Loxley Health Care Limited

Hilcote Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

We inspected this service on 15 and 16 February 2016. This was an unannounced inspection. Our last inspection took place on 19 and 24 November 2015 where we identified multiple Regulatory breaches. We found the service was not safe, effective, caring, responsive or well-led.

At the last inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. We identified both continued and new Regulatory breaches. CQC is now considering the appropriate regulatory response to the problems we found.

The service is registered to provide accommodation and personal care for up to 44 people. People who use the service have physical health and/or mental health needs, such as dementia. At the time of our inspection 32 people were using the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A peripatetic home manager was managing the service. They had not yet applied to register with us.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not managed safely and people were not always protected from the risk of abuse. This meant people's safety, health and wellbeing was not consistently promoted.

There were not enough suitably skilled staff available to keep people safe and meet people's individual care needs.

Safety incidents were not always analysed effectively, which meant the risk of further incidents was not reduced.

People's health and nutritional needs were not always consistently monitored and managed effectively to promote their health, safety and wellbeing.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure decisions were made in people's best interests when they were unable to do this for themselves.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. Staff did not show they understood people's individual needs and behaviours that were linked to their diagnosis of dementia.

People were not always treated with dignity and compassion and their privacy was not always promoted. Staff did not always show they respected and understood people's rights to make choices about their care.

Effective systems were not in place to ensure people received effective and comfortable end of life care.

People and their representatives were not always involved in the planning of care which meant people could not be assured that their individual care preferences were recorded and consistently met.

Leisure and social activities were promoted, but people did not get the support they needed to engage in meaningful activity when they needed to. People did not always receive the right care at the right time.

Relatives felt able to approach staff to complain about the care, but they were unsure who the manager of the service was. This meant there was a risk that complaints would not be made to the right member of staff.

Systems were in place to ensure people's liberty was only restricted when this had been legally authorised. The provider was now informing us of notifiable incidents in a timely manner.

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed.

Medicines were not always managed safely and there were not always enough staff to keep people safe and meet peoples agreed care needs.

People were not consistently protected from the risk of abuse.

Is the service effective?

Inadequate

The service was not effective. People's risk of malnutrition and dehydration was not effectively managed. Staff did not always have the knowledge and skills needed to meet people's needs effectively.

The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were always made in people's best interests.

People had access to healthcare professionals. However, improvements were needed to ensure that people were referred to specialist professionals in a timely manner, if required.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being followed and people who were being deprived of their liberty were being deprived lawfully.

Is the service caring?

Inadequate

The service was not caring. People were not always treated with dignity and compassion and their privacy was not always promoted. Staff did not always show they respected and understood people's rights to make choices about their care.

Staff did not show they understood people's individual needs and behaviours that were linked to their diagnosis of dementia.

Effective systems were not in place to ensure people received pain free end of life care.

Is the service responsive?

Inadequate

The service was not responsive. People and their representatives were not always involved in the planning and review of people's care. People did not always receive the right care at the right time.

There was a complaints policy in place and complaints were managed appropriately. However, people did not always know who the manager was, to direct complaints and concerns to.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm from occurring.

The provider was now notifying us of safety incidents that occurred at the service.

Hilcote Hall

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 was 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 15 and 16 February 2016 and was unannounced. The inspection team consisted of three inspectors and an inspection manager.

Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

We spoke with eight people who used the service, but due to their communication needs they were unable to provide us with detailed information about their care. We therefore spoke with the relatives of five people to gain feedback about the quality of care. We also spoke with, six members of care staff, two cooks, the deputy manager, the peripatetic home manager, the operations manager and the operations director. We did this to check that good standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at the care records of 20 people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included a medicines audit, staff rotas and training records.

During our inspection we shared safety concerns with the local authority. We did this because we had significant concerns about people's health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found that effective systems were not in place to ensure risks to people's health, safety and wellbeing were consistently assessed, monitored and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

People's risk of falling was not effectively managed to protect them from the risk of injury. There had been a high number of falls at the service since 1 January 2016 where 30 falls had occurred. Six of these falls required the ambulance service to be called out to assess and treat the individuals, and one fall resulted in a serious fracture. Records showed and we saw that when a person fell, a review of their risk of falling or a review of the support they needed to prevent further falls was not triggered. For example, on the first day of our inspection we found a person sitting on the floor shouting, "Help me, I'm stuck". We immediately alerted staff to this situation and staff were unable to ascertain how the person came to be on the floor. Incident records showed this person had fallen on two previous occasions since 1 January 2016. We checked this person's care records on the second day of the inspection to see if there was a record of the incident and to see if any action had been taken in response to the incident. No incident form had been completed recording the possible fall and no review of their risk of falling or review of their care needs had taken place. This meant action had not been taken to assess, monitor and manage this person's risk of falling.

We also found that people did not always receive their care as planned to manage their risk of falling. For example, one person's care plan stated they needed support of one or two care staff when walking to manage their risk of falling. We saw this person walk without staff support on multiple occasions throughout our inspection. On one of these occasions this person was very unsteady as they had forgotten to use their mobility aid. Incident records showed this person had fallen on two occasions since 1 January 2016. We also found that basic falls prevention guidance was also not followed consistently by staff. For example, we observed a member of staff escorting a person from the dining room to the lounge without identifying that the person's shoe was unfastened, increasing their risk of falling.

People's risk of developing damage to their skin was not effectively managed. For example, one person who had damage to their skin had been prescribed a pressure relieving cushion to reduce the risk of further skin damage. We saw this person was not always supported to sit on their prescribed cushion, which meant their risk of further skin damage was not being managed as planned. Another person required staff to assist them to change their position every two hours, to reduce their risk of skin damage. Their care records showed and their relative confirmed they were not supported to change their position as frequently as planned. Positional change charts from 11 to 16 February 2016 showed they were frequently not supported to change their position as planned. On one occasion their care records showed a 13 hour gap in receiving support to change position. Staff told us they would never leave the person this long between position changes, but the records did not reflect this. This meant people could not be assured that their risk of skin damage was being managed effectively.

Although we found some improvements in the way people's medicines were managed, further

improvements were required as people's medicines were not always managed safely. On the first day of our inspection, we observed one person spit out a tablet they had been given by staff. No staff were present to observe this, therefore, we immediately told the staff member responsible for medicines administration about this incident. This person's medicines records showed they had taken all of their prescribed medicines as they had been signed by the staff member without checking they had swallowed their tablets safely. We also checked the person's medicines records on the second of day of our inspection to see if action had been taken to replace the medicine that they spat out. Their records showed and the staff member confirmed that no action had been taken. This meant the person had not received their medicines as prescribed and their medicines records did not contain an accurate account of the medicines they had received.

Some people who used the service were prescribed creams to help manage their risk of skin damage. We could not be assured that people received their creams as prescribed because there were multiple gaps in people's cream recording charts. This meant there was a risk that people's skin condition would deteriorate.

The above evidence demonstrates that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that people were not consistently protected from the risk of alleged abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

At our last inspection, we found that staff were not recognising and reporting incidents of abuse. At this inspection, although we found staff now knew how to identify and report abuse, we found effective action was not taken by the staff or provider to protect people from the risk of abuse. Incident forms since 1 January 2016 showed there had been 18 altercations between a number of people who used the service against other people who used the service or staff. Care records did not show that people's risk of abuse or harm was assessed and planned for in response to these incidents. For example, one person had assaulted or attempted to assault other people who used the service on at least four occasions since 1 January 2016. No plans were in place to show their risk of aggression to other people had been acknowledged or was being managed. None of the four incidents triggered a review of the person's care needs. This meant that people were at risk of further abuse, because actions had not been taken to safeguard people from further harm.

Another person who used the service had been identified as being at high risk of abuse and their care plan stated they required 15 minute observations to help manage this risk. We saw and care records showed that these observations did not occur as frequently as planned. For example, observational charts from 11 to 14 February 2016 showed significant gaps in observation levels. On one occasion their care records showed a 16 hour gap between observations. Incident records showed this person had been the alleged victim of abuse on at least four occasions since 1 January 2016. This showed this person was not receiving the agreed level of care needed to protect them from the risk of abuse. When we fed this back to the management team, they were unaware that these checks were not taking place as planned.

The above evidence shows that people were not protected from the risk of abuse or avoidable harm. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found there were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

We saw staff were not always available to keep people safe or meet people's care needs in a prompt manner. For example, we saw one person who required staff support to mobilise and stand, walk in an unsteady manner when staff were not present. This person's care records showed they were at high risk of falling and had fallen on one occasion since 1 January 2016. Another person stood up from their chair and called for staff support but no staff were present. This person then walked into the dining room displaying signs of distress saying, "It's all coming out, please help me", but again no staff were present. The person then started to undress in the dining room as they had been incontinent of urine. We immediately located staff and requested they support this person to have their personal care needs met. We also saw two sets of visitors intervene to try and keep people safe by telling two people who were at risk of falling to, "Sit down" and, "Wait for staff" when they were attempting to stand when no staff were present. Both of these people's care plans showed they were at high risk of falling and required staff support to move.

Relatives and staff confirmed there were not always enough staff to provide people with the support they needed. One relative said, "There's not always enough staff" and, "People wander into other people's rooms and take things. The staff are not always around to stop it from happening, it's frustrating". One staff member told us they felt there were not enough staff available to protect people from the risk of abuse. They said, "A lot of altercations have been unwitnessed so nothing has been done, if we had some staff who could see what's happening they would be reduced". Another staff member told us how they felt staff did not work together effectively to ensure people's needs were met. They said, "There's not enough staff. It's too much stress, the staff don't work together".

The management team and operations director told us they had assessed people's dependency levels and had ensured there were enough staff on shift to keep people safe and meet people's needs. Comments included, "We've increased the number of day staff" and, "The staffing levels are brilliant". Despite these assurances from the management team, our evidence above shows staff were not always available to keep people safe and meet people's individual care needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection, we found that people's risk of malnutrition and dehydration was not always effectively managed. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had not been made.

We found that advice from dieticians was not always followed to manage people's risk of malnutrition and weight loss. One person's dietician had recommended they needed a fortified diet to help manage their risk of weight loss. We asked two cooks which residents required a fortified diet. Although the cooks knew what a fortified diet was and were fortifying some people's food, this person's name was not on their list of people who needed this specialist diet and as a result of this, they had not been receiving their recommended fortified diet. Another person's care records showed they had a high risk of malnutrition and had lost just under three kilograms since our last inspection. Their medicines records showed they were prescribed a dietary supplement to help manage their risk of further weight loss. However, their medicines records showed that during the 14 days prior to our inspection they only received their prescribed supplement on six of the 14 days. Their medicines record showed that on six of the 14 days the supplement was, 'not required' despite the person's weight loss indicating that it was. This showed staff were not managing people's risk of malnutrition and weight loss in accordance with their plans of care.

We saw people didn't always get the support they needed to eat and drink. For example, we observed one person who tipped their hot drink onto the floor when staff were not present. When staff returned they said, "You drank that fast, would you like another". We intervened and told the staff the person had not drank their drink as they had tipped it onto the floor. The staff member then took the empty cup and did not return with a replacement drink. This meant the person did not have a mid-morning drink.

We also found that people didn't always get the support they needed to eat and drink when they needed it. For example, we observed one person who displayed signs of hunger wait until 1.36pm to receive the support they needed to eat and drink. Whilst they were waiting for assistance, they had to sit and watch other people being supported to eat their main meal and dessert for a period of over an hour. During this time, the deputy manager and a member of care staff were both sitting in the same room as this person writing care plans. This showed some staff prioritised writing care plans over meeting people's basic care needs.

The above evidence shows that people's risk of malnutrition and dehydration was not effectively managed in a consistent manner and people did not get the assistance they needed to eat and drink when they needed it. This was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found staff did not always have the knowledge and skills needed to meet people's needs effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found further improvements were needed.

Staff told us they had received some training since our last inspection which we saw had helped them to use hoists and other moving and positioning equipment correctly and safely. However, there were still significant gaps in the staffs' knowledge and skills. For example, two staff told us they had not received training to enable them to manage people's behaviours that challenged, such as agitation and aggression. We saw some staff did not have the skills to manage people's agitation and aggression. For example, on one occasion we saw that staff did not intervene when one person who used the service confronted another person who used the service in a verbally aggressive manner. The staff member did not attempt to de-escalate the situation which led to one of the two people becoming upset. This showed they did not manage the situation effectively because they did not have the skills to do so. We also found that some staff did not have the knowledge or skills needed to comply with the legislation in place to ensure decisions about people's care were made in their best interests when they were unable to make these decisions for themselves.

The above evidence shows that people were not always supported by staff who had received effective training to carry out their role. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the staff and provider did not always follow the requirements of the Mental Capacity Act 2005 (MCA) to ensure decisions were made in people's best interests when they were unable to do this for themselves. The 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.

We saw and the deputy manager confirmed that they and a senior carer were making and writing best interest decisions on behalf of people who used the service. They told us and the management team confirmed they had been asked to do this task. The deputy manager said, "Today I've been doing assessments for the refusal of medicines or personal care. For example a person with Parkinson's refusing to take medicines; it's in their best interest to help manage their Parkinson's. I've never done best interest assessments before". The MCA Code of Practice states, 'Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision maker'. This showed the provider did not act in accordance with the MCA as they were making decisions about medicines without the involvement of a medical professional or the prescriber. There was also no evidence to show staff had sought advice from health care professionals about people's behaviours that challenged that included refusal to participate in personal care tasks before they made the decision to provide this care in people's best interests.

The above evidence shows that people could not be assured that important decisions about their care were being made in their best interests or were the least restrictive option because the right people had not been involved in the decision making process. This was a new breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that prompt referrals to health and social care professionals were not always made in response to people's changing needs. At this inspection, we found further improvements were needed. For example, one person who had attempted to assault or had assaulted other people on at least four occasions since 1 January 2016 had not been referred to a doctor or a community mental health nurse for an assessment of their behaviours that challenged in response to these incidents. This same

person had also fallen on two occasions since 1January 2016, but no advice had been sought from a doctor or other health care professional in relation to their falls. This showed that timely advice had not been sought in relation to this person's complex and changing needs, which meant the person remained at high risk of displaying continued behaviour that challenged and high risk of falling again.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection, we found the provider was following the required procedures under the DoLS. When people had restrictions placed on them in order to keep them safe, the restrictions were lawful.

Inadequate

Is the service caring?

Our findings

At our last inspection, we found that people were not always treated with dignity and respect. At this inspection, we found the required improvements had not been made. A relative drew our attention to a person who was sitting in an area of the home half naked. The relative said, "That should never happen". We saw multiple examples where people's dignity was not promoted or maintained. For example, we saw staff supported two people to move in communal areas using a handling belt. When they assisted these people to stand with this belt, the belt lifted their upper body clothing up, exposing their backs. We also observed two people who used the service taking their clothing off in communal areas. On one of these occasions, we had to intervene and locate staff so the person's dignity could be promoted.

We saw a relative approach a member of staff who was assisting a person to eat their lunch time meal, to alert them that another person who used the service was asking for the toilet. The staff member left the person they were assisting to locate another staff member to support the person who required support to access the toilet. Two minutes later another staff member supported the person who wanted the toilet to sit in the lounge area where some people were eating their lunch. They sat this person down and walked away, despite them smelling strongly of urine and having wet trousers from being incontinent of urine. This meant the staff member had neglected this person's personal care needs, leaving them in an undignified position. They had also not considered the impact of the strong smell on other people who were eating their lunch in the same area. We immediately approached the deputy manager and requested they supported this person to have their personal care needs met.

We saw a staff member accidently knock a cup of water onto one person who used the service. The person said, "You've drowned me, now I'm soaking wet". The staff member replied, "Don't worry; I'll get someone to change your skirt" and left the person. The person continued to tell staff they were uncomfortable in their wet skirt by saying, "My skirt is wet, right to my knickers. I don't know what to do". A second staff member who they said this to ignored the person. The person then said, "It's wet right through to my bottom" to a third member of staff who replied, "Oh dear" and walked away. A fourth staff member then asked the person if they were okay. The person replied, "It's all wet, my skirt". The fourth staff member responded by saying, "Oh okay" then walked away. The person then said, "I can't sit on it, it's too wet, I'm wet through". A fifth member of staff then came and supported the person to leave the dining room to change their clothing. On leaving the person said, "I'm sorry duck, I'm upset, my legs are wet. I'm sorry I'll be quick". This showed four out of the five staff members did not respond with compassion to the person's distress or discomfort. The person also felt they needed to apologise to the staff even though the incident was caused by a staff member initially.

We heard staff telling people to, "Sit down" on multiple occasions. This showed a lack of respect and understanding of people's individual needs and behaviours that were linked to their medical conditions, such as a diagnosis of dementia.

People were not always supported to receive care and support in private areas of the home when privacy was required. For example, a visiting optician was not directed to a private area of the home. Therefore we

saw them completing at least two people's visual tests in communal areas of the home in front of other people who used and visited the service.

We saw that people were not consistently supported to make choices about their care. For example, we saw staff ask one person if they wanted cornflakes or rice krispies for breakfast. This person looked blankly at the staff member and was unable to make the choice. The staff member asked them again and then said, "Shall we get you some cornflakes then?" they then placed a bowl of cornflakes in front of the person. No additional support was given to the person to enable them to make this decision for themselves. For example, no visual examples were used to help the person to understand the two choices. This showed a lack of understanding and respect for people's rights to be supported to make decisions about their care and support.

The above evidence shows that people's right to be treated with dignity, privacy and respect was not consistently promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that effective systems were not in place to ensure people received pain free and effective end of life care. One person's care records showed there was a significant delay in them receiving a specialist assessment of their end of life care needs. Unfortunately the person passed away before the specialist interventions were put in place. The management team told us this was because the referral was not made promptly. This meant the person did not receive the specialist end of life care interventions that are readily available to people at the end of their life.

We did see some positive interactions between staff and people who used the service. However, the poor care we observed outweighed people's positive experiences. Relatives told us they were satisfied with the care their relations received. Comments included, "The staff work hard" and, "I can't fault the workers. They are always polite, cheerful and chatty".

Inadequate

Is the service responsive?

Our findings

At our last inspection, we found improvements were needed to ensure people received care that was responsive to their individual needs. At this inspection, we found the required improvements had not been made.

Relatives told us and we saw that people and their representatives were not always involved in the planning or review of care. One relative said, "I've not been involved in any care planning". Relatives told us and we saw that people and their representatives were not always involved in the planning or review of care. The operations manager told us that all relatives had been written to inviting them to be involved in care reviews, but only one relative had responded to this request. We saw no evidence to suggest these letters were followed up with relatives when they came to visit people, to ensure they understood the importance of involvement in people's care. We saw the operations manager, deputy manager and a member of care staff writing care plans for people who used the service without involving the people or their representatives. This meant these people and their representatives were not being consulted about how they wanted to receive their care and people could not be assured that their individual preferences and needs were being planned for.

Because of the lack of involvement of people and their relatives in the care planning process, care records did not always contain the level of detail required to inform staff about how people wished to receive their care and support. For example, care plans did not always detail how people liked to receive their personal care, such as what clothes and accessories they liked to wear and what toiletries they liked to use. Some staff who had been working at the service for longer periods of time could tell us about people's individual likes, dislikes and preferences, but other staff who were new or temporary could not. This meant some staff did not have the information they needed to meet people's individual care preferences.

We saw that staff did not always follow the information contained in people's care plans. For example, one person's care plan stated they had difficulty expressing their needs, so when they were heard saying they were, 'in pain', 'lonely' or needed 'help', staff should ask them what they would like. We saw this person approach two different members of staff on two occasions saying, "I'm lonely" and "Help, I'm lonely". Neither staff member responded to this person on either occasion. Neither of the staff we spoke with knew how to manage this person's specific behaviours. One staff member said, "Aww, they're always saying that", but offered no reassurance to the person. Staff told us they did not always read people's care plans. One staff member said, "I don't have time to read care plans". Another staff member said, "I looked at a couple of care plans before I started, but not any others. I'm waiting for them to be updated and will look at them then". This meant staff were not always aware of the content of the plans in place that provided them with guidance about how to support people.

We saw that staff were not always responsive to people's individual needs and people did not always get the right care at the right time. For example, one person told us they were in pain, so we immediately told staff. We then saw the person approach two members of staff to inform them they were in pain. Despite telling staff on three occasions they were in pain, the person waited one hour before they received pain relief.

There was a planned programme for leisure and social based activity provision at the service. We saw an activity worker engaged with some people on a one to one or group basis and an external entertainer also visited the service suing our inspection. However, people were not always supported to engage in activities that met their preferences when their behaviours indicated the need for engagement in meaningful activities. For example one person who was observed to be restless and walking around the home seeking staff support on a regular basis was not supported to engage in any activities. This person's care plan recorded they enjoyed activities based around pampering, but no staff worked with this person using these activities when they showed signs of restlessness. Staff told us they didn't have enough time to support people with activities. One staff member said, "We've not got the time to spend with people". Another staff member said, "There's not enough staff". This showed people did not always get the support they needed when they needed it.

The above evidence shows that people did not always get care that met their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were unable to tell us how they would complain about their care. Relatives told us they felt able to complain to staff, but the majority of relatives were unsure who the peripatetic home manager was. One relative said, "I'd tell the manager, but I don't know their name". Another relative said, "I'd just go to reception and ask who's in charge". This meant they were unsure who to approach if they wanted to raise formal concerns about care. Complaints records showed that a formal complaint was being investigated by the peripatetic home manager and provider in accordance with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

Relatives told us they were unsure who was managing the service. One relative said, "We are not sure whose in command since the new people took over". Another relative said, "People are coming and going, but I'm not sure who is who". Only one of the six relatives we spoke with were aware of the outcome of our previous inspection. This relative told us they had requested a meeting with the provider in response to our last inspection. They said, "I think communication could be better. We asked for a meeting with the provider as we didn't know what was going on". Records showed that a meeting had taken place where our previous inspection outcome was discussed with relatives, but this was poorly attended and relatives who could not attend had not had this information shared with them. This showed the provider had not been open and transparent with people and their relatives about the findings of the last inspection.

Since our last inspection management records showed the provider had visited the service on one occasion to complete a quality monitoring audit. This visit took place in December 2015 and the provider devised an action plan to address the concerns they had identified. We found the actions on the provider's action plan were not always being completed as planned. For example, the action plan recorded that, 'methods to ensure that service users receive the correct diet must be improved by 24 January 2016'. However, we found that one person was not receiving their specialist diet as advised by their dietician. Other actions on the plan had lengthy compliance dates that did not support the immediate improvements that were required to protect people's health, safety and welfare. For example, the action plan recorded, 'evidence that quality audits are carried out and any actions implemented by 24 March 2016'. Setting a three month time period to achieve this meant immediate improvements were not always being made.

We found that the management team working at the service on a regular basis were not aware of all the areas of concern/Regulatory breaches from our last inspection. During our inspection, we fed back our on-going concerns to the peripatetic home manager and operations manager about people's risk of malnutrition and dehydration. The operations manager told us they were, "Surprised" by this feedback as they were not aware of any issues with nutrition at the service. This was despite our previous inspection report and enforcement action recording these concerns as a Regulatory breach and the provider's quality monitoring visit identifying this as a concern. This meant the peripatetic home manager and operations manager had not addressed concerns relating to the risk of malnutrition and dehydration because they were unaware of these issues.

Quality checks completed by the management team were not always effective in improving the safety and quality of care. For example a care plan audit had shown a person's care plan had not been updated in response to them falling. The care plan was updated in response to the audit. However, when the person fell on another occasion following this update, the plan was not reviewed again in response to their fall. This

showed the audit had been ineffective in driving sustained improvements to ensure people's care plans contained accurate and up to date information about their needs. Medicines audits had also not identified recording gaps for the administration of creams which raised concerns that people were not receiving their creams as prescribed.

Safety incidents at the service were not being effectively analysed to identify patterns and themes. For example, the management teams analysis of incidents was recorded as, 'Analysis of the incident records shows that there is a high incidence of falls and altercations. Some of the accident forms logged also show that residents have slipped from their chairs or have been found on the floor, and staff have been unsure if they have fallen or have put themselves on the floor'. No action had been taken to identify themes and patterns to help manage people's safety risks. For example, when we looked at the incident forms that recorded people's falls, we found that most falls occurred between the hours of 2pm and 8pm. Analysing information in this detail would enable the provider to manage people's risks more effectively.

Staff were not effectively managed at the service to ensure people's health, safety and wellbeing were consistently met. Communal areas were frequently left unsupervised when there were people present who displayed signs of agitation and restlessness. This left people at risk of harm from altercations and falls. During a lunch time observation we witnessed a senior staff member ask the deputy manager if they should help assist people to eat. The deputy manager replied, "You can do, but you don't want to make a rod for your own back". The senior staff member later returned and said, "There are still four people to do (assist to eat lunch)". The deputy manager replied, "You can help if you want". This showed a lack of leadership and staff were not deployed effectively to meet people's individual needs and keep people safe from harm.

Staff told us they were being supported by the management team through meetings with the peripatetic home manager. However half of the care staff we spoke with felt they could be supported more effectively. Comments included, "It's staffing more than anything. If more staff were on, it would run more smoothly. The residents are challenging and hard to support. We try our best but it's so hard as there is so much to do", "I could be supported more but the manager is there if you need them" and "Communication is always a problem". This meant staff were not always supported effectively.

The above evidence shows effective systems were still not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found the provider had not notified us of safety incidents as required by law. This was a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009. At this inspection, we found that the required improvements had been made and we were now being notified of safety incidents at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always get care that met their individual needs and preferences.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's right to be treated with dignity, privacy and respect was not consistently promoted.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People could not be assured that important decisions about their care were being made in their best interests or were the least restrictive option because the right people had not been involved in the decision making process.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse or avoidable harm.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's risk of malnutrition and dehydration was not effectively managed in a consistent manner and people did not get the assistance they needed to eat and drink when they needed it.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were still not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always available to keep people safe and meet people's individual care needs.

The enforcement action we took:

We removed Hilcote Hall from the provider's registration