Almondsbury Care Limited

# Hillview Nursing Home

## Inspection report

36 Berrow Road
Burnham On Sea
Somerset
TA8 2EX

Tel: 01278792921
Website: www.almondsburycare.com

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Hillview Nursing Home is a residential care home providing personal and nursing care to up to 40 people. The service provides support to older adults. At the time of our inspection there were 36 people using the service.

Hillview Nursing Home is registered to accommodate up to 40 people in one adapted building.

People's experience of using this service and what we found
People experienced poor care which resulted in harm. A number of people had preventable wounds from lack of pressure care. A significant number of people had unexplained bruising. Staff had not followed safeguarding procedures and concerns had not been documented or reported to the relevant authorities. Risks to people were not assessed and monitored. The provider did not have any mechanism in place to learn from incidents.

Medicine was not always managed safely. The provider had not ensured medicines were stored safely and administered as directed. People whose health conditions needed to be monitored did not always have this done.

People's needs had not been fully or accurately assessed. There were significant shortfalls in the assessment of people's skin integrity and wounds. Equipment intended to support people such as pressure relieving mattresses were malfunctioning and some mattresses were found to be deflated. Care plans were not always person-centred; they did not contain information about people's individual preferences.

Staff had not been fully trained or supervised. There were shortfalls in all areas of staff training. There were no records of supervision available. People were not always supported in line with the Mental Capacity Act (2008); decisions recorded were often dated several weeks after admission and showed no evidence people or their families had been consulted about decisions.

Staff did not work effectively with other professionals. Several people had no records of any health visits and staff did not always follow the guidance of health professionals.

People were not always treated with dignity and respect at the service. We observed a number of interactions where staff did not behave in a caring way. We saw that some staff lacked the ability to interact with people living with dementia. However, we saw other members of staff who treated people with kindness, warmth and respect.

The provider did not have effective systems in place to monitor the safety and effectiveness of the service. Shortfalls found at the inspection had not been identified by the provider. There was no system in place of regular audits to monitor the quality of the service. The provider had failed to identify that incidents and

safeguarding concerns had not been reported.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection and update
The last rating for this service was good (published 28 September 2017). This has now changed to inadequate.

Why we inspected
The inspection was prompted due to concerns received about wound care and unexplained bruising for several people living at the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We expanded the inspection to include the caring and responsive domains.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Despite being fully informed of the risks and actual harm to people living at the service the provider took no action to mitigate these risks.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hillview Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment, monitoring the quality of the service and staff training and recruitment at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Inadequate

The service was not effective.

Details are in our effective findings below.

**Is the service caring?**

Inadequate

The service was not caring.

Details are in our caring findings below.

**Is the service responsive?**

Inadequate

The service was not responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# Hillview Nursing Home

**Detailed findings**

## Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and a member of the CQC medicines team. Information was also gathered by an inspection manager and the national enforcement team.

Service and service type
Hillview Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hillview Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We looked at a range of care and nursing records. We checked 13 people's medicines records and looked at arrangements for administering, storing and managing medicines. We also looked at the medicines policy. We spoke with four people living at the service. We spoke with five members of staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with a range of professionals visiting the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We requested records and information relevant to the running and monitoring of the service. We reviewed reports from the local authority safeguarding team, the district nursing team and paramedic reports.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of abuse. The registered manager had not followed reporting procedures in place. We identified people who had experienced harm at the service. This had not been reported to the provider or to statutory authorities.
- Health professionals identified a number of people with pressure damage. Other people were found by these professionals to have unexplained bruising which had not been reported.
- Professionals made the provider aware of risks to people at the home. They provided a list of people with wounds which needed to be managed by nurses employed at the service. At the time of the inspection, no action had been taken by the provider or the nursing staff. We were unable to find wound care plans and there were no records of any care given or dressings changed. When district nurses re-assessed people they found some people had not had their dressings changed for a week.
- We observed a member of agency staff carrying out incorrect moving and handling techniques. They moved the person in an unsafe way. We requested the Nominated Individual who was on site, to take appropriate action to reduce the risk of further harm. We later saw the same member of staff grab a person by the wrist and pull them out of the office.
- Some people living at the service appeared to be distressed and agitated. Two people told us they wanted to go home. Other people were walking around and appeared unsettled.
- Not all staff had been trained in safeguarding adults. Information from the provider showed that almost half of the staff had not undertaken the training within the provider's required timescale.

The provider had failed to protect people from abuse and neglect. People had been harmed. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The provider had not assessed risks to people living at the service. People had not been fully assessed in respect of their mobility or skin integrity. People's care plans contained incorrect information about their risks and care needs.
- People who either had pressure damage or were at risk of this were not monitored. People who were immobile and nursed in bed were found to have insufficient protection from harm. Special air mattresses designed to reduce the risk of pressure damage were either not in place, deflated, damaged or on incorrect settings.
- Information for staff in respect of people's needs was incorrect. For example, one person who was nursed in bed, needed to be repositioned, and had pressure wounds. The handover sheet which was used to inform both permanent and agency staff of people's care needs, incorrectly noted this person as independent with intact skin. Following an assessment by health professionals, who made the provider aware of the incorrect

information, this was not updated.
● Whilst walking around the building we found an unlocked cupboard which had a sign stating it was to be kept locked. On opening the cupboard, we found a used incontinence product and a pair of gloves. The cupboard contained the hot water boiler and there were very hot pipes which were uncovered. There was a risk somebody could open the door and burn themselves on the pipes as well as an infection control risk from the used incontinence product. We raised this issue in the morning but by 5pm still no action had been taken.

The provider had failed to assess risk and ensure people's safety. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not always managed safely, and improvements were needed.
● Arrangements were not in place to ensure the safe storage of medicines. The clinic room was not always locked during the inspection and not all medicines were secured within the clinic room.
● Although a medicines fridge was provided, the recorded temperatures indicated medicines were not always stored in accordance with the manufacturer's directions. There was no evidence that any action had been taken to address this.
● For medicines which have a reduced shelf life after opening, it was not possible to always see when these had been opened and some had been opened longer than the manufacturer's directions.
● For people with health conditions that require regular monitoring, information was not present to support staff to take appropriate action if readings were out of the expected range.
● When people were prescribed medicines in the form of patches, charts were available for staff to record where these patches were applied. However, these were not always completed, meaning it was not possible to tell whether they were being rotated correctly, or that the patches were being removed when a new patch was applied. There was no monitoring recorded to show that patches remained in place and when some new patches were applied the record showed that the old patch could not be found.
● Arrangements were not in place to maintain a continuity of supply of medicines. We saw for one person that they had not received their analgesia for four days.

Medicines were not managed safely. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●The provider had not always ensured staff were recruited safely. Two members of staff who were recently employed had no references from previous employers and no DBS check had been undertaken. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. A third member of staff only had one reference in place.
● A subsequent audit by the provider of staff recruitment identified recruitment shortfalls for 41 staff.
● Records showed that when registered nurses registrations had expired the provider had not confirmed their registration had been renewed. This meant the provider could not be sure that staff employed as registered nurses were still legally entitled to deliver nursing care.

The provider had failed ensure people were supported by staff who had undergone safe recruitment checks. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were sufficient numbers of staff in place to meet people's needs.

Learning lessons when things go wrong
● The provider had not learnt lessons when things when wrong. Incidents had not been reported or recorded in a way that provided oversight. For example, several people were found to have unexplained bruising. This had not been reported or investigated which meant the provider was unable to know when it had occurred, and therefore unable to identify the causes or develop any learning from this.
can you reduce the line space
● Another person had become trapped between their bed rails and the mattress but their risk assessment had not been updated to reduce the re-occurrence of this. We raised this with the provider who arranged for a member of staff to update the person's risk assessment and care plan.

The provider did not assess, monitor and mitigate risks relating to the health and safety of service users. This was a breach of Regulation 17) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were unable to be assured of the safe management and control of infections as only 63% of staff had infection prevention and control training which was in date.
● We were not assured that the provider was preventing visitors from catching and spreading infections as we were not always asked for proof of a negative COVID-19 test on entering the service.
● We were not assured that the provider was meeting shielding and social distancing rules as we saw no evidence of this.
● We were not assured that the provider was admitting people safely to the service as records did not show any testing had been carried out.
● We were not assured that the provider was using PPE effectively and safely as we found discarded PPE in a cupboard.
● We were not assured that the provider was accessing testing for people using the service and staff as no records were available to demonstrate this.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found a used continence product and a pair of gloves discarded in a cupboard. We brought this to the attention of the nominated individual who was overseeing the running of the service.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed as we found widespread concerns about the safe running of the service..
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was following government guidance for visiting in care homes. At the time of our inspection there were not restrictions on visitors.

Inadequate

# Is the service effective?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- People's care needs were not accurately assessed, and care was not delivered in line with national standards, the provider's policies or the regulations. Staff at the service failed to accurately assess the risk of pressure damage and to take action to mitigate this.
- Admission assessments in several people's care files were not dated.
- One person had a wound to their foot. There were no records of any nurse assessment of this wound, no wound care plan and no treatment plan. A second person had serious injuries to their feet. They required dressings to be changed every 72 hours. However, there was no record of these dressings having been done at the required frequency. We saw one record which was unsigned and undated; this was not in line with the Nursing and Midwifery Council (NMC) Code of practice (Code) in respect of record keeping.
- Other people living at the home also had not had skin assessments and had undocumented wounds and skin lesions. In the weekly reports to the provider the registered manager had recorded no pressure ulcers for several months, however, health professionals identified a number of people with pressure-related damage.
- Assessments in people's care plans had sections that were blank. For example, one person who had moved to the home in October 2021 had an admissions assessment in place. The admissions assessment did not include their height, weight or an evaluation of their dependency.

Care and treatment was not provided in a safe way. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not keep accurate, complete and contemporaneous records. This was a breach of regulation 17( of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The copy of training records we received showed that only 52% of staff had received training in moving and handling people. This meant the provider could not be sure people were supported to move safely. We observed an episode of harmful moving and handling practice during our inspection. We informed the nominated individual and asked them to intervene and prevent further potential harm.
- Training records provided did not contain any evidence of staff having received an induction. Staff new to care should undertake the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Staff did not receive the appropriate training to enable them to carry out their role. This was a breach of regulation 18) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not supported to live healthier lives and advice from other agencies was not always followed.
● The district nursing team advised the provider that two people needed to be referred to the specialist tissue viability service. When they returned one week later this referral had not been made.
● One person needed a specific wheelchair with specially adapted footplates. At the time of our inspection they were seated in the wrong wheelchair without the required footplates. Their care records contained no information about their need for a specific wheelchair. Health professionals visiting the service confirmed the person was incorrectly seated.
● Health professionals visiting the service raised a number of concerns about people living at the service. Some people could be assisted to sit out but instead were being looked after in bed. Additionally, the provider did not have the correct type of moving and handling equipment to move people safely.

People did not always receive safe care and treatment. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs
● The service was not fully adapted to meet the needs of people living at the service. There was some signage for example, to navigate people to toilets. However, carpets were of a mixed pattern which was causing one person confusion, as they thought there were trying to pick bits up from the floor. There were corridors with no signage, a lack of objects for people to engage in.
● A lift was available and communal areas could be accessed by wheelchair. There was sufficient room to enable staff to use a hoist. However, on our first visit specially adapted chairs were not in use and were being used to store additional cushions and other items.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Not all staff had completed training in understanding the MCA and DOLs, the provider's training matrix recorded only 41% of staff had completed this training.
● One person's records showed they were admitted to the service in April 2022. However, their DOLs application was dated 30 October 2018. All their capacity assessments and best interests' decisions were

recorded on the same date at the end of June 2022. A second person's DOLs application was dated February 2021 which was over a year prior to their admission. This meant the records showed the provider had applied to deprive the person of their liberty over two years before they were admitted and could not be relied upon to be accurate.

● Other capacity assessments and best interest decisions had all been documented on the same day. For some people this was several weeks after admission to the service. This meant that these decisions had not been made before delivering care and treatment but several weeks later.

● We reviewed people's care files. Staff had not completed any of the consent records within people's files, for example to give consent to photography. Their capacity to consent had not been assessed and, where one was appointed, their legal representative had not been included in this decision. We saw care records which contained photographs which had not been consented to.

● The legal representative for one person had taken the decision that it was not in their best interest to undergo a medical biopsy. Staff at the service did not adhere to this decision and arranged for the person to have the procedure.

Peoples rights were not protected in accordance with the Mental Capacity Act (2005). This was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People had enough to eat. Their preferences were recorded in their care plans along with any allergies. We observed a member of the catering staff discussing choices with people; this member of staff addressed people by name and was aware of their preferences.

● People had eating and drinking assessments in place where required. The handover records accurately reflected the needs identified in people's care plans.

Inadequate

# Is the service caring?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not treated well at the service. As referenced in the safe domain people had been harmed at the service. We observed mixed attitudes amongst the staff on shift in the way people were treated.
- We observed two episodes of staff transferring people by hoist. The first person was handled roughly by staff who did not use correct techniques. They ignored the person they were trying to hoist and pulled and pushed them into position. At no point did they speak to the person. We also witnessed a member of staff hoist a person from a wheelchair to a special supported chair. During this they did not speak with the person, explain what was happening or make any eye contact with them. Neither of these two episodes showed any care, concern or warmth.
- We observed a member of staff helping somebody to eat. They did not speak or engage with the person at all. We then observed a second member of staff supporting the person with a drink. Again, they did not engage with the person but sat chewing gum and periodically holding the drink to the person's mouth. There was no attempt to engage with them.
- We observed one person who needed assistance with personal care being ignored by staff. Two members of staff walked past and took no action. We intervened and asked staff to support the person.
- At times during the inspection people were confused and anxious. One person approached the inspector appearing anxious, the inspector asked a staff member if they would support the person. The staff member responded that they had only recently started working at the service and they did not know how to respond.

Supporting people to express their views and be involved in making decisions about their care

- Some people at the service were living with dementia. This meant that they could not always express their needs verbally. Care records contained minimal information to inform staff about people's preferences.
- We could find no evidence in people's records that they had been consulted about their preferences.

People were not always treated with dignity and respect. This was a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, we also observed other members of staff engaging with people in a warm and caring way. It was evident that some members of staff knew people well and had a warm and caring relationship. They spoke with people about their interests and family members.

Inadequate

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People did not receive personalised care which met their needs and preferences. Care plans were generic and contained minimal personal information. There was little information about what was important to people. For example, one person's care plans had their name on the top but the information within the plan was for another person; it had been copied with just the name changed. Another person's assessed needs care plan stated they, "Need assistance with all activities of daily living." There was no further detail to inform staff what the person's needs were or how they would like them met.
- Staff did not ensure people's individual needs for pressure relief were assessed and managed safely. Some people had pressure-relieving mattresses in place. However, none of the care plans in place for people documented accurately any pressure risk and individual measures in place to relieve this such as individual mattress settings and how to change them.
- People had a section in their care plans for end of life care. However, this was nursing based, it contained no personalised information. There was no record of any discussions with people or their families.

People did not always receive person-centred care which met their needs and preferences. This was a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider's policy stated, "Agreed methods of communication and interventions will be recorded in the person's care plan in a prominent and consistent way so that all care staff know exactly what has been agreed to meet the needs of service users, their relatives and carers." This information was not available in people's care files.
- One person used a message board to communicate in writing. Records showed staff used this to communicate with them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans did not always contain information to guide staff about personal histories and interests. For example, one person's care plan sections 'meaningful activity records' and 'life history'

sections were blank.
● One person's social activity care plan stated, "Staff should continue to explore what activities X likes to do. ", and continued, "X likes to do the following hobbies or leisure activities: topics of conversation." There was no actual information about interests or hobbies.
● People had limited opportunities to engage in activities. There were no activity staff employed by the service. During the inspection we observed people sat in the lounge without any meaningful engagement.

Improving care quality in response to complaints or concerns
● There were no records of complaints made available to us during the inspection. However, the provider's regional quality team became aware of the widespread concerns at the service whilst investigating a complaint.

Inadequate

# Is the service well-led?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;;

● The service was not person-centred and did not achieve good outcomes for people. People at the service experienced neglect and abuse. There were no systems in place to capture people's experiences or to monitor their well-being and happiness.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● We identified widespread and serious failings in relation to the safety, quality and standard of the service. There was no effective system in place to monitor the quality of the service, identify and rectify shortfalls. At this inspection we identified breaches of nine regulations.

● A provider visit in May 2022 found that care plans were not person-centred and were not easily available. An action plan was in place, some actions had been marked as completed, however the actions had not been completed. However, the visit failed to identify the poor nursing care. There were no audits available in respect of daily records, body maps, food and fluid charts.

● Medicines audits were not undertaken consistently and did not identify unsafe medicines practice found at the inspection.

● We have asked the provider for audits in respect of wound care, mattresses (including pressure-relieving), health and safety, infection control, and other systems to monitor the quality of the service. We have not received any of this information.

● The provider did not have an effective system in place to ensure staff were recruited safely. There was no system in place to ensure registered nurses had renewed their registration and were legally entitled to practice. The provider's records showed that some nurse's registrations had expired a year previously but there were no checks to ensure their registrations had been renewed.

● The provider did not have effective governance systems to ensure that staff had essential training and that lessons from incidents were shared for learning and improving care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff meetings were not held regularly. The last staff meeting had been held over a year before our inspection. This meant there was no formal structure to raise issues or suggestions, reflect where things had gone wrong or share good practice.

● There was no system in place to gather feedback and suggestions from people living at the home and

their families and friends.

Working in partnership with others; Continuous learning and improving care
● We were unable to identify partnership working that took place. The sections in people's care plans for professional visits were not completed. This meant the provider could not be sure staff were following the instructions of healthcare professionals.

The provider failed to monitor the quality and safety of the service. The provider did not seek and act on feedback. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● For several months harm to people was not identified or reported. People had experienced skin damage due to poor pressure management and were bruised from poor moving and handling. This was not documented or reported. The registered manager in post consistently reported there were no pressure ulcers. Health professionals identified 17 people had skin damage related to inadequate pressure management. This was not reported to either the provider's quality team or the local safeguarding adults' team.

The provider was not open and honest with people when things went wrong. This was a breach of Regulation 20 Duty of Candour of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive person-centred care.<br><br>regulation 9(1) |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always treated with dignity and respect.<br><br>regulation 10(1) o |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People were not always supported in accordance with the Mental Capacity Act (2005).<br><br>Regulation 11(3) |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to assess risk and ensure people's safety. |

| | |
|---|---|
| Treatment of disease, disorder or injury | Medicines were not managed safely |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had failed to protect people from abuse and neglect. People had been harmed.<br><br>This was a breach of regulation 13(2) |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not assess, monitor and mitigate risks relating to the health and safety of service users.<br><br>Staff did not keep accurate, complete and contemporaneous records.<br><br>Regulation 17(2)(b)(d) |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to assess risk and ensure people's safety.<br><br>Medicines were not managed safely |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures | Regulation 20 HSCA RA Regulations 2014 Duty of candour<br><br>The provider was not open and honest with people when things went wrong. |

| | |
|---|---|
| Treatment of disease, disorder or injury | |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff did not receive the appropriate training to enable them to carry out their role. This was a breach of regulation 18(2)(a) |

**The enforcement action we took:**

We served a notice of decision to remove the location Hillview Nursing Home.