Avonpark Village (Care Homes) Limited

Hillcrest House Care Home

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

Summary of findings

Overall summary

We carried out this inspection in response to concerns raised relating to the quality of care and support people were receiving. These concerns related to all three locations, Hillcrest Care home, Alexander Heights Care Home and Fountain Place Nursing Home which are all located in Avonpark Village. Due to this we inspected all three locations and found there were some similar themes relating to the service provision. Therefore some of the findings in the reports will be repeated.

The inspection took place on the 18, 19 and 23 May 2016 and was unannounced. It was carried out by two inspectors for each location with support from an inspection manager. On the third day two inspectors and CQC pharmacist inspector attended covering the whole site.

Hillcrest House can provide accommodation and personal care up to 34 people living with dementia. At the time of our visit there were 20 people accommodated

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider. 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. The registered manager was not present during our inspection. We found the service was not well led.

Permanent staff were aware of the procedure for safeguarding adults from abuse. They knew the signs of abuse and the expectations placed on them to report allegations of abuse. However, some staff were not confident to report abuse they may witness from other staff. Some staff were not able to convey without significant prompting a good understanding of the procedures for safeguarding adults from abuse.

Risk assessments were in place for moving and handling and for people at risk of weight loss and for choking. Members of staff knew the actions needed for them to minimise risk. Where people had sustained injuries such as bruising the reporting of these events was inconsistent. For example, staff had not followed the procedure of documenting the injury on a body map and taking photographs. Action plans were not developed on how to monitor the injury and an investigation was not conducted which meant the potential of abuse was not considered.

The relatives we spoke with said care was not consistent because there was a heavy reliance of agency staff. Staff told us they were often short staffed and on all the days of the inspection agency staff were used.

We saw during mealtimes that people were asked to select their preferred meal from the available choices. Permanent staff enabled people to make day to day decisions. However, some agency and relief staff showed a lack of knowledge about the people's ability to make daily living decisions. This was due to staff not having sufficient information when they came on duty to meet people's needs.

Mental Capacity Act 2005 (MCA) assessments were in place but were not always completed correctly about the decision makers. Staff had approached the Office of Guardianship about lasting power of attorney for some people and although they were informed none was in place, MCA forms were completed indicating one was in place. Staff had approached relatives without legal powers to make decisions on behalf of their family member for their consent to take photographs, medical care and for vaccines. MCA assessments for specific decision were completed for some people who resisted personal care. The best interest decision reached was not developed into a detailed care plan which gave staff guidance on how to deliver personal care using the least restrictive option when people did not accept personal care.

New staff said they had an induction when they started at the home but their description of the programme covered was inconsistent. For example one member of staff said their induction covered four shadow shifts and watching training videos before starting work unsupervised. Another member of staff said their induction had covered two shadow shifts. Staff said training was provided but they said the quality of the training was not always suitable for new less experienced staff. Staff did not all have regular one to one meetings with their line manager.

Permanent staff we observed had good interaction with people. We observed people approaching permanent staff for attention and we saw staff respond to reduce the person's level of anxiety. However, agency staff didn't always know people's preferred first name and tasks were not always explained before they delivered care and treatment.

Care plans were not person centred and contradicted assessments of needs. They lacked detail on how staff were to meet people's needs and lacked people's preferences on how staff were to deliver their care. There was no central source of information for staff to update their knowledge of people's needs as two systems were in use that included written notes and electronic hand held devices.

Relatives said the activities provided to their family member were good. The activities coordinator said there were one to one activities in the morning and group activities in the afternoon. Staff said when there was permanent staff on duty there was more time in the afternoon to participate in group activities. . They told us activities were limited at the weekends.

People had access to healthcare professionals for their ongoing health needs. However, care plans were not developed where needs assessments had identified oral, eye and chiropody needs. Relatives told us they were kept informed about important events as they occurred.

We found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

"The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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 is not safe.

Permanent staff were able to tell us the safeguarding of vulnerable from abuse procedures including the types of abuse but not all staff felt confident to report their suspicions of abuse.

Staff were not deployed to meet people's needs. Staff said the service was often short staffed. Relatives said there was a lack of continuity of care because of the reliance of agency staff.

Risks were assessed and action plans developed to minimise risk. Agency staff were not provided with sufficient detail to assess and mitigate risk when they delivered personal care. Incidents and accidents were not effectively monitored.

People did not benefit from safe systems of medicine management.

Is the service effective?

Inadequate

The service was not effective.

People were assisted by staff to make day to day decisions. People's capacity to make specific decisions was not always assessed. Members of staff showed a lack of understanding of the principles of the Mental Capacity Act (MCA) 2005.

Members of staff attended training the provider had set as essential but they said the quality of the training was not always suitable for new staff. One to one meetings with the line manager to discuss performance, issues of concern and training was not regular for all staff.

People had access to health care professionals for their ongoing healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People received care and treatment from permanent staff that

knew their needs and respected their human rights.

Members of staff were respectful and consulted people before they offered support but some agency staff did not interact with people and were seen undertaking tasks without first explaining what was happening to the person

Is the service responsive?

Requires Improvement

The service was not responsive

People's needs were assessed but care plans were not developed to meet people's assessed needs. Care plans were not person centred as they did not give staff direction on how people liked their care needs to be met

There was an activities programme in place and there were opportunities for one to one and group activities. Activities were limited at weekends.

Is the service well-led?

Inadequate

The service was not well-led.

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

Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted.

Not all staff felt they were supported by management to raise concerns or question practice. They did not feel that concerns raised had been acted on and responded to appropriately

Hillcrest House Care Home

Detailed findings

Background to this inspection

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

We carried out this inspection in response to concerns raised relating to the quality of care and support people were receiving. The inspection took place on the 18, 19 and 23 May 2016 and was unannounced. This inspection was carried out by two inspectors with support from an inspection manager who reviewed the information relating to the well-led domain.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We used a number of different methods to help us understand the experiences of people who use the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with three people who use the service and two relatives about their views on the quality of the care and support being provided. During the three days of our inspection we observed the interactions between people using the service and staff

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included five care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

During our inspection we spoke with the regional manager, the deputy manager, three registered nurses, three care staff, which included agency workers, and the activity co-ordinator. We spoke with housekeeping staff and staff from the catering department.

Inadequate

Is the service safe?

Our findings

The numbers of staff employed were not adequate to cover all shifts and agency staff were used to cover any shortfalls. The relatives we spoke with said agency staff were used to maintain staffing levels. One relative said there was a lack of "continuity and a lot of agency staff". Another relative said on the day of their visit there was no regular staff. Staff said the staffing levels were not appropriate to meet people's needs. A member of staff said "there shouldn't be two agency staff on duty. The people here are vulnerable and unpredictable. It shouldn't happen." Staffing rotas were not organised to support people's level of dependency and there was reliance on agency staff. The staffing rota showed during the day there were at least two staff and a senior on duty from 8am to 8pm.

Staff told us the staffing levels were not adequate to meet people's needs. A member of staff said "some people need two staff with personal care". They said morning routines were very busy as staff were "giving people their breakfast as well as getting people up. The activities coordinator is tied up in the kitchen serving breakfast to people in the dining room and not supporting people with activities." Another member of staff said "there is a lot of agency staff. It's double the work because they don't know people. Relatives are concerned about the lack of regular staff."

The people living in Hillcrest were not able to tell us about their experiences of the home. We used the Short Observational Framework for Inspection (SOFI)." We saw agency staff who were not able to address people by name and on one occasion incorrectly addressed one person they were directing away from an incident. This meant the person was not aware the request was directed at them because of the nature of their dementia.

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

The potential risks were assessed to people's care and treatment. For example, risk assessments were developed for people with a history of falls, for developing malnutrition and for people with mobility needs. Risk assessments described the risk and the actions needed to minimise the risk. For example, moving and handling risk assessments detailed the staff and equipment needed for each move or technique. Permanent staff said risk assessments were developed by the seniors and reviewed monthly. They said there was an expectation they report to seniors any changes to people health and wellbeing which may impact on their risk assessment.

Permanent staff were aware of the potential risks to people and where risks were identified, the actions needed to minimise the risks to people's health and wellbeing. A member of staff said equipment such as hoists and sensor mats were provided for people at risk of falls and with mobility needs. They said people at risk of malnutrition were weighed weekly and fortified supplements and snacks between meals were provided.

We spoke with staff about the people we had observed with bruising to their hands and arms. One member

of staff said some people at times were physically challenging towards others and sustained bruising. Permanent staff said the procedure was to take a photograph of the bruising and complete a body map [template used to document injuries to specific areas of the body]. When injuries had been sustained there were no body maps available in either the accident or incident file or people's care plans to indicate details of these injuries. Daily reports of people with bruising were inconsistent about the location of the bruising, documentation was missing for some people we observed with bruising and body maps were not completed. For example, for one person staff had noted bruising on the right hand at 15:29 and night staff had noted bruising to the left and right hand at 21:31. Body maps were not completed for bruising on both hands and missing from the body map was an action plan which included an investigation to establish the cause of the bruising. This meant staff were not assessing injuries and had not considered bruising a concern of potential abuse.

Accidents and Incidents were not recorded or monitored effectively. Where accidents and incidents had occurred, there was no full description of the accident or incidents and only the initials or first name of the people they concerned entered which made it difficult to identify who they were.

Information recorded in accidents and incidents logs was not always consistent with information in people's care plans. The care plan for one person stated they had broken skin on their hand from a spoon. The action for this in the person's care plan was to observe this person during lunch to prevent the same incident occurring however, on the back of the accident log for the same incident it stated that the person had been hit by another person with a spoon and this is how they had sustained the injury.

An entry in another person's 'falls diary' stated they had been found lying on the floor. In a column that stated 'any injury' this had been ticked but no details of this injury were included. The entry for 'preventative measures' was: "need to observe (X) offer why in room" which did not make sense or clearly state how preventative action should be implemented. It stated in the falls diary that accident forms should be completed in all cases when someone had fallen. This had not been completed.

When we reviewed the accident log, we saw there had been an entry on the same date for this person and it stated they had a red mark to their back but there were no further details available about this. When we asked staff where we might find this information, they said they were unable to tell us as they didn't know where it was kept. When we reviewed the care plan regarding mobility for the same person, we saw an entry stating an alarm mat should be placed in their room so staff were aware when this person got out of bed in the night to help ensure their safety. When we asked staff whether an alarm mat was in place, they said there was no requirement for this in their care plan and therefore, a mat was not in use.

There were a number of entries in the diary which were kept on the unit to enter GP and other healthcare visit requests. Of these, there were two entries which indicated an accident or incident had occurred but these had not been recorded in the accident/incident file. One of these entries stated large bruises had been seen on a person's legs and the GP was to be contacted and the second entry stated a person had fallen in their room. When we asked the deputy manager where the accident and incidents forms were kept, we were told that they were sent to a central office and copies should be filed in people's care plans. Of the care plans we reviewed, no accident or incident forms had been filed.

On the second day of the inspection we observed an incident which placed one person at harm from poor risk management. People needs were not evaluated by staff who knew their current needs. We saw two members of staff not permanently employed at the home assisting one person to walk. One member of staff said they had received instruction from a permanent staff that the person was able to walk with two staff but we observed this person was not able to support their weight and was lowered to the floor. These staff were

told by the senior on duty use a hoist specifically adapted for another person when this individual needed assistance to transfer to a wheelchair from the floor where they had been lowered. The hoist as stated by the risk assessment for assisting the person from the floor was not available and had to be found from within the Avonpark site. It later transpired from a GP visit that the person needed emergency medical attention.

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

We observed a medicines round on days one and three of the inspection. On day one of our inspection, although the member of staff administering the medicines wore a tabard indicating that she should not be disturbed during the round, due to the low number of staff on the unit she was called away on more than one occasion to assist other staff. This meant there was an increased risk of errors being made during the administration of medicines.

One the same day, we observed that one person needed assistance from staff to sit up to enable them to take their medicine, the staff member administering the medicines was not able to help this person to sit up on her own and pressed the call bell for help. The call bell was cancelled after about 30 seconds however, no one came to assist. This meant the staff member had no one to assist her to administer medicines to this person and this delayed the completion of the medicines round. The staff member told us they had concerns about staffing and often had to leave the medicines round to help staff.

We were told two people were receiving medicines covertly. When we asked the staff member about assessments of capacity and best interests decision reached to covertly administer medicines they did not know this information. The staff member was unable to tell us what should be considered when giving medicines covertly, such as whether crushing tablets or adding them to food would alter the effect of a drug. One of the medicines was given with food where the label had instructed it to be dissolved on the tongue or swallowed whole with water and therefore, this was not given as prescribed.

On day one of the inspection, we saw another person had been prescribed a thickening agent for their drinks due to having problems with their swallowing. When we asked staff the directions for this thickening agent, we were not given a consistent answer to this. However, on day three of our inspection, we saw that for people prescribed a thickening agent there were clear instructions on the amount to use and the consistency of fluids each person needed to provide them with the support that had been identified by an external specialist. We observed that these directions were available to members of staff preparing drinks and that they followed these.

The storage of medicines was not always safe for some topical medicines. On the first day of our inspection we saw eye drops were stored at room temperature which was contrary to the storage instructions according to the labelling. When we raised this with the staff member at the time of the inspection they took immediate action to correct this and when we observed a medicines round being carried out by an agency care worker on day three of our inspection, we found that medicines were kept securely and within the appropriate temperature range.

There was a daily record for the storage temperature of medicines kept at room temperature and in the clinical room fridge and staff were able to tell us what they would do in the event that temperatures went outside the required storage ranges.

Although we did see the provider had arrangements in place to monitor the competency in administration or management of medicines staff were not always competent in this. When we asked the staff member

administering the medicines on day one about their training they told us they had received very little. When we asked whether they had received specific training for example, in the storage and administration of eye drops, they said "No, am I supposed to have training in this?" During the observation of the same staff member doing a medicines round they had not consistently checked the medicines labels for expiry prior to administration, therefore medicines were not administered safely. The staff member told us their training had included two and a half hours face to face training from an external provider followed by completing two medicines rounds under supervision. Since these supervisions had been completed they had not received any further supervision.

On day one, we asked the same staff member to show us records on disposal of medicines. They told us they had asked for help and support in particular for training in ordering, receipt and disposal of medicines but had not received training despite this and was therefore unable to clearly show us and demonstrate their knowledge of this information. When we asked how they would manage this, they confirmed they would ask for advice from staff working on Fountain Place. They were unable to locate information on the disposal of medicines until day two when they located a book which had been signed by a pharmacist but had not been signed by staff to confirm disposal and whether this had been witnessed. This book was also in poor condition and some pages were ineligible and stuck together. We were told this book was not kept in the unit, but in a cupboard on the upper floor which was not currently in use. The staff member was unsure whether this was the right book and whether other documentation was available with regards to the disposal of medicines. However, on day three of the inspection, when an agency care worker was on duty it was noted that there was an audit trail in place of medicines received into the home, administered and returns of unwanted medicines including those that were refused or where prescriptions had been changed.

We observed that within the MAR chart folder copies of the relevant medicines policy had been printed out but the date for review of these was for March 2015. When we raised this with the Regional Manager who was present on the inspection he told us that the policies had been reviewed but not printed out and undertook to get revised copies printed out.

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

During observation of the medicines round on both days one and three, Medicines Administration Records (MAR) were all completed correctly and any errors or omissions had been documented as appropriate. There were clear instructions to staff members on how to make decisions around the provision of pain relieving medicines for those people who lacked verbal communication or who had cognitive impairment. This meant people would get their pain relief in a consistent manner.

The people we observed sought the attention of the staff and their behaviour showed they welcomed their attention and were not fearful of the staff. The relatives we spoke with said they had no concerns about the safety of their relatives.

Permanent staff said they reported suspicions of abuse to their line manager. These members of staff were able to tell us about the safeguarding of adults procedures including the types of abuse and the actions they must take for suspected abuse. They were able to describe incidents of poor practice which they reported under whistleblowing procedures to the registered manager and confirmed action was taken to protect people from abuse. However, one member of staff said they would not report alleged abuse witnessed to a senior member of the team. They said they would not feel supported or encouraged to report concerns. One agency worker was not able tell us their responsibilities towards safeguarding people from abuse. This

agency worker was not able to convey a clear understanding of safeguarding vulnerable adult's procedures. During the inspection we identified at least three incidents where staff had raised concerns with regard to the conduct of other staff. We could find no evidence of the action taken by the management team in response to this whistleblowing.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw safe recruitment and selection processes were in place. We looked at the files for four of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Inadequate

Is the service effective?

Our findings

The concerns raised with us included issues about how new staff were inducted when they commenced employment. We asked to see the records relating to staff induction. The documentation related to all three locations and showed that not all staff had received a full induction when they commenced employment and some records for some new staff were missing. The documents that we were given did not contain any evidence that new staff completed or had enrolled on the Care Certificate. We asked the managers, who were available on the day of the inspection, about the missing documents but these could not be found and the managers could not confirm if the induction for all staff had been completed.

The Nominated individual told us that there was not a policy relating to the induction of new staff. They told us that new staff induction was managed at a local level and although it was expected that new staff would complete a two week induction this would be dependent on the staff member's previous experience and skills. The senior management could not confirm what proportion of the induction would be face to face learning, computer based learning or shadow shifts. The Nominated Individual told us that in response to the concerns raised a formal induction policy was being developed.

New staff us that they received an induction when they started work at the home. A member of staff recently employed said their induction covered training videos and shadow shifts where they observed more experienced staff. They said their induction was adequate for their role but they had previous experience of working with people living with dementia. Another member of staff said they had completed two "shadow shifts."

The concerns raised with us contained issues with regard to staff training. We asked to see the records relating to staff training. The records we looked at contained information for staff at all three locations. We looked at the records with one of the senior managers. The records were disorganised and did not contain information relating to all staff training. The senior manager agreed with our findings. We asked to see a training matrix to confirm what staff had completed training to ensure that they had the skills and competencies to fulfil their roles. The training matrix was not available and the senior manager could not confirm if one was in place. The deputy manager who was available on the second day of our inspection visit could also not confirm if a training matrix was in place.

Permanent staff said they had received training in relation to their role, but they were not always able to explain the learning from training received. Staff said there was "a lot of training" and one member of staff said the quality was not always suitable for people with no experience of working in a caring environment. They said it was "a waste of time, we came out not having any knowledge. It was not suitable for staff with no experience."

People did not always have their needs met by staff who received sufficient information in order to carry out their roles and responsibilities. Agency staff had been provided with minimal information in relation to people's needs. On the first day of our inspection we spoke to an agency worker about the information provided about people's needs. This agency worker said they were provided with a hand held electronic

device to record tasks and assigned specific people to provide personal care to. However, they were not aware of other people who may need their support. For example, we saw one person requiring support from staff in the dining room and as this agency worker was present we drew it to their attention. This agency worker told us they didn't know the person's name or the nature of their needs.

Permanent staff said since hand held electronic devices were introduced handovers were not taking place. They said staff they had to scroll through the recorded information to update themselves of the tasks that had taken place before they came on duty. A member of staff said "It would be nice to be updated. There is no discussion before staff start it's all online." Another permanent staff member said "there are no paper sheets with handover information. It's all online."

On the second day there was a verbal handover for staff. We observed the morning handover on the second day of our inspection. One permanent senior health care assistant was on duty with three agency staff. The information verbally handed to the agency staff was limited and included comments such as "This is a dementia unit; expect the unexpected" and "They're all ok to be washed and dressed". The information in relation to one person was "X needs hoisting and is on a pureed diet with thick and easy in drinks". No information in relation to the type of hoist required or where the agency staff could locate the appropriate sling was provided. The number of scoops of thickener was also not provided. A relief member of staff on the second day of the inspection said when they arrived they were given a brief handover as the hand held electronic devises were not working .On the third day of our visit the regional manager had introduced handover sheets for agency staff which gave them essential information about the people living in Hillcrest.

There was a lack of opportunity through staff supervision to review individual personal development and progress. We requested a copy of the supervision timetable for 2015 and 2016 for all staff. One was not provided to us. We looked the documentation relating to staff supervision. Across all three locations 45 to 50 staff were employed. Of these only nine staff had received supervision in 2016. Only four staff had received an end of year appraisal.

Permanent staff said one to one meetings were taking place to discuss training needs, concerns and performance was from their line manager. One member of staff said since their employment five months previously they had not had any one to one meetings with their line manager. Another member of staff said their one to one meeting happened three months previously. They said their preference was to have one to one meetings with the registered manager and not with the senior care assistant as they didn't have full confidence that their concerns would be passed on to the registered manager.

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

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met. We found people's consent to care and treatment was not consistently sought in line with the MCA 2005. Where people had the capacity to consent to their care and treatment, the consent was not recorded.

Mental capacity assessments were completed for people who lacked capacity to consent to their care and treatment.. There was a lack of understanding from staff about the decision makers and the arrangements that must be in place to make best interest decisions on behalf of people without capacity. For example, relatives without power of attorney to make best interest decision were asked to give their consent. This meant best interest decisions were not made for people who lacked capacity and staff were not following the principles of the MCA act. For example, the Office of Public Guardianship responded to queries from staff by confirming an active lasting power of attorney was not in place for one person. Staff had indicated a lasting power of attorney for finances was in place and had accepted this person as the decision maker for care and welfare.

Some people's care records had copies of Enduring power of attorney, which only gave power for decision making around finances and property. However we found staff had been consulting with relatives with an Enduring power of attorney for finance, making decisions around health and welfare, such as end of life care plans, flu vaccinations and do not attempt resuscitation (DNAR).

Mental capacity assessments around decisions for consent to care plans such as personal care and day to day decisions were completed by staff, without consultation with the legal representative. Some mental capacity assessments were incomplete with no date and no signature. Best interest decisions where people lacked capacity to make a certain decision, was not clearly recorded.

The registered manager had made applications for DoLS authorisations as required. Applications had been submitted to the Local Authority Supervisory body and they were awaiting a response. We found where people were still waiting for an assessment to authorise their deprivation of liberty, that the least restrictive options in their care plan had not been considered. We found the following statement in people's care records "Less restrictive treatment and measures cannot be provided due to declining dementia."

This was in breach of Regulation 11 of the Health and Social Care Act (2008) Regulations 2014.

We saw permanent staff enable people to make daily living decisions such as choice of meals and participating in activities. During mealtimes we heard staff ask people to make decisions about the choice of meals. The staff asked people "what would you like for breakfast and would you like tea or coffee?" Permanent staff were aware of how to enable people to make daily living decisions for example, what people wore. A member of staff said people were shown the choices available to assist them with decision making. Another member of staff said "we explain the tasks before we start any form of personal care."

Communication care plans in place lacked details and did not give staff up to date guidance on the person's preferred method of communication. For example, care plans stated the staff found verbal communication with one person difficult but the person gave eye contact and smiled to show they were "happy". Staff were instructed to observe for body language. The body language and how staff were to respond was not included in the communication care plan. When the care plan was reviewed on 19 April 2016 it was recorded "unable to communicate will shout at other people" but the care plan was not updated.

Permanent staff said there were people who at times were resistive towards personal care. A member of staff said "when people agree to personal care staff explains the task. When people resist personal care they are given time and at times people agree when staff return. Sometimes we are persistent with our requests;

we can't leave some people in wet beds. There are other people who will become physically challenging towards staff attempting to deliver personal care. We know the signs and keep our distance. There is a behaviour plan in place." During our observations of people we saw people become physically challenging towards staff. We saw staff speak calmly to the person and asked them to stop the behaviour.

"Mental Capacity Act (MCA) for day to day decision forms for personal care" were completed by staff to make best interest decisions for people who resisted personal care. Staff documented the reasons for the assessment for example; the person may shout at staff and become physically challenging towards staff. "Mental Health/Cognition" care plans in place described the behaviours exhibited which staff found difficult to manage. However, there were inconsistencies between the MCA day to day decision forms and the care plans. For example, MCA assessment for personal care was developed for one person who was resistive to personal care but the behaviour care plan dated 7 April 2016 stated "no concern with challenging behaviour." Detailed action plans were not developed on how staff were to deliver personal care when people were physically challenging. Where staff were directed to complete reports of behaviours observed and to complete incident reports where aggressive behaviours were exhibited, records of behaviour charts were not maintained. This meant staff were not able to assess the causes for staff to respond appropriately to triggers.

People were supported to eat their meals. For example, where required, people were assisted by staff and had access to adapted cutlery and crockery. One person's comments about the food were "The food is very nice." At mealtimes staff asked people to select their meal preferences from the choices available and offered alternatives where the choice of meals were declined. Staff offered refreshments and snacks between meals. People chose to eat in the dining room or in their bedrooms. This depended on people's preferences.

Permanent staff said people at Hillcrest enjoyed the meals served. They said meals were at regular times and snacks were served between meals. A member of staff was able to describe people's preferences for example, one person preferred small meals and liked desserts.

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering staff; they had information of all people's dietary requirements and allergies. This also included people's likes and dislikes which staff would let them know each day. They explained that people had a choice of meals. Meal choices were made the day before and this information was given to the catering staff. They said if people did not like what was on the menu or had changed their mind about their choices then they were able to request alternatives. The kitchen was clean and tidy and had appropriate colour coded resources to ensure that food was prepared in line with food handling guidance. The kitchen had been award a Food and Hygiene rating 5 by the food standards agency. The food standards agency is responsible for protecting public health in relation to food in England, Wales and Northern Ireland.

Relatives said the staff kept them informed about important events. Where some people had lost weight, advice had been sought from outside healthcare professionals and their weight had been monitored. We saw during our inspection someone said they felt unwell and their GP had been asked to see them in response to this. However, this was not always consistent and some people had not services from chiropody and dental care. The staff we spoke with were unable to tell us whether a chiropodist or dentist visit had been requested to help with this. A member of staff said oral hygiene was difficult because some people were reluctant for staff to provide this for them.

Requires Improvement

Is the service caring?

Our findings

We saw positive, caring interactions from permanent staff. They engaged with people in a kind and friendly manner. For example, we saw staff try to help a person who had told them they were feeling unwell. They offered reassurance and tried to ascertain why they felt unwell. They did this by asking whether they were in any pain, what they could get them to try to help them feel better and asked how they could make them feel more comfortable. People we saw spoke positively about the staff. They said "The staff are lovely", "They are all friendly" and "I am happy here".

We saw staff support people at meal times and encourage people to eat their meals. We heard staff say "you need to eat" and "do you want to try your soup". We saw some staff not interacting with people when they were assisting them.

On the third day of our visit we noted a calm atmosphere as two permanent staff were on duty and these staff knew the people living in Hillcrest. We saw staff respond to people's behaviour promptly and reduce their anxiety. For example, staff knew the signs and responded appropriately when one person needed assistance with personal care. We also saw staff ensure there was equipment and points of interest for people who walked around the home.

The environment was adapted for people living with dementia. We saw there were points of interest for people who liked to walk around the home. Memory boxes were installed on bedroom doors which helped people locate their bedrooms. A roof garden was created for people who liked to be outdoors in periods of good weather. People's bedrooms were personalised and en-suite facilities were provided.

Relatives we spoke with said there were relatives meetings where their views were gathered. They said staffing levels and continuity of staff was a topic often discussed. One relative said there were issues with the laundry which they raised at these meetings.

Staff said "The staff here care about the residents. This is a good place, but we need more staff" and "I have always put my heart into this job and treat people like I would my grandparents". A member of staff said there was "banter and staff joined in this banter." Another member of staff said "we talk to people and I show them I care."

Lifestyle profiles gave basic information to staff on the times people liked to rise and to retire, where people spent their time such as in the lounge or bedroom and their preferred activities. However, this information was not used to develop people's preferred routines on how staff were to deliver personal care in their preferred manner. A member of staff said staff gave a "personal touch" they said staff ensured people's preferred first name was used. They spent time talking to people about their previous employment history, where they lived and they made the conversation about the person.

People's privacy and dignity were respected. We saw staff were polite and knocked on people's doors to seek permission to enter before going into their rooms. Staff gave us examples on how people's rights were

respected. They said curtains were closed before they delivered personal care and they knocked on bedroom doors before entering. A member of staff said "we explain what is happening, we respect people's wishes and we explain."

Requires Improvement

Is the service responsive?

Our findings

People's care needs were assessed monthly and a score was given for their level of dependency. For example, the level of dependency with personal care. However, we found inconsistencies with the monthly scores overview and the assessment of need. For example a score of three was given in the monthly assessment to one person registered blind with a sore eye on May 2016. This meant they were registered blind and required assistance but the assessment on how this score was reached was blank. The care plan in place for current medical/mental health lacked detail. It stated "registered blind and "hard of hearing." The action plan states "uses hearing aids and requires help in all day to day life." A care plan for the sore eye was not in place. A member of staff said " X has always had a sore eye. No one has ever said anything about treatment." Another member of staff said topical medicines were prescribed and the family had consented to no further intervention.

This person was also given a score of four on the assessment tool dated May 2016 for oral hygiene which meant they were "totally dependent on carers for assistance with oral hygiene". A lesser score was recorded in the overall monthly tool for the May 2016. A care plan for assisting the person with oral hygiene was not in place. Online records showed on two occasions staff supported this person with oral care. It was stated for 14 May 2016 "oral care from staff was unhappy" but there was a lack of detail about the incident and the actions staff took.

We reviewed the care records of six people. The content of the risk assessments and care plans lacked sufficient detail to enable staff to take a consistent approach to keeping people safe and in ensuring a person's needs were met. For example, in one person's care plan, they had been assessed as being at risk of pressure ulcers. It stated in their care plan their "skin integrity needs continued observation" however, there was no further documentation for specific details on what needed to be done to protect their skin and how to monitor this further. Where information on additional equipment such as pressure relieving mattresses was to be entered in the care plan, it stated "X sleeps on a ….." and nothing had been entered to confirm what equipment this should be. Although it stated in this person's care plan they had previously had a pressure ulcer which had since healed, it also stated they had a new wound in the same area following this. Staff were unable to confirm whether this person's skin was still intact. In their care plan it had stated a few weeks prior to our inspection this person's skin was intact, however, when we asked staff whether the person was still being visited by the district nurse for wound care they told us nurses still visited this person regularly. We asked for the notes which detailed district nurse visits, but again, staff were unable to locate these for us to see.

Care plans lacked detail and did not give enough guidance to staff for people to be at the centre of their care. People's preferences on how they liked their care delivered was not part of their care plans. For example, the personal care for one person dated 29/10/2015 stated "requires assistance from two staff due to unpredictable behaviour." The staff were directed to "assess daily for mood" and were to encourage to undertake "as much for herself. Staff to explain in a calm voice using short sentences." The care plan did not say the personal care the person was able to manage for themselves and the action plans did not give staff guidance on how to assess the person's mood, a description of the "unpredictable behaviour" and how to

encourage the person. .

A new electronic data capture system in recording and monitoring care given had been introduced where information on people's daily notes and care plans was recorded electronically. On day one of our inspection, we saw all staff had hand held electronic devices which they would refer to and also enter information on care and treatment people had received. However, the staff we spoke with told us they would record some information in both paper and electronic notes as they were not confident the system was working effectively and were also unsure what information needed to be entered electronically and which on paper documents. This impacted on time available for members of staff to perform other tasks and also led to confusion as to where to look for information on the care people required.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relative told us they were invited to reviews but were not clear on the frequency of the meetings. They commended the activities coordinator for their enthusiasm and their commitment to providing activities to people.

The activities coordinator told us there was a "loose" programme of activities in place. One to one activities were planned between 10:30am and 11:45 and group activities happened in the afternoons. They said one to one trips out usually took place in the mornings.

Staff said there was not much time to sit and chat with people during the day but there was more time in the afternoons to "sit and chat" with people. They said there was an outdoor rooftop area for people and during periods of good weather access was provided. It was also stated that the activities coordinator organised outings and relatives took family members out on trips. Another member of staff said "after lunch there is an hour and we put on music. We help the activities coordinator with arts and crafts."

A member of staff told us there were limited activities planned over the weekend when the activities coordinator was not available. This member of staff told us it was not possible to allow people to go into the garden as there were not enough staff to support them to ensure people's safety in doing this. During our inspection, the activities we saw were an inflatable ball being thrown for people to catch in the lounge area on day one and a balloon being passed around to people in a similar fashion the following day. The activities coordinator said there were a number of group activities arranged and told us about a recent party for the Queen's birthday celebrations. We were told that flower arranging, dogs for therapy and live music and dancing had been available and people had enjoyed these activities.

There was a procedure in place which outlined how the provider would respond to complaints. People told us they knew what to do if they were unhappy with any aspects of care they were receiving.

Inadequate

Is the service well-led?

Our findings

The registered manager was not present during the inspection; however, members of the senior management team including the Nominated Individual, a regional manager from another area, a newly appointed regional manager for the Wiltshire area and a home manager from another area were present.

We found that there was a lack of quality auditing and governance processes. The lack of clear quality auditing process had not informed the senior management team including members the board and Nominated Individual of the concerns identified in this report nor were they aware of the whistleblowing and safeguarding concerns that staff had raised. As a result no actions had been taken to assess, monitor, mitigate risks and improve the quality of the service. Limited action had been taken to address shortfalls identified in previous CQC inspection reports and to prevent the reoccurrence of issues.

During the inspection we asked the Nominated Individual to explain how the service was monitored. The Nominated Individual told us that the registered managers of services were responsible for conducting a range of audits which were then sent to the Quality and compliance manager. The Quality and Compliance manager then highlighted any trends, patterns or issues and these were reported to the senior management team at board level. In addition to this Area Managers completed a monthly visit to each service to assess the quality of care and to complete additional audits. Records of these monthly visits were also sent to the Quality and compliance manager for review and formed part of the report sent to the board. We were informed during the inspection that the quality and compliance manager had been on an extended period of leave. .

We found some audits had been completed by the registered manager for example to infection control and medicines. However when we asked to see audits relating to staff induction, staff supervision, a staff training matrix and a dependency tool used to determine safe levels of staffing (this had been completed by the second day of our inspection) and audits relating to care planning these were not available. We asked to see how the service had gained the views of people using the service, their relatives and other professionals we were told that surveys had been conducted but these "could not be found".

We saw a range of meetings had taken place with relatives, people who used the service and staff. These meetings had taken place in January 2016. The relatives meetings raised some issues including lack of activities and stimulation for people, a lack of staff presence in communal areas, and ongoing issues with staff recruitment. At the staff meetings discussions took place between the manager and staff asking what action had been taken since the last CQC inspection. Not all staff had read the CQC report and so were not aware of any improvements that were required.
In addition concerns were expressed by the manager that he was not receiving accident /incident and safeguarding reports. The minutes of the staff meeting state "I am receiving less forms each month but this is not due to less incidents" and "as with the accident forms all safeguarding issues must be reported to x at the time of the incident along with the completed form". We asked to see an action plan as to how concerns raised at the meetings were going to be addressed. We were told that one was not available. The senior management team, who were available on the day of the inspection visits, could not assure us and were not

aware of the issues raised at the meetings nor were they aware of any actions that had been taken to address these concerns.

During the inspection we reviewed the records relating to staff supervision. Only nine staff of the 45-50 staff employed had received supervision across all three locations from January to May 2016. We reviewed all nine supervision records. Of these three raised concerns with regard to the conduct of other staff or issues with performance. In addition during the inspection one staff member told us that she had raised concerns with regard to the conduct of another staff member. We reviewed the personnel files for all of these staff and could find no evidence of any action being taken including disciplinary action or increased supervision. The managers available on the inspection visits were not aware of these issues or of the actions taken in response to this whistleblowing.

During the inspection we saw a memo from the manager to staff dated 5 April 2016. The memo raised concerns that meals prepared for people were being taken by staff. The manager had highlighted that this was not acceptable and was to stop immediately.

We asked to see the records relating to the provider's monthly visits. The folder we were given contained provider visits for the October, November and December 2015 and April 2016. We asked the regional manager and Nominated Individual for the documentation relating to the visits for January, February and March 2016. These could not be provided. The provider visit forms which we saw had not identified any of the concerns highlighted in this report with the exception of the ongoing issues with staff recruitment.

During the inspection we spoke to the Nominated Individual who stated that whilst he was aware of issues with regard to retention and recruitment of staff and that the locations were not the "best performing homes in the group" he was not aware of the whistleblowing concerns, the lack of ongoing supervision of staff, issues relating to staff induction and training, the lack of accidents and safeguarding forms or the issues highlighted in the memo to staff. The Nominated Individual confirmed that no action plan, that he was aware of, had been developed in response to these concerns. The Nominated Individual confirmed that the quality and compliance manager was off sick and had been for some time. They agreed that the lack of safeguarding and incident/accidents reporting should have been considered a risk and should have warranted further investigation. When we asked them if they felt that their oversight of the locations seemed overly reliant on one person and if that person was not available then the system did not appear robust, they agreed.

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

We spoke to the Nominated Individual about the concerns that had been received and any action that had been taken in response to this to keep people safe. The Nominated Individual told us that a number of staff had been suspended pending a full investigation. Following this any disciplinary action would be taken if this was required. Retirement Villages were developing a formal induction policy and would review the training provided to staff. The current Registered Manager was unavailable and so an interim manager was been sought to commence employment as soon as possible and in addition the senior management team would have a presence at the services for as long as required.. The Nominated Individual provided assurance that they would work with both us and the local safeguarding team to ensure that any remedial action or improvements would be implemented as a matter of urgency. Following the inspection we formally wrote to the provider to seek these assurances. The provider confirmed this and agreed that the home would not consider any additional admissions to any of the three locations until such time as the safety of people at the service could be assured.

The people, staff and relatives we spoke to told us that they felt that the registered manager was approachable and was working hard to improve the standards of care at the service. As the registered manager was not available we were unable to discuss with them their views on the concerns raised or how they hoped to develop the service in the future.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not developed for all areas of need and they lacked detail on how staff were to meet people's needs in their preferred manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 was not followed by the staff for people who lacked capacity to make decisions. Relatives were able to give their consent for care and treatment when they did not have the legal powers to make these decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient staff were not deployed to meet the needs of people. Care was inconsistent because there was a heavy reliance on agency staff who did not know the people they were caring for. Members of staff did not have the training needed to undertake their roles and responsibilities. Permanent staff did not have opportunities to discuss performance, concerns and training needs with their line manager. Agency and relief staff were not provided with sufficient information to meet people's needs

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 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of harm because members of staff were not taking the necessary steps to mitigate risk to people when they were delivering personal care. Equipment to support people who fell was not available. People were not safeguarded from unsafe systems of medicines. Where staff had raised concerns from incidents and accidents that occurred these whistblowing from staff were not taken seriously and acted upon.

The enforcement action we took:

warning notice

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 Processes were not operating effectively to prevent potential abuse to service users. The staff were not always recognising the signs of abuse and taking appropriate action to prevent abuse from occurring.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of quality auditing and governance processes. As a result no actions had been taken to assess, monitor, mitigate risks and

improve the quality of the service.

The enforcement action we took:

impose condition