Akari Care Limited

Hillfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The unannounced inspection took place on 2 and 3 October 2017. We last inspected Hillfield in November 2015. At that inspection we found the service was meeting all the regulations that we inspected and rated it good overall. However some improvements were required on the availability of activities to people who lived at the service and also to ensure that all care reviews were completed regularly.

Hillfield provides residential and nursing care for up to 50 people, some of whom are living with dementia. The service is based within a residential area in the west end of Newcastle. At the time of our inspection there were 22 people living at the service.

The service had a manager in post who was in the process of registering with the Care Quality Commission (CQC). The previous registered manager had left the organisation and deregistered in August 2017. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although people and their relatives felt that the service provided safe care, we found a number of issues which needed to be addressed.

We found people's thickeners where stored in unlocked cabinets within one of the dining room areas. Thickeners are usually powders added to foods and liquids to support people with swallowing difficulties. There is a risk associated with these if digested by people. The management of medicines required improvement, with security of medicines, times of administration, recording and disposal some of the issues we found during our inspection. People were able to access the third floor to the service which was currently out of use. This area was hazardous as it was being used for storage in parts and was not lit well.

Although parts of the service were clean and tidy and people deemed the service as clean, we found issues with infection control. Clinical waste was not secure outside of the building, equipment and rooms were not always satisfactorily cleaned and there were odours in places. We received negative comments on the laundry system and the manager and registered manager said they would look into this.

Quality monitoring systems were in place at the service but they had not been completed for a number of months in most cases and the manager did not have a full oversight of how the service was being delivered on a day to day basis. We found a very large cactus plant in the lounge area of the service which the manager had not seen since they started working at the service in July 2017. Feedback about communication between staff within the service was mixed, and was an area which needed to be improved upon. Staff commented that they were not communicated with very well, particularly in connection with handover.

Staff did not always receive the support they required to help them provide effective care to people. Staff had not always received timely supervision or annual appraisal. Recruitment was not robust, with no checks on the nurse registration requirements taking place. However, the provider had made positive efforts to recruit more permanent staff.

Record keeping was in need of review, with some care plans, risk assessments and other monitoring records, either out of date or not in place at all. A new deputy manager was in the process of reviewing this information. We also found records were not secure in parts of the service.

People on the whole felt that food and refreshments at the service was satisfactory as recent improvements had been made. Although we made one recommendation with regards to the dining experience at the service.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes.

People were supported to have choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. People and their relatives felt that the staff at the service kept them up to date with information and enabled them to be involved with planning and review of their care needs.

People and their relatives were extremely positive about the activities available and the improvements made in this area. People had been able to participate in a range of planned events, including being taken out of the service for trips.

People and their relatives felt permanent staff were kind and caring but they were less positive about short cover staff (usually agency). We found some staff practices were not respectful and did not always support people's dignity. For example, standing over people while supporting them to eat.

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

Following our inspection, the provider sent us an action plan of how they were going to address these concerns.

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 using the service were not always assessed and acted on.

People's medicines were not managed safely. The service had not followed infection control procedures and kept the service clean and tidy in all areas.

Recruitment procedures were in place to minimise the risk of unsuitable staff being employed, although checks on nurses registration had not been completed.

Staff knew how to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not supported through regular supervisions and appraisals.

People were supported to maintain a healthy diet. Although meal time practice needed to be improved.

People's rights under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were protected.

Staff supported people to access external healthcare professionals to maintain and promote their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always treat people with dignity and respect or promote their independence.

People and relatives felt that the permanent staff were kind and caring and we saw examples of this during the inspection.

People were supported to access advocacy services where appropriate.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care planning and delivery was personalised, however we found that staff had not always acted or responded in a timely manner and recording was in need of review.

The service had a complaints policy and people and their relatives said they would use it, although records were not always fully maintained.

People were supported to take part in activities they enjoyed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and their relatives had mixed views about the management of the service, as did staff.

We found the service did not demonstrate good management and leadership.

Quality monitoring systems in place had not identified the concerns we had found during the inspection.

Hillfield

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 October 2017 and was unannounced on the first day which meant the provider did not know that we were going to inspect. The inspection was carried out by one inspector, one bank inspector, one specialist advisor and one expert by experience. A specialist advisor is a person who specialises in a particular area of health and social care, for example medicines, moving and handling or quality assurance. This specialist advisor was a tissue viability nurse specialist. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider about deaths, safeguarding incidents, deprivation of liberty applications and serious injuries. We also contacted the local authority commissioners and safeguarding teams for the service, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection.

On the first day of our inspection we spoke with two visiting GP's and a community nurse who was visiting the service.

We placed a poster in the reception area of the service to alert visitors to our inspection and invited them to contact us to offer their experiences of the service.

During this inspection we carried out observations using 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.

We spoke with ten people who used the service and seven family members and friends. We also spoke with

the regional manager, manager, deputy manager, two nurses, one senior member of care staff, the cook, activity coordinator, maintenance person and six members of care staff. We observed how staff interacted with people and looked at a range of records which included the care records for nine people who used the service, medicines records for 21 people, five staff personnel files, health and safety information and other documents related to the management of the home.

Inadequate

Is the service safe?

Our findings

During the inspection we found shortfalls in the safe management of medicines. The medicine trolleys held within the two locked medicines rooms were not always secured to the wall as per the provider's policy and good practice guidance. We also found one medicines room was unlocked at times.

Staff left medicines trolleys unlocked as they administered medicines to people in their bedrooms or other communal areas. We also observed a variety of medicines and thickeners being left unobserved and not secure on the top of medicines trolleys. In 2015 NHS England issued an alert which was distributed to care homes. It was made to make them aware that a person had died in a care home following ingestion of a thickening powder. Thickeners are usually powders added to foods and liquids to bring them to the right consistency for people with swallowing difficulties. We also found thickeners in unlocked cabinets within dining areas of the service. In some cases the same person's thickeners were being used for a variety of different people.

Staff were not aware of the information available to them for the administration of 'as required' medicines to people. 'As required' medicines are medicines used by people when the need arises, for example, tablets for pain relief. The manager had prepared information sheets for each person's 'as required' medicines, however, both the nurse and senior care staff on duty were unaware of this information. This meant that staff did not have all the necessary information to ensure that people received their medicines when they should and in what circumstances. This information is particularly important for those people who lack capacity or live with dementia as it supports staff to recognise when their 'as required' medicines may need to be administered.

Topical medicines records were not always completed when administration occurred. Topical medicines refer to applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. We saw four people whose records of topical medicines had not been completed, with one not having been completed for 12 days. We were therefore unable to ascertain if their topical medicines had been applied.

One person had time specific medicines prescribed to help treat a particular health condition. We looked at their medicine records and found they had not yet had them administered. We noted the staff member was about to start a medicines 'round' on another floor of the service which would have meant a further delay. We asked the staff member about the person's medicines and they confirmed they had not had them yet and immediately took the medicines to them. Another person who was prescribed a similar time specific medicine had also not received their medicines at the time they should have. When we asked staff about this, we were told they were asleep. We, however, had seen them awake in their bed.

Disposed medicines were kept in a box in the medicines room. However, the arrangements for disposed medicines did not meet NICE guidance, which states the medicines disposal box should be tamper proof and held within a locked cabinet. The National Institute for Health and Care Excellence (NICE) is an organisation which provides national best practice guidance and advice to improve health and social care. We also found that one person who had passed away still had their medicines held which should have been

disposed of after the specified seven days.

The upper level of the building was not in use for accommodating people. Staff used it for training on some days. We noted that some of the rooms were in disarray, with items of furniture and equipment stored in them and were not habitable. As the area was mostly unused, it was not well lit and dark in places. The lift to the upper floor was accessible by everyone. During the first day of inspection we were in the lift with one person who pressed the wrong number and took us to the upper level. I explained we were on the wrong floor and continued to the correct level. This, however, posed a risk of harm to people who may have accidently found themselves on the upper level and who may have become disorientated. The manager told us their estates department had been contacted, although it had not been addressed yet.

People deemed the premises as clean. One person said, "They [domestics] go round and round polishing the floors. It's clean." We did not always find this to be the case during the inspection. We saw that the frame of one person's wheelchair was heavily soiled with dirt we assessed to be food debris. In one toilet was a standing aid. The equipment was rusty from prolonged contact with urine and made the rest of the room smell strongly of urine. We saw that two people had toilet seat risers. The riser's and the toilet were dirty and soiled with dried urine and faeces. We found a commode chair that was soiled with dried urine and had been stored away unclean. Bathrooms were not always clean, and in one person's bedroom there was a pair of false teeth in a pot which was very dirty.

Outside of the property were large separate waste disposal bins which were used to store, for example, used continence pads in sealed bags. We found, however, the bins did not have secure lids and meant waste was on display. We brought this to the attention of the manager and they said they would address this immediately.

Many rooms, including those on the top floor were used as storage. However, we found these rooms accessible to people as they had not always been locked. We found rooms with a variety of equipment, household waste, bin bags, hoovers and catheter bags. The cleaning cupboard was also not always kept locked during the inspection. This room contained hazardous material including chlorine releasing tablets and bulk liquid cleaning products, which posed a risk to people, for example if digested.

There was a hand wash basin in the sluice room which was being used for storage and appeared not to be in use. It is important that staff should be routinely using this facility to decontaminate their hands after using the sluice. A sluice room is where used disposables such as incontinence pads and bed pans are dealt with, and reusable products are cleaned and disinfected.

On occasions we observed staff not wearing protective personal equipment, for example aprons. We saw this occur when one staff member entered the kitchen area and also when one staff member was observed completing a personal care task for one person who lived at the home. This was poor practice and could have led to cross contamination or other infection control issues arising.

We checked every mattress in the service. Of the people using pressure relieving mattresses, eight out of the 13 mattresses that were in use were set incorrectly. Some types of these mattresses need to be set according to a person's weight. The mattress pressures that were incorrect were either set at too high or too low a pressure which put people at risk of skin damage. People's daily recording charts included a section which showed that their mattresses needed to be checked. We found these records had not always been completed and in some cases not at all. Bed rail checks should have been completed daily for one particular person. We found these had not always been completed.

These are breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment.

Following our inspection, the provider sent us an action plan of how they were going to address these concerns.

Recruitment procedures were in place. We checked the records of six staff, including those recently employed. References had been applied for and received. Application forms had been completed with full details of employment history. When staff had been offered positions, the provider had carried out pre-employment checks to ensure they were suitable to work with vulnerable adults. These checks included vetting checks by the Disclosure and Barring Service (DBS). We found that the provider had not checked any of the PIN numbers of nursing staff, including those from an agency. All nurses who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN. This meant the provider could not be assured all nursing staff were entitled to practise as a nurse.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing.

The majority of people, relatives and staff we spoke with all thought there were not enough staff on duty. Comments included, "There is not enough staff, there is a lady on this floor, I think she needs 1:1 care but that means everyone else has to wait"; "The weekends are worse, they bring in agency staff and they don't know you. We have complained about this"; "I believe they have good staff, but they have a lot of agency staff and high turnover" and "You have to wait a while for staff." Although one person commented, "The best thing about living here is they are all helpful. They are good people, they are very kind. Ask them to do something, and it's done. I've been here about two years and I can't find anything wrong with the place. When I press my buzzer, the staff come straight away."

A number of care staff told us that the provider had used agency staff over the past few months due to staff shortages. We were able to confirm through records that, on occasion, agency staff had not arrived for a shift which had meant the service was short staffed. We saw from records the provider had recently recruited a number of new staff to replace vacant posts. The manager told us, "This is a positive as we won't have to use agency as much then."

The administration of medicines, particularly during the morning period, took an excessive amount of time with some days the 'round' not completed until after 11am. One staff member told us, "The medicines are sometimes still being given out at dinner time." We saw over the lunch time period that people were not supported as they should have been during meals. For example, two people who required support with their meal were left unattended after their food had been served to them.

We noted that a dependency tool had been completed. A dependency tool is a document which provides a formula for calculating how many care staff are required to provide adequate support to people. We saw that the calculations were in line with the number of staff on the rota. We discussed the issues in connection with staffing with the manager and the regional manager and they said they would review staffing in the light of our discussions.

One member of care staff told us if a member of staff was on their break on the ground floor (for example) it meant the other staff member was left on their own. They said, "[Name of person] needs one to one support. We can't leave her on her own as she is very unsteady." We looked at the care records of this person. A care plan was in place which had been recently reviewed and confirmed that at times the person required

additional support but was not at the levels indicated by care staff, nor were they funded for one to one support. We brought this particular issue to the attention of the manager, who confirmed that staff were mistaken in their understanding and felt that staff were undermining the person's independence and ability.

People told us they felt safe and comments included, "Yes it's safe here"; "The staff treat me properly"; "I feel I'm treated well here" and "I feel safe living here, the staff want to do the best for you." Relatives felt that their family member was safe. Comments included, "She [person] is safe yes"; Her [person] belongings are safe here too" and "I have no reason to doubt they are not (safe)."

The care staff we spoke with were able to describe signs and symptoms of abuse, and the action they would take to ensure people remained safe. One member of staff told us, "I would report straight to the manager. I would listen to the resident and not form an opinion, but let them know I needed to report it." Another said, "I have had safeguarding training and I would say straight away." Staff had received suitable safeguarding training.

Some of the windows did not have handles on them as they had fallen off. One person's bathroom had a toilet and sink with a sign stating, 'do not use'. We asked a member of care staff about this. They said the toilet and sink had been out of use for about four weeks but that it was "down for repairs" and "There are a few that don't work." The maintenance person told us that this was in hand as the estates department had been and completed a review of the outstanding work to be completed in the service. The regional manager confirmed this to be the case and said work was due to be completed very soon.

Staff carried out regular safety checks of window restrictors, wheelchairs, beds and electrical equipment. Required test and maintenance certificates were in place, including for gas and electrical safety, lifts and fire fighting equipment. Accidents had been recorded and monitored for any trends occurring.

Requires Improvement

Is the service effective?

Our findings

Staff did not always feel supported. The staff we spoke with told us they had not received regular supervision or yearly appraisals. Comments included, "I had one supervision with the previous manager"; "I have had supervision, but I cannot remember when" and "My last supervision was about a year ago."

We reviewed staff records and found staff had not received appropriate support to ensure they could meet the needs of people in a safe and effective way. Two staff records we checked had not had supervision or annual appraisal for over a year and others we reviewed were limited in the amount of support staff had received, including since the new manager came into post.

Induction was not robust. The staff we spoke with told us they had received an induction when they started to work at the service. However, we were told this had not always been before they were expected to undertake certain care tasks. For example, one member of staff told us they had been working in the service for only a few weeks and said they were using moving and handling equipment with people without having completed their moving and handling training. They said they had just been 'shown' what to do. Another member of staff said, "On the first day I was straight on the floor. I did shadow someone, I did two weeks of that but didn't get any training until about a month after I started. I was going in blind. We have people here who have diverse needs. We are going through the training now though." We spoke with a bank nurse who regularly worked at the service. They said they had not received an induction and had not been invited to participate in any training provided by the provider.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing.

We asked staff to describe the training and development activities they had completed. One staff member said, "The training is much better now than it was." Another member of staff confirmed some shortfalls with training but then said, "We are going through the training now though." When we looked at training records we confirmed that although there were some gaps, that the provider had a comprehensive training plan in place to ensure that all staff received suitable training, including bank staff.

We saw training was taking place on the day of the inspection. Staff told us this included health and safety, nutrition, mental health and food safety training. One staff member said, "Since the new provider took over there has been training every week. There is a twelve week course on mental health. I've put my name down for it." Other training staff said they had completed included, dementia care awareness, National Vocational Qualifications (NVQ) in care at levels two and three and management and team leadership. NVQ has been replaced with diploma level certificates in health and social care. Staff said they found the training provided helped them with their roles and responsibilities.

We observed a daily handover between nursing staff. Nursing staff from night shift went over each person and discussed any overnight changes and any pertinent issues which nurse day staff needed to be made aware of. For example, the night shift nurse reminded day shift that one person had a visit from a GP later in

the day. After the nurse handover, the nurse on day duty communicated the handover to all of the care staff on duty. We discussed the handover with the manager as staff were communicating, what appeared to be the same information twice. We spoke with care staff about the quality of handover. One staff member said, "Handovers are poor. I had been off a week. One lady was back from hospital and her needs had changed. She needs a pureed diet now but I was not told this. The information is only handed over once so if you've been off you don't know." Another member of staff said, "Sometimes it's hard as you only get told what's happened that day, not what's happened over the week so I read the handover sheets." It was confirmed that the manager did not attend handover's. When asked about this the manager said, "I don't attend them but the staff tell me what is going on." However, we did not always find evidence of this.

One GP told us, "There is occasions when telephones are not answered which is annoying. There has been an odd inappropriate referral, but never a case I can remember where the staff have not been in touch when they should have." We noted in the comments book held in reception there had been two entries from visiting podiatrists which had complimented the staff for being helpful.

Records we reviewed showed that people had access to a range of healthcare professionals this included dentists, chiropodists, consultant geriatricians and GP's and one member of staff confirmed that community nurses visited the service regularly. We saw a number of people had been referred to the specialist 'falls' team and also to speech and language therapists to support them with concerns in connection with choking. This information confirmed that the provider ensured that people had access to additional healthcare when it was required.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. 11 people currently had an authorised DoLS application in place and the service had a record of when these were due to expire. Staff were complying with their legal responsibilities. Best interests decisions had been made when this was required with input from family, healthcare professionals and others, including staff who knew the person involved well.
We noted that copies of lasting power of attorney (LPA) were not routinely kept. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related.We discussed this with the manager and they said they would arrange for copies to be obtained.

During lunchtime observations on the first day of inspection we found no menus on display, however, this had been rectified on the second day. We asked care staff if they knew what was for lunch. One staff member said, "The trolley gets sent up and we have to decipher what it is." For lunch we saw people were offered a choice of mince or cheese pie with a selection of vegetables. One person asked if they could have egg and chips as an alternative to the main menu and this was catered for.

A member of staff told us that the menus had recently been updated after staff had discussed with people

the types of food they preferred to see on the menu. The cook and activity coordinator confirmed this and showed us additions to the menu. People we spoke with told us menus had improved lately after discussions had taken place. One person told us they had been 'taster' sessions with the activity coordinator to try some of the new foods.

People's comments included, "I get a cup of tea brought to me all the time"; "If I need help to eat and drink, I just ring"; "The food is alright, I guess"; "I'm diabetic and the staff are aware"; "I get enough to eat and drink and usually there is a good choice" and "The food is good. Yes I am happy, thank you."

People received fortified foods when this was required, including milk shakes for example. However, we noted that the service had no butter in stock and staff confirmed they used a substitute brand and that they normally had no butter available. When we asked a number of people about this, they all said they preferred butter but there was never any available. We raised this issue with the manager who said they would address this.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people and their relatives about the caring nature of staff. Comments included, "Staff will sit and talk if they have the time"; "No-one takes time to converse with [person], [person] has Alzheimer's but still needs social contact"; "We have had a number of different and new people [care staff] – some are good and some just don't give a hoot"; "They have one person who is a listening/talking expert who comes and talks to us"; "The staff are nice and caring"; "The staff all know me, they listen and I find them caring"; "Staff treat me the way I prefer and they listen to me"; "The staff that I know, I like, but there is a few comings and goings" and "Some of the new staff and stand-in's (agency staff) don't know everyone as well and have not had a chance to prove they are caring, so hard to comment. The staff who have been here some time seem caring enough."

People and their relatives felt that care staff treated them with respect and were able to offer examples of how they had shown this. Comments included, "Staff knock and ask before they enter"; "The staff respect my choices"; "Staff ask before they act"; "From what I've seen the staff treat my wife with respect"; "I feel she is treated with respect" and "They knock before entering when I am here."

We spent time observing staff care practices in the dining areas. We saw that people were not always treated with respect. For example, we saw that one person required staff assistance with their meal. One member of staff stood over this person when providing assistance; there was very little interaction or discussion and no explanation as to the support being provided. Half way through the meal the staff member asked a second staff member to 'take over' helping this person. This meant there was no continuity of care being provided for the individual being supported. The second member of staff continued to stand over this person. We heard staff refer to people who needed assistance in their bedrooms as 'bedroom feeds'. Such labelling and task orientated care practices do not suggest that staff have a positive regard or an understanding of older people or people living with dementia. We spoke with the manager about this issue and they said they would look into the matter.

There were nine people sitting in the dining room on the first floor of the service. This made the area cramped. This was not conducive to creating a relaxed comfortable atmosphere, although we did note that people were not rushed with their food.

We recommend the provider reviews their dining experience for people in line with good practice and ensuring that dignity is maintained.

We also observed people having meals in their bedroom. One particular person needed full support from staff as they were not fully sighted. We observed assistance was given in an extremely effective and person centred way, with the staff member explaining what each individual mouthful was. The person responded well and appeared to appreciate the care given.

We observed other positive examples of staff explaining to people what they were going to do. For example, while giving medicines or when about to complete a personal care task with them. Staff bent down as they

talked to people, so they were at eye level as maintaining eye contact helps enhance effective communication. We asked staff why they bent down to communicate with people and one staff member said, "I would not like someone standing up talking down to me if I was sitting or in a wheelchair. Some people are also hard of hearing and it means they can hear us better. It's just a better way all round to speak to people like that."

The provider had taken into account the diverse needs of people and we saw that one couple had been provided with living accommodation to support this. One staff member told us, "It's really good that they [couple] have been given a lounge area and a separate bedroom. They [provider] have tried to make it like home for them…it's nice to see."

People had the perception of feeling included in their care planning as did relatives, including invitations to care review meetings. One relative told us, "I'm always invited to the meetings but I can't attend." Another relative told us, "Yes the care plan has been discussed."

At the time of the inspection families gave any additional support to their loved ones, which meant that we were not made aware of any person requiring the use of an advocacy services. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. The provider had literature on display to support people and their families should additional support from this type of service be required.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in 2015 this key question was rated as required improvement. Activities for people needed to be developed and care plan reviews were not always completed as they should have been.

Part of the inspection team consisted of a specialist whose core role was the provision of expert advice in the prevention and the treatment of wounds.

One person's Waterlow Score, (an assessment of the person's risk of developing pressure damage or "bed sores") indicated they were was at very high risk. Despite this there was no positional change frequency specified on their care plan, although information held within the person's room indicated that they were 'turned' every two hours. We found other examples where a person required positional changes, but this was not documented in their care records.

One person's wound dressing record had not been updated every three days, indicating a change of dressing had occurred, as advised by a specialist tissue viability nurse. This had not been highlighted as an issue or cause for concern by staff, yet we were not able to fully establish if the dressing had, in fact, been changed as it should have been. We also found wound assessments had not been always been completed in order to assess the wound and confirm if an improvement was noted.

People's daily record charts were completed by a range of care staff and were meant to be signed off by the nurse in charge. We found they had not always been signed by the nurse in charge. This meant that staff in charge may not have been aware of any issues arising during the day with regard to the interventions the person had received, for example refusing food or fluids. One person's fluid charts showed that they had not achieved the recommended daily target for a few days, however, as the nurse in charge had not signed, we could not be sure if they were aware and could not see if any action had been taken from other recordings. However, nursing staff confirmed before the inspection was completed that a GP had visited the person and the situation was being monitored. One member of nursing staff said, "We should have recorded all of that. Sorry."

Records held were not always up to date. People's dietary needs were not always up to date in the kitchen, although we saw no evidence of people receiving incorrect nutritional support. We also found that care plans were not always as detailed as they should have been, for example those in relation to maintaining a safe environment, dependency rating, falls risk or medicines care planning.

These are breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance.

Following our inspection, the provider sent us an action plan of how they were going to address these concerns.

People told us that the provider was responsive to requests. Comments included, "My wife was moved to a

different room as we requested"; "I have always found the staff to do what they have been asked. I have never had any cause to complain at all about that" and "Staff are busy, but if you ask for something they will always try their best to get what you need, always have for me anyway." One GP told us, "Staff are all very nice and very helpful when it comes to our visits."

A pre-admission assessment was carried out before people started using the service. This considered the support needs people might have and whether the service was able to meet them.

Where a support need was identified during the assessment process a care plan was drawn up describing how staff should best support the person. This included details of how the person wished to be supported where they were able to express this, or guidance made in people's best interests. Care plans were in place for areas including medicines, personal care, mobility, moving and handling and nutrition. We saw that care plans were detailed and personalised. For example, one person had a care plan in place covering their behaviours that can challenge the service. This contained guidance to staff on triggers that could cause the person to become anxious and steps they could take to reassure and calm them.

We asked care staff what they would do if they noticed a change to a person's health or presentation. Comments included, "I would report a wound to the nurse" and "I would tell the nurse and seek their advice if I was concerned about someone not eating or drinking." A member of care staff told us, "The staff know the residents well, and the nursing staff can rely on the carer."

Hospital passports had been compiled. These included details of the person's needs and their likes and dislikes. The aim of the hospital passport is to provide hospital staff with important information about the service user and their health needs when they are admitted to hospital.

People felt included and not socially isolated. The provider now employed a staff member, who people and relatives called a 'bubbly and very active' activity coordinator. Relatives told us there had been a big improvement in the activities available to people who lived at the service. Comments included, "I have access to all areas as long as the staff know"; "Activities girl is taking me out to shop for Christmas"; "I never feel lonely here, staff try to involve everyone, especially the ones on their own"; "That girl (activities coordinator) is really great. She has been a god send here" and "We have seen such a difference since [activities coordinator] came to work here, she's so bubbly and is just the sort of person you need in that job."

The service employed an activity coordinator to support people with their social needs. They were passionate about providing the best possible social support to people living at the service. We spoke with the activity coordinator who said, "Today we are playing bingo in the lounge, later today it's our book club. We tend to keep the book club sessions shorter as some of the residents drop off to sleep during the book readings, so keeping the sessions shorter means residents keep their attention on the book" and "I take people out as much as possible, weather permitting. Sometimes for a walk and sometimes further afield. We hire transport and take as many as possible. I like to rotate people so as many as possible get a turn." We looked at social activities planned and saw a variety of stimulating events for people to participate in.

People told us they knew how to complain. Seven complaints had been received since the last inspection, five being since July 2017. Although complainants had been responded to, there was no formal log completed of the outcome of if the complainant was satisfied and what action had been taken. One person told us, "I know how to complain and I make sure I get feedback." Another person said, "If I needed to complain I know how too." One visitor we spoke with was confident in how to complain and said, "I would go to any of the staff or the manager, although I don't know them (manager), I feel sure they would deal with

any concern as any of the staff would."

Care staff understood how important it was to listen to and act upon peoples complaints. They told us if they received a complaint, "I would take it to the manager"; "I would try and resolve it myself or if I couldn't resolve it I would pass it onto the manager" and "I would take the details, make sure I logged it properly and take it to the nurse." One relative raised a concern with us regarding laundry procedures and that often clothing was returned in a poor condition or had to be discarded. They said it had been previously raised but nothing seemed to have been done about it. We discussed this with the manager and the regional manager and they told us they would look into the issues raised, including discussing with relatives at the next meeting held for them.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who was in the process of registering with the Commission. They had worked as a nurse with for the provider for two years and had been promoted to manager of Hillfield, taking up the role in July 2017. Before this report had been finalised, the manager notified the Commission of their intention to withdraw their application to register and also of their intention to resign from the company.

There was little oversight of the service by the manager. Audits were very limited and there was little evidence of any taking place in recent months. For example, the medicines and kitchen audits were last completed in May 2017 and the last health and safety audit presented was dated 2015. Checks that had been completed were not always signed off by the manager, including for example, fire drill and evacuation procedures. There had been a full and very detailed audit which the provider had undertaken just before the new manager had taken up their post, but little since. We asked if the manager conducted any audits on wound care or documentation and were told, "The deputy is starting audits now, the deputy has recently started and has gone through all of the care plans and many need reviewed." The audits which had been completed had not identified the issues we had found during our inspection.

We found a "mattress weekly check file" which was used to document that mattresses were set to the correct level. The checks had not been completed since 15 March 2017. We advised the manager many of the mattresses were set incorrectly. She told us, "I don't know what else we can do; we have it written in the care plans and on the beds." The manager was unaware staff were not signing the daily check sheets to check the mattress settings and we saw no record that showed this was part of the manager's regular checking processes.

People had daily record charts which staff used to document care interventions, including food and fluid intake, repositioning and mattress checks. These were stored in the 'nurses' office. These charts were not accessible all of the time and appeared to be updated in bulk, rather than in response to an event in the person's care. In one nurse office, the charts from previous months were not easy to locate and were piled on the floor and in various cabinets within the room. We asked the manager why daily charts were kept in the 'nursing office' and she told us, "They are easier to check when they are in one place." Despite this it was found that the daily charts were not always completed fully.

Record storage and security at the service needed to be improved. We found an unlocked cupboard at the bottom of a staircase which was full of archived records, including the care records of previous 'residents'. We also noted that one of the rooms used by staff to store current care records had a broken key pad which meant it was not secure. During the inspection we also noted people's care records were left unattended in communal areas as staff who were in the process of updating were called away to deal with other issues. We spoke with the manager and the regional manager about this and they said they would address these issues.

Actual recording posed an issue as not all staff wrote in a clear manner and we read a number of care record entries which were illegible. Senior staff were aware of this as we saw directives instructing staff to write

clearly, but this still was not being followed.

These are breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance.

We had mixed views from the people we spoke with and their relatives about the new manager and the service as a whole. Comments included, "We don't know the manager"; "We think the service is good"; "The manager always speaks"; "We don't see much of the new manager, the last one would come and see you and check everything was okay…but I suppose they are still getting their feet under the table"; The atmosphere is a happy one" and "I cannot say I have really spoken with them to be honest."

A number of staff felt that the manager spent too much time in their office. One staff member said, "[Manager's name] hardly comes out to talk to the resident's…it's a shame." One member of nursing staff felt they did not know the manager and said, "No, I don't (know the manager well) she doesn't speak to me much, she does her job, and I do mine – she is new to me". We asked the manager about this and they told us they did complete regular 'walkarounds' although confirmed they did not record this. However, during the inspection we did not see the manager completing any walkarounds over the two days of inspection and found no evidence to suggest they had previously completed these regularly.

We asked the manager about a large (over a metre high) cactus which had been donated to the service many years ago. It was situated on a window sill in the ground floor lounge as we deemed this to be a risk to people, particularly those living with dementia and those at risk of falls. The manager did not know there was a cactus but after discussion went immediately to remove the plant to a safe position in their office. This showed that the manager was unfamiliar with the service environment even though they had been in post since July 2017.

Prior to the inspection we looked at the provider's website and noted some information was out of date. For example it mentioned a mini bus was available at the service which was not correct as the service hired any transport from other services.

The provider had sent in notifications of incidents or serious accidents and had displayed previous ratings on their website and within the service which are legally required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's were not protected from receiving poor care and treatment and were not always kept safe. Safe practices in medicines management was not always followed. Risks had not always been assessed and infection control procedures needed to be improved. Regulation 12 (1) (2) (a)(b)(c)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have fully robust quality assurance processes in place as they had not identified the concerns we found during our inspection. Regulation 17 (1) (2) (a)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received suitable support, including supervision and annual appraisal. Nursing staff PINs had not been monitored or checked. Regulation 18 (1) (2) (a)(c)