Hillgay Ltd

Hilgay Care Home

Inspection report

Hilgay
Keymer Road
Burgess Hill
West Sussex
RH15 0AL

Tel: 01444244756
Website: www.hilgaycare.co.uk

Date of inspection visit:
19 July 2016
20 July 2016

Date of publication:
08 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 inspection took place on 19 and 20 July 2016 and was unannounced. Hilgay Care Home provides residential care for up to 35 older people. There were 28 people living at Hilgay when this inspection took place, some people were living with dementia. The house is situated in a residential area of Burgess Hill in West Sussex. Accommodation is arranged over three floors with a passenger lift connecting each floor. There is a large conservatory attached to the lounge /dining room and a smaller sitting room on the ground floor. A spacious and attractive garden is accessed from the conservatory or from the main front door of the building.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first inspection since the new provider was registered in July 2015. The registered manager had been in post for five months at the time of the inspection. They told us that a number of changes had already been made and plans were in progress as part of an ongoing development programme. We identified a number of areas of practice that needed to improve and four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to inadequate levels of staffing, lack of support at meal times, lack of person centred care and poor management oversight. You can see what action we asked the provider to take at the back of the full version of this report.

There were not always enough staff on duty to ensure that people's needs were met. People, their relatives and staff told us that there were not enough staff and our observations confirmed this. Staff were rushing between tasks and they had little time to spend with people. People often had to wait for support with their care needs and some people did not receive the support they needed. We identified this as an area of practice that requires improvement.

People told us they enjoyed the food at Hilgay and that they could choose what they liked to eat. One person said "It's usually nice, tasty food." However some people were not supported effectively at meal time because staff were not always available to help them. One staff member said "We need more hands, especially at lunchtime." We identified this as an area of practice that requires improvement.

Care plans and risk assessments did not reflect people's individual needs and lacked detail and information to guide staff in how to care for people safely. Risks to people were not consistently managed. Some people had been identified as being at high risk of falls however there was no clear guidance for staff in how to provide care safely or how to manage the risks. This was identified as an area of practice that needs improvement.

Care plans were not updated when people's needs changed. Staff told us that they did not often refer to the

care plans as they were "Not very useful." Care plans were written in a generic way and did not always provide personalised detail such as people's interests, preferences or specific wishes. The registered manager planned to introduce a new format but these were not yet in place. People were not supported to follow their interests and many people told us they were bored and did not have enough to do. A staff member said, "We haven't got the staff to do activities with people, we have no time to spend one to one with people, and people don't get to go out." This was identified as an area of practice that requires improvement.

People and staff expressed mixed views about the management of the home. One person said "They aim to provide a good service." One staff member said, "It's hard for them coming into a new team but I have found them to be supportive. I am 99% happy with the manager and the team." Systems for monitoring the quality of care provided were not always effective. For example, where people's needs had changed their care plan had not been amended to mitigate risks. There was no auditing system in place to monitor, analyse and review the effectiveness of care plans. We identified this as an area of practice that requires improvement.

People told us that staff were caring, one person said, "The staff are kind and make sure I am alright." Although most of the interactions that we witnessed between staff and people were kind and caring, we also saw some exchanges that were less positive. A staff member was heard to speak sharply to a person who was living with dementia. Staff did not always respond to someone who was frequently calling out, this meant that other people were disturbed by the noise. This caused them to complain about the person, within their hearing, leading to a possible loss of self-esteem and dignity for the person who was living with dementia. However, staff had developed positive relationships with people they were caring for and we saw many examples of caring and compassionate support.

Staff said they had access to training and received regular supervision to support them in caring for people. Staff had undertaken a range of training in the past year including courses specific to the needs of people living at Hilgay such as dementia awareness and diabetes training. Staff were able to demonstrate a good understanding of the Mental Capacity Act 2005 (MCA) and they were effective in seeking people's consent before providing care.

People and their relatives spoke highly of the staff and told us that they felt safe living at Hilgay. One person told us, "I definitely feel safe here, that's the reason I'm living here." Staff had a firm understanding of how to safeguard people from abuse. Recruitment procedures were robust and ensured that staff were suitable to work with people. People's medicines were managed safely by staff who were trained and assessed as competent in the administration of medicines.

People told us they could access health care services when they needed to and that staff supported them with this. A relative said "They are very quick to contact the doctor and to tell us." A health care professional told us that staff were knowledgeable about the needs of the people they were caring for, saying "The staff work well with us, they are able to tell us about the residents and they help people to carry out the exercise programmes that we give them."

The registered manager had a firm understanding of their responsibilities with regard to notifying CQC of relevant events. A system was in place to record and respond to complaints about the service and the registered manager monitored incidents and accidents. Some audits had been undertaken to measure care delivery including, an infection control audit. An action plan identified tasks that needed to be undertaken and these were either completed or in progress. A recent external audit of medicines had been undertaken by a pharmacist and the registered manager was in the process of working through the action plan resulting from this audit. Both the provider and the registered manager were committed to developing the service to

provide a more person centred experience for people living at Hilgay.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff to keep people safe and meet their needs.

Risks to individuals were not consistently managed and clear plans were not in place to guide staff in how to meet people's needs and keep them safe.

There were systems in place to ensure staff were suitable to work within the care sector. Staff had a firm understanding of how to protect people from abuse.

People's medicines were managed so they received them safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always receive the support they needed at meal time.

Staff received the training and supervision that they needed to support people effectively. Staff understood the importance of seeking consent from people in line with Mental capacity Act 2005 (MCA).

People had access to health care professionals and were supported with their health needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always protect the dignity of some people.

People's privacy was respected and staff maintained confidentiality.

Staff knew people well and had developed caring relationships with the people they supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always personalised and lacked details and guidance for staff. Care plans were not always updated to reflect changes in people's needs.

People were not supported to have meaningful occupations or activities that reflected their interests.

There was a complaints system in place and people knew how to make complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well- led

Systems for assessing and monitoring the quality of care provided were not consistently effective.

People's care records were not accurate and up to date and systems for auditing care plans were not effective .

There were systems in place to ensure that incidents and accidents were reported and actions taken to reduce risks of recurrence.

Hilgay Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 July 2016 and was unannounced. The membership of the inspection team for the first day included two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned on the second day.

Before the inspection we reviewed information we held about the service including previous inspection reports, any notifications (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) prior to the inspection (this is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.) This enabled us to ensure we were addressing relevant areas at the inspection.

We spoke to 16 people who use the service and four relatives. We were shown around the building and spent time observing care and support over two days. We interviewed eight members of staff and spoke with the registered manager. We spoke with the provider by telephone and five visiting health and social care professionals who were happy for us to include their views within this report. We looked at a range of documents including policies and procedures, care records for five people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the providers systems for allocating staff and other information systems.

This was the first inspection for Hilgay since the new provider was registered in July 2015.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Hilgay, one person told us, "I definitely feel safe here, that's the reason I'm living here." Another person said, "I certainly don't see people as being unsafe, the staff are lovely and caring," a third person said, "It's safe here, especially at night when it's better than being on my own." Despite these positive comments we found that some aspects of the service were not always safe.

There were not sufficient numbers of suitable staff to meet people's needs and to keep them safe. People told us that there were not enough staff. Their comments included, "They have cut down on staff," and "There's not enough staff, people who need help have to wait for it." One person said, "The problem here is lack of staff," and "There is never enough staff, people are left waiting and some people need a lot of care." All the staff members who we spoke with expressed concerns about staffing levels. Their comments included "Mornings are difficult, we used to have eight staff members on duty now it's been cut down to five," and "We don't have enough staff on duty." We asked staff what impact this had on the people that lived at Hilgay, one staff member told us "I refuse to cut corners, but it means people are waiting for longer." Another said "Call bells are not always answered quickly." A third staff member said, "There's often no staff around in the lounge areas in the morning because they are all helping people to get up," and another told us, "People need more assistance then they used to, some need support from two members of staff and we haven't got enough. We all do our best to promote people's independence but we haven't got enough staff."

The registered manager told us that they were actively recruiting to vacant posts and were in the process of adjusting the rota to better suit the needs of the service. The staff rota confirmed that the number of staff covering shifts was consistent and agency staff were used to cover for planned absences and vacancies. We asked the registered manager how the staffing level was decided upon. They explained that a tool was used to calculate the number of care hours that were required, based on the needs of each person. They confirmed that this had resulted in a reduction in staffing levels. However the tool did not give an accurate reflection of the needs of people. For example, one person required support from two staff members but this was not taken into account in the calculation. This meant that the number of hours specified for supporting people was incorrect. The registered manager agreed that the tool needed to be revised.

Our observations during the inspection confirmed what people and staff had told us. People were often left in the lounge, sitting room and conservatory areas with little staff support. This meant that staff were not around to help them if they needed support. For example, during the morning one person needed support with their personal care. They were becoming anxious because there had been no staff around to call on for more than twenty minutes. The inspector went to find a member of staff to attend. Some people were not able to get out of their chair or move around without assistance but they had no way of alerting staff if they wanted to move. For example, one person was seen to try, unsuccessfully, to get the attention of a staff member who was hurrying through the lounge area. They were softly spoken and staff did not notice them calling. This happened on more than one occasion until the inspector drew the staff member's attention to the person who was signally for help. During the morning there were very few members of staff seen in the communal areas. No staff were seen talking with or spending time with people. The Registered Manager was

offering cold drinks to people as it was an exceptionally hot day. One person was seen to go and find a staff member as they were worried about another person who they feared was getting too hot because they had been sitting in the conservatory all morning. Throughout the morning care staff were supporting people to come downstairs into the communal areas but once they were seated the staff member went back to help another person. Staff told us they were very busy and we noted that they appeared to be rushed and hurried. When staff members came into the room they spoke to people around them, briefly checking if they were alright before hurrying off to help someone else.

Some people who were living with dementia were agitated, calling out for help and shouting when no staff responded. People told us that this happened frequently. One person told us, "If there were more staff on duty they could give them the time they need and that would make things better for all of us." Staff told us that they didn't have time to spend with people. One staff member said "It we were less pressurised for time we could spend time with the residents but we are just rushing from one task to the next." Another staff member said, "I would like to be able to spend time with people chatting but it's not possible," and a third said, "It's very difficult, people could be unsafe, for instance if they are at risk of falls and we are not around to supervise them."

At the end of the lunchtime meal some people were able to leave the meal table independently however many people needed staff support to do so. We noted four people were left sitting at the dining table for a considerable time. They had to wait at the table with no company or stimulation until staff were free to support them to another chair. One person was left at the table after other people had moved away and we noted that they had fallen asleep with their nose on the table. It was another fifty minutes before a staff member asked if they would like to move to a more comfortable chair, to which they replied "Yes please." This meant that they had sat at the meal table for over three hours. A staff member said "We need more hands, especially at lunchtime," another staff member said "We could do with a hostess at lunchtime to support the meal- we can't do everything" and a third said "Some people are very slow and we can't rush them so others end up waiting for ages because we haven't got enough staff," and "We have to help in the kitchen too."

The failure to ensure staffing levels sufficient to meet people's needs was a breach of regulation Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not consistently managed. One person had needs that required a high level of support including use of a hoist to transfer with two care workers. A risk assessment indicated that risks associated with mobility were high, including being at high risk of falls. However there was no clear guidance for staff in how to provide care for this person or how to manage the risks. Staff told us that this person could mobilise with support but that a hoist was needed for transfers to and from the bed. This was not clear from documentation in the person's file with no care plan to show how care should be provided safely. This meant that staff did not have the guidance they needed to provide care safely, this potentially put the person and staff at risk of injury.

We noted that at lunch time people were supported to come to the dining area but there was little space for their walking frames. This meant that some areas of the room became over crowded with equipment causing a trip hazard for people and staff. One person wanted to help themselves to a drink on the sideboard however they had to negotiate five walking frames to reach it. This number increased later to eight walking frames. Staff had not identified this as a potential risk.

A person had a falls risk assessment completed on a monthly basis and this indicated that they were at high risk of falls. The action plan stated 'Maintain current level of mobility and mobilise safely with minimum risk

of injury.' There was no specific guidance for staff in how to reduce the risk or support the person to maintain their mobility. Risks had been assessed for other people but similarly there were no clear plans in place to identify how these risks would be managed and no guidance for staff. We raised this issue with the registered manager who told us that they were aware that the generic plans that we had seen were not detailed enough to guide staff. The registered manager showed us new risk assessment and care plan documents that were to be introduced over the coming weeks. These were designed to give more information and guidance to staff in how to manage risks and provide care in a safe and effective way. As these were not yet in place we have identified risk management as an area of practice that needs to improve.

Staff were knowledgeable about safeguarding adults. They described how they would recognise signs of abuse and what they would do if they suspected abuse had taken place. Staff had a firm understanding of their responsibilities with regard to the provider's safeguarding and whistleblowing policy. A whistleblowing policy enables staff to raise concerns about practices in their workplace.

The provider had a robust system for recruiting new staff. Prior to their employment staff's suitability to work in the health and social care sector had been checked with the Disclosure and Barring Service (DBS) and their employment history gained. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people.

People were supported to take their medicines safely. Staff had received training and understood the procedures for giving medicines. People's medicines were stored, administered and disposed of correctly and MAR (Medicine Administration Records) charts were completed accurately. Some people were prescribed, 'as required' (PRN) medicines. As required medicines are meant to be taken occasionally when there is a specific need, for example, tablets for pain. People told us they could ask for pain killing medicines when they needed to and we observed staff checking if people needed their PRN (as required) medicines.

Requires Improvement

Is the service effective?

Our findings

People told us they had confidence that the staff knew how to care for them effectively. One person said, "The staff are all good, they help me with my exercises," another person told us "I think they have had a lot of training." A third person said, "They are very experienced in providing care, the younger ones soon learn what to do, I think the care is very good here." Despite these positive comments we did identify some areas of practice that needed to improve.

We observed the lunchtime meal on both days of the inspection. There was little conversation and we did not see staff encouraging or facilitating discussions, the atmosphere remained subdued and quiet throughout. Most people came to the main dining room for the meal. The room was pleasant and the tables were laid with salt and pepper cruets and jugs of water. The music that had been playing had finished and people sat in silence waiting to be served. Some people had their food sitting in an arm chair with over-knee table. A menu was on display on the wall but the text was too small for some people to read, one person was heard asking another what the menu said, "I can't read it" they replied. When staff brought people their lunches they explained to some people what was on the plate. We noted that some people were using coloured plates to assist them to distinguish the food and others had plate guards to enable them to remain independent. People were offered a tray of sauces to choose from and were supported to help themselves. Staff were coming in and out of the room to bring people their meals but there was no constant staff presence within the room. This meant that people were not always given the support they needed, including encouragement as well as physical support to eat their meal.

We noted that there were periods when there were no staff in the dining room which meant that some people did not receive the support they needed or they waited a long time for a staff member to be available to support them. For example, one person was seen to be moving their food around the plate but not eating anything. After about forty minutes a staff member noticed and offered help saying, "Your food must be stone cold by now, shall I get you a spoon?" The staff member did not reheat the food and the person ate only another small mouthful of food. Another person had been assessed as at high risk of malnutrition. The care record included guidance for staff stating ' Will need a lot of help, encourage to do things eg. say gently but firmly, "Drink your drink." ' However we did not see staff offering help and encouragement to this person and we noted they ate only a small amount of their meal.

The registered manager told us "Everyone eats together unless they want to eat in their room." However one person, who was living with dementia, was sitting alone in the small sitting room to eat. Staff had not offered them the opportunity to eat in the main dining area. A staff member brought their food and prompted them to eat independently, saying, "I can't stay with you very long, I have to help with the washing up." The person was left talking to an empty room and was heard to say, "I don't know what I'm eating, I can't see well, does anyone know what I'm eating?" Although they managed to eat their meal they seemed to be agitated and distressed. We checked their care record and it stated that the person "Enjoys meals" and was "sociable, and enjoys chatting with residents and staff." It referred to them being helped to the dining table for lunch and back to the sitting room, however we did not see this happen during the inspection.

Due to these concerns with regard to people not always receiving sufficient support at meal times we have identified this as a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they liked the food at Hilgay and that they had plenty to eat. One person said, "The meals are what I like, it's the best thing in the day." Someone else told us "The meals are very good," and a third person said, "It's usually nice, tasty food." We noted that there was fresh fruit available in the lounge area and staff said people could help themselves if they wanted to. People told us they were offered choices about what to eat, one person said, "There's plenty of choice, the menu is good." The chef told us that people could contribute ideas for the menu, saying "We talk about the menus in resident's meetings and try and provide whatever they want. For example, someone asked if we could have salmon sometimes so that is back on the menu now." People's dietary needs were identified in their care plans, and the chef was aware of these as well as people's individual preferences. Where it was noted that someone was losing weight staff ensured that food and fluid charts were put in place to monitor their intake. We noted that this was discussed as part of the staff handover so that staff were aware of the support people needed. For example, staff were told that one person had been reluctant to drink that day, despite the hot weather, and needed to be encouraged. We noted that there were large drinks containers in the lounge area for people to help themselves to drinks. However there were no glasses with the drinks so people had to ask staff for a glass before being able to help themselves. Many people were not able to help themselves and we saw staff offering drinks throughout the day and people were given a choice of hot or cold drinks.

Staff told us they had access to training that was relevant to their roles. Records confirmed that all staff had completed a range of training including mandatory training such as manual handling and safeguarding awareness. Many had also undertaken training specific to the needs of people living at Hilgay such as dementia awareness and diabetes training. Staff told us that they had received a thorough induction and had been well prepared for their caring role, one staff member described having completed an induction booklet and shadowing staff on shift. Some staff had completed NVQ at levels 2, 3 or 5. An NVQ in care is a nationally recognised qualification which has now been replaced with the National Diploma in Care.

We asked staff what difference the training made to the care they provided. One staff member said, "I take a different approach to working with people, you know how to handle the situation," another staff member said, "The simplest things can make a big difference, for example using a coloured plate for someone with dementia," and "I understand a lot more since doing the training." Staff told us they had regular meetings with a supervisor and records showed these happened every two months. They said that they found supervision meetings useful and that they were able to express their views. One staff member said, "The manager is understanding and supportive," another said "I do feel supported by the management team."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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 or authorisations to deprive a person of their liberty were being met.

Staff had received training in the MCA and DoLS. They were able to describe the relevance of the legislation and guidance to their roles. One staff member said "When people are unable to make decisions for

themselves we have to make decisions that are in their best interests." Another spoke about ensuring that people's choices are respected, saying "I always ask permission before helping someone, it's important to get their consent." Staff were aware that some people at Hilgay had DoLS authorisations in place and understood what this meant. One staff member explained, "We raised a DoLS for someone who does not have capacity because we need to keep them safe. Their family were involved in the decision making process." Throughout the inspection we noted that staff were seeking consent from people, for example, we heard them asking, "Is it ok if I help you now or would you like me to come back later?" and "Would you like me to do that?" and " Can I give you your tablets now?" This showed that staff understood the importance of seeking people's consent to care.

People were supported to access health care services when they needed to. People told us that the staff would call a doctor if they wanted them to, One person said, "I usually manage my own appointments but staff will help me if I ask," another person said, "The staff call the GP if needed, or they get a nurse in." A relative said "They are very quick to contact the doctor and to tell us." We spoke with a visiting health care professional who told us "The staff work well with us, they are able to tell us about the residents and they help people to carry out the exercise programmes that we give them." Another visiting health care professional said, "The staff are good, people are well cared for and they let us know quickly if there are any problems." People's records showed that people had accessed a variety of health care professionals including physiotherapists, opticians, and district nurses. People who had mental health needs and who were living with dementia were referred to mental health services for support. Records showed that staff were proactive in making sure that people were referred quickly if their needs changed.

Requires Improvement

Is the service caring?

Our findings

People and their relatives spoke highly of the care staff at Hilgay. Their comments included, "The staff are kind and make sure I am alright," and "The staff are very caring," and "The staff are all very understanding." Relatives told us "The staff have been fantastic, one in particular is very helpful," and "The staff are all lovely, kind people who go out of their way to make it nice for the residents here." Although the majority of interactions that we witnessed between staff and people were kind and caring, we also saw some exchanges that were less positive.

One staff member was heard to speak sharply to one person who was living with dementia, telling them "Don't do that, it's not very nice," in a critical tone of voice. Another staff member was heard to ask people if they wanted the music on in the sitting room or would they prefer the TV, one person answered saying they would like music, but the staff member replied, "There are other people here," and put the TV on instead. A person who was living with dementia was vocal and called out continuously but staff members did not always respond. This meant that other people in the room began to find the noise disturbing, those who were able to move unaided, left the room. One person told us they found the noise annoying saying, "The staff should do more with them." Another person began telling them to "Shut up." This meant that the person who was living with dementia was not supported to maintain their self- esteem, dignity or respect. This is an area of practice that needs to improve.

We also observed many positive interactions between staff and people. For example, one staff member was heard to ask someone, "How did you get on at the eye hospital?" they conveyed genuine interest and concern. Another staff member was seen supporting someone to stand from their chair, they had a gentle and calming approach, giving clear instructions and reassuring the person to give them confidence. People had developed positive relationships with staff, we heard one person ask a staff member about their recent holiday and whether they had been surfing, there followed a brief but lively conversation between both parties. People told us they were happy with the care they received and they felt that staff were compassionate and caring. One person said, "I feel that I am well cared for here and it's a safe restful atmosphere," another person said, "When they have time the staff do try and chat to us." We observed that people were comfortable in the company of staff.

Staff spoke warmly about the people they were caring for and they were knowledgeable about their needs. One staff member said, "I love my job, I'm committed to the people here, it's so important that they get the care they need from people who know them well." Another staff member spoke about someone they cared for saying, "They need a lot of encouragement, it's important that they keep mobile it helps them to be active and alert." Another staff member told us, "We get to know the little things that people like," and a third staff member said "I know people well, for example, (person's name) likes to talk about their family, their husband and children." People told us that staff knew them well and they felt able to talk to them about their care. One person said, "They know me well and understand my ways, we rub along ok." Another person said "The carers are very supportive, you can't fault the care. But it is harder with new staff who don't know you." A relative told us, "The care staff are good and I trust them but they are very busy."

People said that visitors were always made welcome and we saw relatives being greeted by staff and offered drinks. People told us they could make choices about their care, one person said, "I can have my breakfast in bed in the mornings which is really nice then I get up when I'm ready." Most people had signed their care plans and we saw that they had been involved in reviewing their care on a monthly basis. Records indicated that people had been consulted for example one care plan review stated, 'She says she is happy with her personal care and daily routine.' People told us they attended residents meetings and that there were also family meetings held quarterly. We saw some notes from these meetings that indicated people were invited to express their views on the care provided and to make suggestions about the running of the home. People told us they were able to personalise their bedrooms and we were invited to view some rooms which were attractively decorated and contained people's personal memorabilia.

Staff understood the importance of maintaining confidentiality and protecting people's privacy. For example when someone needed support with personal care a member of staff spoke to them quietly in a discreet way to protect their privacy. Peoples care records were kept in lockable filing cabinets and staff were careful not to leave their information lying around.

Requires Improvement

Is the service responsive?

Our findings

Care records were not always personalised and did not always reflect the needs and preferences of people. There was a lack of focus on things that mattered to individuals, including their interests and little clear guidance for staff in how to support people. Care records included action plans for delivery of care. These gave only generic guidance, for example, an action plan to support someone with personal hygiene said, 'Maintain a good level of hygiene whilst maintaining dignity, respect and independence.' There was no guidance for staff in how to achieve this or any specific information that was relevant or important for the individual. Despite the lack of detail we noted that the person did appear to be well dressed and their personal hygiene had been maintained. We saw these generic care plans were in place for most people and lacked information about people's assessed needs, choices and preferences. Staff said that they did not always refer to people's care records. One staff member said, "I know what needs to be done and the care plans are not that helpful anyway." This meant that people were at risk of receiving inconsistent or inappropriate care that was not personalised or responsive to their needs and preferences.

People's background and life history was recorded for some people but not everyone, and staff told us that this was something that they were working to improve. Changes in people's care needs were identified by staff but this did not always result in a review of the care plan. For example, one person had suffered a fractured hip bone and this was recorded within their care record. They told us that they had received additional help and support from staff on their return from hospital but the care record had remained unchanged and did not indicate an increase in needs following the fracture. This showed that care records were not always an accurate reflection of the care needed to guide staff in meeting the needs and preferences of each person in a consistent way.

The provider's aims and objectives were included within the service user handbook. A stated aim included to 'Offer individualised programmes of meaningful activity.' However we did not see evidence of this. People were not always supported to carry out person- centred activities in the home or the local community and they told us that they didn't have enough to do. Their comments included, "There's nothing to do here," and "I like it when we have quizzes but there's not much provided," and "I am quite satisfied except there could be more to do." One person said, "There used to be an activities co-ordinator, they organised crafts, exercises and music and movement sessions. Since they have gone we get bingo a couple of times a week and sometimes nail painting but staff are often too busy to even do that." One person told us they used to go out regularly with a staff member but this was no longer possible. They spoke of missing their contact with the local community.

The registered manager told us that the activities co-ordinator had left and there were no plans to replace them because staff were keen to take on the activities role themselves. We asked staff what activities and occupations were available for people at Hilgay. One staff member said, "Its difficult at the moment, sometimes activities don't happen, I feel sad that we don't get enough social time with the residents." Another staff member said, "We haven't got the staff to do activities with people, we have no time to spend one to one with people, and people don't get to go out." A third staff member said "Sadly, it's very limited, we try and take people into the garden."

The registered manager told us that the administrator had been arranging some activities for people and we were shown a plan for a week which included bingo sessions, gentle exercise, nail painting and a craft session. Staff members were named as facilitators for some of these events however they told us that they rarely had time to carry out these pursuits. Staff told us they would like to do more with people but that they often did not have the time. It was not clear if people's personal preferences and interests had been considered when designing the activity plan or what else was available if people didn't like what was on offer. For example there was no indication of what activity was available for the gentlemen living at Hilgay when nail painting was taking place.

Relatives and visitors also commented that people did not have enough to do. One relative said "My only real criticism of the place is that people haven't got enough to occupy them and they get bored." A visiting health care professional commented, "There is not enough going on since the activities co-ordinator left." Our observations on the first day of the inspection were that most people were left with no stimulation for most of the day. The planned activity was nail painting but that did not happen. Some people were able to entertain themselves by reading a book or paper but there was nothing for other people to do. Music was playing in the lounge during the morning and after lunch but it was the same CD which was played all day. Staff spent no time just sitting and talking with people or trying to engage them with an activity. We saw on person was asked if they would like to fold the napkins before lunch and one person was escorted to take a walk around the garden in the afternoon. No other meaningful occupation was seen.

On the second day of the inspection a number of activities were seen taking place including a music session with an external entertainer, bingo and a quiz. People were seen to be thoroughly enjoying the music session, many people were singing, playing percussion instruments and clapping along with the music. People commented afterwards on how much they had enjoyed the session and the atmosphere was happy and relaxed.

We looked at people's care records to see how they usually spent their days. We saw some evidence that events had happened, including a tea party with an entertainer, some exercise and games sessions and quiz and bingo. However these events were happening infrequently, for example, one person's daily activity record had only 21 entries out of a possible 200 days and this was similar for other people. This meant that people's social and emotional needs were not always supported.

People did not receive the care and treatment to meet their assessed needs or which reflected their preferences or wishes. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints system in place and people told us that they knew how to make a complaint. The registered manager took actions to investigate complaints received and we saw this recorded including correspondence sent to the complainants. People and their relatives said they would feel comfortable to make a complaint if they needed to. The registered manager spoke about learning from complaints and gave an example of having made changes to ensure that relatives were kept informed of actions taken following a complaint.

Requires Improvement

Is the service well-led?

Our findings

People and staff had mixed views about the management of the home. Most people that we spoke to said they were happy, their comments included, "I think they are doing their best," and "They aim to provide a good service." One person said "They are making a lot of changes, it's a lovely place and it would be sad if they can't get it better organised."

The registered manager had been in post for seven months at the time of the inspection. Some people said they didn't know who the registered manager was, one person said, "I am aware of who they are but I don't feel that I know them yet," another person said they did not know who the manager was but they could tell us the names of other staff members. A third person said "We don't see the manager in the home often." The registered manager was not aware of some aspects of the day to day practice within the home. For example, we discussed reductions in staffing levels and what impact this had on people. The registered manager was not clear about how individual people had been affected. This meant that there was not an effective system in place to monitor and assess the quality and safety of the service. We identified this as an area of practice that requires improvement. The registered manager told us that they planned to spend more time observing and being involved with care in the home.

There were not effective systems and processes in place to ensure that care records were accurate, up to date and that identified risks to people were managed effectively. For example, where people's needs had changed their care plan had not been amended to mitigate risks. There was no auditing system in place to monitor, analyse and review the effectiveness of care plans. This meant that the provider did not have effective governance and quality assurance systems in place to monitor the quality, safety and experience of people. We identified this as an area of practice that requires improvement. The registered manager was aware that the current care planning system was not adequate and told us of plans to introduce a new model.

The lack of management oversight and failure to maintain accurate, complete and detailed records in respect to each person using the service is a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Most staff were positive in their views of the registered manager and the owner. One staff member said, "It's hard for them coming into a new team but I have found them to be supportive. I am 99% happy with the manager and the team." Another staff member told us, "It's a good team and I feel supported by the manager and the owner." A third staff member said "There has been a lot of changes and it will take a while to settle down, but I have faith in what they are trying to do."
Some staff expressed less favourable views, one said that they found the registered manager to be unapproachable, another said that they didn't feel able to express their views openly. We discussed these comments with the registered manager who gave an open and honest response, saying "I am aware that some people have found it difficult to talk to me, I am working on that. I am very straightforward and I want people to be honest with me."

The registered manager described a programme of change that was planned to improve the culture of the home. This was based upon having a more person centred model of care. Staff were aware of this approach and understood the vision and values that the provider was working towards. They told us, "It's about providing a warm friendly atmosphere that's a home from home for the residents," and "We are aiming for person focussed care, we are not there yet but that's what we are working towards," and "We are here to support people as individuals, we're here for them." The registered manager spoke of the importance of including staff in developing the service and described a workshop event that had been held. A staff member also spoke about the workshop. They said "I think we all understood it, we want it to work because that's what it should be like, everything should be centred around the people here but unless we have enough staff it won't work." This showed that staff understood the vision and values of the service but that this was not yet embedded within their practice.

The registered manager said that they were well supported by the provider and the management team at Hilgay, which consisted of a care manager and a two senior carers. There was little external support for the registered manager who said they would like to be linked in with other similar services to benefit from joint learning and to keep up to date with changes within the care sector. This was something they planned to arrange.

The registered manager had a firm understanding of their responsibilities with regard to notifying CQC of relevant events. They had some systems in place to monitor the quality of the service and to drive improvements. This included regular audits with action plans attached. For example an infection control audit had been completed in May and actions identified had been either completed or were seen to be in progress. The registered manager had oversight of accidents and incidents and explained how patterns were identified and what changes were made as a result. The provider had not yet undertaken a quality assurance survey to gather the views and opinions of people living at Hilgay and their relatives, however the registered manager told us of their plans to do this in the near 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive the care and treatment to meet their assessed needs or which reflected their preferences or wishes

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always given the support they needed to eat and drink

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective governance arrangements in place to drive improvements and ensure the safety of services provided. The provider had not ensured that care records were accurate and detailed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified staff to keep people safe and meet their needs.