensured people could have individual time and supported people to engage in a range of activities, including supporting people with things such as the application of make-up. They described how one person enjoyed having the bible read to them. This meant there were a range of activities and events to help support and stimulate people.

People told us they were able to make choices. They told us they could make choices about meals, when they went to bed, whether they spent time in their room or in the lounges with others and if the wanted a bath or a shower. People's likes and dislikes were recorded in the care records and on food preference forms. One person told us they had chosen to have a nap on their bed in the afternoon. We observed a care worker enquired if a person would like cordial added to the water jug in their room. The person said they would and the care worker did this for them. The cook told us that in addition to the regular menu available at the home there were a number of "call order" items people could ask for at any meal, such as baked potatoes, salad or omelettes. This meant people's choices and personal preferences were supported and respected.

The provider had in place a complaints policy and information about how to raise a complaint was on display and available throughout the home. The manager and the regional manager told us there had been no formal complaints in the last six months. He said any formal complaint would be logged on the provider's system and would be monitored to ensure a proper response was made. The manager confirmed complaints could not be closed on the system until all the actions had been completed. People told us they knew how to raise a complaint but had not had cause to do so recently. The manager and regional manager told us about a facility on the providers recently introduced feedback system. They described how people or relatives could press a button which would send a message stating they wanted to speak to someone immediately. The system sent a message instantly to the manager, regional manager and chief executive. One of these individuals would respond to this request, usually on the same day. This meant the provider had a complaints policy in place, there was a system to formally respond to any complaints and people knew how to raise concerns if they wished to.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager formally in place at the home. A manager had been appointed and was already overseeing the running of the home. She stated she was in the process of making a formal application to register with the CQC. Our records showed an application was in progress. The acting manager and regional manager were present on the day of the inspection.

During the inspection we noted some records were not always up to date or were not available. For example, the manager told us they had recently introduced new recording forms to ensure that rooms were cleaned on a regular basis. We found these documents were not always completed and there were gaps, often as long as three days, when no record had been made that rooms had been cleaned. These included rooms used on a regular basis, such a bathrooms and toilets and sluice areas. We could therefore not be certain that appropriate cleaning processes had been followed because records were not up to date.

We asked the clinical lead about how people were supported with topical medicines. Topical medicines are those that are applied to the skin, such as creams and lotions. The clinical lead told us these would be recorded on special MAR records kept in people rooms and would be completed by care staff. However, she told us these had been removed the previous night as part of the regular change-over of documentation. They told us the topical MARs had been destroyed because she thought they were no longer required. These documents form part of a person's care record and should be retained in line with national guidance regarding the retention of individual care and health records. This meant we were unable to be assured that people had received their topical creams appropriately because records had been inappropriately disposed of.

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

Other records maintained at the home were up to date and contained good details. Records relating to people's food and fluid intake, daily records, those relating to safety systems (fire and water) and staff were all complete and stored securely. Regular and appropriate notifications of significant events at the home had been fully forwarded to the CQC.

The acting manager and regional manager demonstrated the audit and monitoring system used by the provider, utilising tablet (hand held computer) technology. They showed how a range of daily and weekly checks were completed by both the manager and nursing staff, including checks on medicines, care plans and a range of other aspects of the home and the environment. Checks were made to ensure MARs were dated and coded and appropriate numbers of medicines were in stock. There were also direct checks on individuals, where the manager spoke to the person directly and asked specified questions including issues related to privacy and dignity, staff attitudes and if they had any current concerns. Any matters that arose from these audits would be highlighted as actions and allocated to an individual to complete within a given time scale. These would be monitored by the manager and regional manager. The manager told us actions could not be closed until it had been recorded that all parts had been completed.

The manager was also required to conduct regular walk round checks on the home, including; was the home clean and tidy, did people look well cared for and were charts complete and up to date? These checks could also be undertaken at various times during the day. Any matters were noted as actions and were monitored until completed.

The home also had a computer tablet based feedback system that allowed professionals, relatives and people using the service to give immediate feedback on their experiences at the home. The manager showed us copies of entries on the system from professionals, relatives and people who used the service. Within the previous month there had been seven people who used the service who had entered information onto the system. All these people had said there were 100% satisfied with the service. 73% of 15 responses from relatives had indicated they were highly likely to recommend the home to a friend. People told us there were regular residents' meetings and they were able to make suggestions to improve the running of the service and discussed the changes made, such as the moving of benches and the introduction of certain meals.

Staff were also encouraged to take part in an electronic engagement process. Staff comments recorded were overwhelmingly positive. Comments included, "I want the home to be the best"; "I love working here" and "I enjoy my job and would like to do more training to ensure I do my job to the high standards expected." This meant the provider had a range of methods and system to monitor and audit the quality of the service provided at the home and take action to improve the service, where appropriate.

Staff told us the manager had only recently taken up post but they felt positive about the future of the home and that improvements were being made. One staff member told us, "It's a good change. She is bringing in subtle changes and they are all for the best." Comments about the new manager had also been posted by staff on the computerised feedback system. These comments included, "The manager is easy to approach and always listens to what you have to say" and "The new manager listens and is very helpful." Staff confirmed there were regular staff meetings and they could contribute to the discussion about the service during these meetings. This meant that, at this early stage staff were positive about the influence and support from the manager.

The manager told us she was still settling into the new role and was getting to grips with the provider's reporting systems. She said she had started to make small changes such as minor amendments to improve staffing and had already highlighted the need to refurbish the bath and shower rooms at the home. She said she and the clinical lead had regular meetings and were working together to improve the home and introduce changes to benefit the people who lived there. The local community matron told us, "I don't have any real concerns with Hillside. I haven't really got to know the new manager very well yet but she seems to be settling in well and leaving (clinical lead) to get on with the nursing side of things. (Clinical lead) leads a tight ship."

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 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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to assess, detect and prevent the spread of infections. Regulation 12(1)(2)(h)

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 Processes were not in place to ensure accurate, complete and contemporaneous records were maintained for each service user. Regulation 17(1)(2)(b)(c)

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 Systems were not in place to ensure sufficient numbers of suitably qualified competent, skilled and experienced staff were employed and deployed. Regulation 18(1).