Barchester Healthcare Homes Limited

Hilderstone Hall

Inspection report

Hilderstone
Nr Stone
Staffordshire
ST15 8SQ

Tel: 01889505468
Website: www.barchester.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 September 2017 and was unannounced.

Hilderstone Hall is a care home providing accommodation, personal and nursing care for up to 51 people. At the time of this inspection 35 people were using the service. At our last inspection we saw that there was a dedicated dementia care unit called Memory Lane but we were told during this inspection that this was no longer being utilised.

The provider did not have a registered manager 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. The provider told us that a new manager had been recruited and that they would start their application to register with us once they were in post. An operations manager was temporarily managing the home until the new manager came into post.

At our previous inspection on 21 April 2015 the home was rated 'Good'. At this inspection the home was rated '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.

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

Risks to people's safety, health and wellbeing were not always identified and managed safely and people

did not always receive their planned care.

People were not always protected from the risks of avoidable harm and abuse because incidents of possible abuse were not identified and reported to the local authority as required. Action was not always taken to protect people from further occurrences.

There was not always enough suitably skilled staff to keep people safe or to meet their needs.

We found that medicines were not managed safely and people were at risk of not receiving their medicines as directed by the prescriber.

The provider did not have effective systems in place to consistently assess and monitor risks to people or the quality of care provided. This meant that issues with the quality of the care were not reliably identified and rectified.

The provider did not notify us of allegations of abuse which is a condition of their registration and required by law.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not always followed to ensure people were supported to consent to their care. We identified one person who was potentially being unlawfully deprived of their liberty.

Staff received training but the skills learnt were not put into practice to ensure people received safe and effective care.

People enjoyed the food and had choices about what they ate and drank but risks in relation to people's eating and drinking were not always minimised and risk management plans were not always followed.

People had access to healthcare professionals though this was not always sought in a timely manner and professional advice was not always followed and this placed people's health at risk.

People and relatives told us they were happy with the care they received and the way they were treated. However, people's right to dignity was not always respected and promoted.

People's preferences, likes and dislikes were recorded in their care plans but staff were not always aware of these and routines within the service meant that people's preferences were not always catered for.

Some people had access to activities though others were not supported to engage in meaningful activity.

There was a complaints procedure in place and formal complaints were responded to in line with this procedure. However, informal complaints were not always acted upon appropriately.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health, safety and wellbeing were not managed in order to keep them safe.

People were not protected from the risk of avoidable harm and abuse. Incidents of alleged abuse were not reported to the local authority for investigation, so that people could be protected from further abuse.

Staff were not always available to keep people safe and meet people's needs.

Medicines were not managed safely so that people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent was not always sought in line with the Mental Capacity Act 2005 and people's liberty was restricted unlawfully.

Staff had received training but the skills learnt were not put into practice to ensure people received safe and effective care.

People had access to healthcare professionals though professional guidance was not always sought in a timely manner or followed correctly.

People enjoyed the food and could make choices about their meals and drinks, however risks in relation to eating and drinking were not always minimised.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported by staff to make choices about the care they received. However, people told us they were happy with the care and support provided. People's right to

privacy and dignity was not always respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's likes, dislikes and preferences were recorded in their care plans, however, people's preferences were not always catered for.

Social activities provided were not suitable for everyone and this placed some people at risk of social isolation.

Formal complaints were responded to in line with the provider's policy and procedures. Though we saw that when people made verbal complaints, they were not always supported to have their concerns listened to and acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was in breach of the condition of their registration because there was no registered manager in post.

The provider had not sent us information they are required to by law.

The provider did not have effective systems in place to assess and monitor the quality of service provided to people.

People who used the service were unaware of who was running the home.

Hilderstone Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 12 and 13 September 2017 and was unannounced. The inspection was undertaken by two inspectors on 12 September 2017 and three inspectors on 13 September 2017.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed the information we had received from the public and the local authority. This included complaints about the service and monitoring visits. We used this information to formulate our inspection plan.

We spoke with four people who used the service, three visiting relatives, six members of care staff, one nurse and a chef. We did this to gain people's views about the care and to check that standards of care were being met.

We spoke with a number of people who worked for the provider and these included an operations manager who was currently managing the home, a registered manager from another home who had provided some management support, the Regional Director, the Senior Regional Director and the Regional Clinical Development Nurse. We did this to help us understand how the home was being managed.

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 observed how the staff interacted with people in communal areas and we looked at the care records of ten people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included five staff files, rotas and quality assurance records.

Inadequate

Is the service safe?

Our findings

People's risks were not safely managed to ensure they were protected. A number of people were assessed as being at 'very high' risk of falls and these risks were not managed safely. We saw there had been a high number of unwitnessed falls at the home and sufficient action had not been taken to avoid recurrences. For example, we saw that one person had 15 falls between April 2017 and the time of our inspection. All of these were unwitnessed in communal areas of the service. Their care plan stated that they had a sensor mat in place next to their bed at night time, in order to alert staff if they were to get out of bed, but there were no measures in place to reduce their falls risk during the day time. We saw them walking around communal areas unsupervised. Although their falls risk assessment had been reviewed monthly, no changes were made despite the person having regular falls so it was not clear to see how their falls risk was being managed. A referral had been made to the falls team though this was not done as soon as the high risk was identified and they had not yet been seen by the falls team to help reduce the risk. This meant action was not taken to reduce the risk of further falls and injury and people remained at risk of harm.

We observed people being supported unsafely to use equipment to help them to move and this left them at risk of harm. A standing hoist should only be used when the person has some ability to participate in the transfer, otherwise the practice is unsafe. We observed one person being supported by members of staff to transfer using a standing hoist but they did not participate in the transfer and were not encouraged to participate which made this practice unsafe. When we asked staff about this practice, they told us they did not know whether the person had been assessed as being safe to use the particular piece of equipment. This demonstrated that staff were not following care plans and risk assessments and this placed people at risk of harm.

Some people who used the service displayed behaviours that challenged, such as verbal or physical aggression. We found that these behaviours were not always effectively assessed and planned for, to promote people's safety and wellbeing. For example, we saw that one person had assaulted another person who used the service on more than one occasion. This had not triggered a review of this person's risks, so action had not been taken to prevent a similar incident from occurring again. Some staff we spoke with were unaware of this behaviour which meant they were unable to support them effectively. One staff member said, "[Person's name] is not aggressive to other residents. If they are we step in the middle and diffuse it." The person's care plan stated that they could be aggressive to staff but did not mention aggression to other people who used the service. This meant that the risks associated with this person's behaviours that challenged towards other people who used the service had not been assessed and plans were not in place to guide staff on how to protect people from these risks.

People's risk in relation to health needs were not always monitored and managed safely. One person had diabetes and their care plan stated that 'random monitoring' of their blood sugar was required but it did not state how often. Records showed that their blood sugar levels had been checked four times since their admission to the service in June 2017. All readings showed that their blood sugar was higher than expected which left them at potential risk of harm but no action had been taken to ensure their safety. This meant the person's condition was not monitored appropriately which compromised their health. We raised this issue

with the provider and they told us they would take immediate action to ensure the person had the support they required.

People's risk in relation to developing pressure sores was not always managed. Records showed that one person had a grade two pressure sore. Topical creams had been prescribed to manage this. However there was no evidence that these creams were being applied. Therefore we could not determine whether they were receiving this treatment. In addition, the person had been identified as needing to be repositioned every four hours to protect them from the risk of their skin deteriorating further. Their care plan stated they were unable to relieve their own pressure areas and records showed that staff had not supported them to reposition themselves at the times specified within their care plan, as the frequency of positional changes had exceeded the specified four hours. This meant their skin was at risk of further deterioration.

People's nutritional risks were not always managed well. For example, one person was at risk of choking and they had been assessed by a Speech and Language Therapist (SALT) as requiring thickener in their drinks to reduce the risk of choking. We saw they were given a drink without the correct amount of thickener directed by the SALT. This meant that the person was at increased risk of choking because staff were not following the instructions given the SALT. It was recorded in the person's daily notes that they were, "still needing prompts to swallow" but their care plan had not been updated to confirm they needed these prompts. We observed that they were not given these prompts when being supported to eat and this meant the person was at risk of not having the correct support to keep them safe whilst eating and drinking.

Medicines were not always managed so that people received them safely. We saw that one person had not received ten of their prescribed medicines for three days as they were out of stock in the home. The nurse in charge told us they had looked into the issue and the medicines would be available for the person the following day or the day after. No immediate action had been taken to ensure the person had their medicines so there was a risk that their health could deteriorate if they did not have their medicines as prescribed. When we informed the provider of this, they took action to ensure the person had their medicines available to them the same day.

Some people were prescribed 'as required' medicines such as pain relief and anti-anxiety medicines. Protocols in place for the use of these medicines were not detailed which meant that staff might not know or recognise the signs when people needed these medicines. For example, the protocol for one person's anti-anxiety medicine did not include details of how they displayed anxiety or what measures to try to help the person before medicines was given, so there was risk they would not receive their medicines safely. We saw that they had a protocol in place for their pain relief medicines but this was not followed as records showed that medicines were given which was not in line with the protocol in place.

When people were prescribed topical creams, we saw that effective recording systems were not in place to ensure they were applied as prescribed. For example, one person's topical creams record showed their cream was applied once daily, when it was prescribed to be applied twice daily and on one occasion records showed the cream was not applied at all during the day, so they were not being supported to have their creams as prescribed.

The above evidence demonstrates that people did not always receive safe care. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from avoidable harm and abuse. We saw incidents of potential abuse recorded on incident forms, or in people's daily records that were not always reported to the local authority in line with local safeguarding adult's procedures. Records showed that one person had hit another person

in the face. This incident had not been recognised as abuse and appropriate action was not taken to protect people who used the service from abuse. Following this incident staff recorded, "Staff to try and know whereabouts of residents to minimise risks." This did not adequately address the risk and we saw both these people were regularly unsupervised in communal areas which meant that there was a risk of further abuse.

The staff we spoke with were able to tell us about the different types of abuse which may occur and how to recognise these. However, records showed that when incidents of potential abuse had occurred, this had not been recognised and reported in line with local safeguarding adult's procedures. We also saw that action had not been taken to prevent further abuse following incidents and that incidents continued to happen despite staff being aware of the risks. Staff told us they would report incidents of abuse to the manager. However, there had been periods when there was no manager at the service. One staff member said, "It would be good to know how to report to the local authority because sometimes there is not a manager in. We put the incident reports under the office door." Staff did not have the knowledge of how to report incidents of abuse to the local authority which meant that incidents had gone unreported and people were left at risk of further abuse.

The above evidence demonstrates that people were not consistently protected from potential abuse and improper treatment. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always deployed effectively to ensure that people were protected from harm or exposure to the risk of harm. We observed that communal areas were regularly unsupervised despite some people being at significant risk of falls and people being at risk of abuse from others. We saw one person needed help to move and they were trying to attract attention from staff when they walked past the door of the small lounge. When they were unable to get the support they needed, we saw them shuffling to the edge of their chair and attempting to stand which left them at high risk of falling. Forty minutes later we saw that the person had moved their armchair into the doorway by shuffling it along whilst sat in it, which left them at further risk of falling. This showed that people were at risk of harm as staff were not present to support them.

We observed one person walking without their frame whilst carrying a hot drink. They looked unsteady and shouted for help. There were no staff present so we intervened and took the drink from them to prevent an accident. When we looked at the person's records we saw they had a number of unwitnessed falls and one of these had resulted in a fractured hip. Their care plan stated that they needed to use a waking frame but needed frequent reminders to use it. On the occasion we observed, no staff were present to remind the person to use their frame which left them at risk of further falls. This further evidenced that staff were not deployed effectively to keep people safe from harm.

Staff we spoke with told us there was not enough of them to meet people's needs safely. One staff member said, "People are waiting for us, we know that." Another staff member said, "I don't think there is enough staff. The lounges need more supervision, we have unwitnessed falls and incidents of residents hitting other residents but we can't always be there." We saw a number of incident records which showed that the majority of falls and incidents were unwitnessed. The acting manager told us that a tool was used to assess the required number of staff and this was reviewed monthly. However we could not see evidence of this. This tool also relied upon people's dependency levels being accurately assessed to ensure the correct number of staffing hours were planned to meet their needs and we could not see evidence that this was being done. This meant that we could not determine how the provider had assured that there were enough staff to meet people's needs and keep them safe.

The above evidence demonstrates that there were not always sufficient staff deployed to meet people's

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

We raised our concerns about staffing levels with the provider at the end of the inspection. They responded immediately to our concerns by increasing the staffing levels whilst a review of the care needs of people who used the service was completed. This action meant the immediate risk of harm to people through unsuitable staffing levels was reduced. We will check that safe staffing levels have been sustained at our next inspection.

The provider followed safe recruitment practices. Staff files we viewed included appropriate references, including those from previous employers. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

The principles of the Mental Capacity Act 2005 (MCA) were not followed correctly in order to protect people's rights. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Most staff we spoke with did not have a good understanding of the MCA, so they were unaware of their responsibilities in supporting people's decision making. One staff member said, "The MCA is briefly covered in the refresher training." We found that people's capacity to consent to their care had not been assessed when required. For example, one person had recently moved to the home and had some complex care and support needs. There was no evidence that they consented to their care plans or that their capacity to consent had been considered. Another person's care plan contained no evidence that they consented to their care. We also saw a number of examples where relatives had signed consent for the home to take photographs of people without having the legal authority to consent on behalf of the person. This meant the principles of the MCA were not always being followed.
The above evidence demonstrates that consent was not always sought in line with the MCA. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 authorisation 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 that some people's liberty was restricted and the correct authorisation for this had not been applied for. A staff member told us that one person was not allowed to spend time in their bedroom because it was unsafe. We looked at the person's care records and saw that their capacity to consent to this had not been assessed and a DoLS authorisation had not been requested to ensure that this was in the person's best interests. When people did have DoLS authorisations in place, staff were not aware of these which meant that people were not consistently supported to ensure that their care was provided in the least restrictive way possible. This meant that the MCA had not been followed to ensure that people consented to their care when they were able to and that plans in place were in their best interests.

The above evidence demonstrates that when people were deprived of their liberty, it was not always lawfully authorised. This was a further breach of Regulation 13 (5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported effectively by staff who had the required knowledge and skills. For example, we saw staff using unsafe moving and handling practices despite training records showing that most staff training was up to date. Staff told us they had received training. One staff member said, "I did a mandatory update day, it covers a lot of things but very quickly". However, we could not see evidence that staff competency was being checked to ensure that the training they had received was effective. Some staff

said they had received supervision and appraisals whilst other staff said they hadn't. We saw some records of supervision but there was no clear plan in place to ensure that staff had regular support and guidance and that their competency to deliver effective support was checked. This meant the provider could not be sure that staff were delivering effective care.

Discussions with staff identified that some people required support to manage their behaviour. We found that people were not always supported appropriately to manage their behaviour to reduce the risk of harm to themselves and others because staff were not provided with effective training to manage people's behaviours. One staff member said, in relation to behaviour that challenges, "We would benefit from more training." Another staff member said, "We've had no training on how to manage behaviour, we are not registered for behaviour that challenges." We saw that a number of incidents had occurred between people who used the service and staff were unable to describe how they effectively supported people on these occasions. This lack of effective training and guidance meant that staff were not equipped to manage the behaviour.

People were supported to have access to healthcare professionals. However, referrals were not always made in a timely way and professional advice was not always followed. For example, one person was referred to the falls team for advice and support in managing their falls risk. However this was not done until they had already experienced a high number of falls. Another person was referred to the falls team, the referral was not accepted and staff had not explored any alternative support for the person so they continued to experience the same issues without professional advice or support. We saw that professional advice was not always followed when it had been given. For example, a community psychiatric nurse (CPN) had advised that one person's medicine to help with anxiety was changed to a different type of medicine, this had not been done and staff had not followed this up to ensure that professional advice was actioned to help the person manage their healthcare needs. This person continued to display anxiety. When we asked the provider about this, they told us they were unaware of the recommendation from the CPN and that they would follow this up to ensure the person had the correct medicine and support.

Risks in relation to eating and drinking were not always managed well. For example, one person had a recent assessment by a Speech and Language Therapist (SALT) who had advised they needed thickener in their drinks to reduce the risk of choking and it was detailed that these recommendations were in their best interests. However, we saw and records showed that they were given drinks with less thickener than recommended by the SALT and there was no evidence that the SALT had advised that this practice was safe. This meant that staff were not following the risk management plan in relation to the person's eating and drinking.

We observed that people enjoyed their lunch and the food served was hot and looked appetising. One person said, "The food is alright, they do very reasonable lunches here." A relative said, "The food is superb." Soup was offered as a starter and we heard one person say, "Thank you, that was nice." People had a choice of food and drinks. We saw that deserts were showed to people on a trolley, which encouraged people to make their own choices. When people needed support to eat and drink, we saw that staff sat with them and talked to them whilst supporting them and that people were given the time they needed to eat their meal.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with were happy with care provided and the way staff treated them or their relatives. One relative said, "They're very nice here. They look after [Person's name] well." Another relative said, "They're ever so kind to [Person's name]." We saw staff chatting to people whilst they supported them to move and discussing the television programmes they all watched last night and we saw that people were smiling and enjoying the chat. However, some staff told us that they often did not have time to spend with people. One staff member talked about a person who was nursed in bed. They said, "[Person's name] loves company and cuddles but we just don't have an opportunity to go in." We observed that staff were busy and didn't have time to stop and sit with people. We saw one person alone in the small lounge. They looked uncomfortable and restless as they were walking around the room, sitting down then standing up and were frowning. Staff walked past the door but no one came to speak to the person for 13 minutes. They were not offered reassurance or asked how they were feeling. This meant that staff did not always have the time to talk and listen to people so that they felt they mattered and were given the reassurances they needed.

We saw that people were given some choices about their care. For example, we saw people were given choices about the foods they ate at mealtimes and where they would like to be supported to sit. Staff told us how they encouraged people to make their own choices. One staff member said, "People can make choices. We talk to them and you get to know their communication, you can show them two options and look at their eyes to see which they like best." However, some choices were made for people by the staff. For example, we saw that some staff put aprons on people without asking them or advising them of what they were doing. Another person was looking at a newspaper and dropped it on the floor. A staff member took the newspaper away and gave them a book to look at instead, without offering them a choice.

Staff told us how they promoted people's privacy and dignity. One staff member said, "We make sure people's bedroom doors are closed when we are supporting them and put a towel across them to cover them up." However, we saw that dignity was not consistently promoted. We saw one person sat at the dining table in their wheelchair and they had fallen to sleep with their head on the table. They were dribbling and other people were sat at the table eating their breakfast. A staff member woke the person and asked them to pick their head up, then they left and the person returned to the same position. This was not dignified for the person. Additionally they were not offered the opportunity to spend time in their room to relax or to sit in a more comfortable chair which would have been a more caring approach in supporting the person.

We also saw that some undignified language was used by staff in person and in care records. For example, we heard a staff member say to a person, "I thought you were being a good boy this morning?" We also heard staff refer to people who needed support at lunch time as "the assisted's". These were not examples of respectful or dignified care and support. We saw in care records that one person was referred to as being "foul mouthed." Another staff member told us that one person "kicks off sometimes." These were not dignified or professional methods of recording or describing a person's distress.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. Although people's preferences were recorded in their care plans, we saw and staff told us that people's preferences were not always catered for. For example, we saw in one person's care notes that they were supported to bed at 6.40pm. The person was not able to tell us if this was their choice and their care plan did not contain this information. When we spoke with staff they told us they were directed by senior staff to start assisting people to bed after tea time because it can take it a long time. A staff member said, "After tea we have to start putting people to bed. They don't have a choice." This meant that people's individual preferences were not prioritised over the needs of the service and support was task-led rather than tailored to people's preferences.

People were not always supported to follow their interests and take part in social activities. A staff member said, "Only the more able people are included in activities. We never have evening activities and people need stimulation." We saw one person sat at a table on their own whilst others participated in a game; we observed they had no interaction with people or staff for a long a period of time. The game only included people who were able to express a wish to participate and we saw that other people were not supported to engage in meaningful activity. There was an activities coordinator at the home; however we observed they spent much of their time supporting people with care needs rather than activities. This meant there was a risk of people being isolated and some people were not supported to participate in activities suitable for their needs.

Care records showed that people had been involved in some elements of care planning. For example, care records contained information about people's preferences and some staff were aware of people's preferences. For example, we saw one person being asked if they would like to sit near the television as the news was about to start. Staff told us that the person enjoyed watching the news. However, staff overall were not consistently aware of people's preferences so person centred care could not always be provided. For example, a staff member told us they would talk to one person to try and distract them if they became anxious. When we asked the staff member what the person liked to talk about they said they did not know.

We saw that when people had made formal complaints, these had been responded to in line with the provider's policy and procedures. However, when people made verbal complaints, we saw that these were not always responded to appropriately. For example, we saw and staff told us that one person said they wanted to see the manager because they had asked for tea five times and not got it. Their requests to see the manager were not responded to and this resulted in them becoming upset and throwing their drink. This showed that people's concerns and complaints were not always encouraged and responded to in good time so that the provider could learn from these complaints in order to make improvements.

Inadequate

Is the service well-led?

Our findings

There was no registered manager at the home since 6 June 2017. As part of the provider's condition of registration they are required to have a registered manager in post. This was a breach of Regulation 5 of The Care Quality Commission (Registration) Regulations 2009 (Part 2).

At the time of the inspection, the provider told us that a permanent manager had been recruited but not yet started. An operations manager was responsible for the management of the home until the new manager was in post. The provider told us the new manager would start their application process to register with us as soon as they were in post.

We found the provider had not informed us of some important events that had occurred in the home, which is a requirement of registration with us. We had not received any notifications of abuse or allegations of abuse in relation to people who used the service since 2 September 2016. However, incident logs and people's care records showed that incidents of potential abuse had occurred. This meant the provider was not meeting the requirements of their registration with us by keeping us informed of risks to people.

This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009 (Part 4).

We spoke with a person who worked for the provider and was a registered manager at another of the provider's services. They had been providing some management support at Hilderstone Hall. They told us that the process for reporting safeguarding adults concerns was that staff would complete an incident form which would be reviewed by the manager who would make a safeguarding adults referral to the local authority if required. Staff also confirmed that they followed this process. However, as there had been no consistent manager at the home, this process had not happened and no alterative system had been implemented to ensure action was taken when allegations of potential abuse were made. This meant that safeguarding adults concerns had not been identified and reported as required, investigations had not taken place, protection plans were not implemented and people remained at risk of further harm or abuse as a result of this.

There was no effective system in place to ensure that accidents and incidents were analysed to look for trends and actions were not taken to manage risks to people. A person who worked for the provider told us that incident and accidents are usually monitored by the manager and inputted onto the provider's clinical system to be discussed at a monthly clinical governance meeting. However, we could see no evidence that this had been completed at Hilderstone Hall or that monthly meetings had been taking place which meant that incident and accidents were not being consistently reviewed. A number of people who worked for the provider had provided management support to the service and we saw that some incident forms had been signed by various different managers. However, the lack of consistency meant that no one had clear oversight of the needs and risks of people and therefore suitable risk management plans had not been put into place.

We identified during the inspection that some people were not receiving their planned care. For example,

one person did not receive support to be repositioned every four hours to reduce the risk of skin damage. The current manager and provider were not aware of all of the issues we identified. A senior carer told us they were responsible for checking people's daily records to make sure they received their care as planned. We asked them what they did if they identified that people were not receiving their planned care. The senior carer said, "I check the records daily, if there's any problems with the night staff then there's not a lot I can do about it but if it's the day staff I just go to them and tell them." This was not an effective way to ensure that people received their planned care as there was no clear record of actions taken and people continued to not receive their care as planned.

Effective systems were not in place to ensure people's care needs were being managed effectively. For example, the current manager and provider had not identified that plans were not in place to help staff manage people's behaviours towards others. This meant staff did not have access to the information they needed to manage these behaviours in a safe and effective manner. As a result of this, people were at risk of receiving unsafe and inconsistent care.

We found that some quality checks were completed by staff at the home but these were ineffective in driving improvements to the safety and quality of care. An audit of care plans had been completed by a regional manager in July 2017 which identified actions to be completed in order to improve the quality of the care plans. However it did not state who would complete the action and how compliance would be monitored. We saw some of the issues identified from this audit were still apparent during our inspection. For example, the audit identified that 'regular' checks were referred to but no specific timescales were given. We saw that no specific timescales were identified in relation to one person's blood sugar monitoring which meant they were at risk of receiving inconsistent care that did not meet their needs and there was a risk that timely medical attention may not be sought. This showed effective action had not been taken to make and sustain the required improvements identified from the audit.

The above evidence demonstrates that systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of management oversight at the home. People and relatives we spoke with were not clear about the management arrangements at the service. One relative said they had "no idea" who the manager was and people told us there had been no recent resident or relatives meetings to share information with people who used the service. Records showed that the last resident and relatives meeting took place in April 2017 and there were no plans for another to be held. The current manager told us that a meeting was due in October 2017 but no arrangements had been made. This showed that there was little opportunity for open communication between the management team and people who used the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition
Treatment of disease, disorder or injury	The provider did not have registered manager in place.

The enforcement action we took:

We issued a Notice of Decision to impose positive conditions on the provider's registration to ensure risks were addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	We found the provider had not informed us of some important events that had occurred in the home, which is a requirement of registration with us. We had not received any notifications of abuse or allegations of abuse in relation to service users since 2 September 2016. However, incident logs and people's care records showed that incidents of potential abuse had occurred and we had not been notified about these. This meant the provider was not meeting the requirements of their registration with us by keeping us informed of risks to people.

The enforcement action we took:

We issued a Notice of Decision to impose positive conditions on the provider's registration to ensure risks were addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Consent was not always sought in line with Mental Capacity Act 2005.

The enforcement action we took:

We issued a Notice of Decision to impose positive conditions on the provider's registration to ensure risks were addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care.

The enforcement action we took:

We issued a Notice of Decision to impose positive conditions on the provider's registration to ensure risks were addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not consistently protected from potential abuse and improper treatment and people's liberty was restricted unlawfully.

The enforcement action we took:

We issued a Notice of Decision to impose positive conditions on the provider's registration to ensure risks were addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process were not established or operated effectively to ensure that people received a good quality and safe service.

The enforcement action we took:

We issued a Notice of Decision to impose positive conditions on the provider's registration to ensure risks were addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff deployed to meet people's needs.

The enforcement action we took:

We issued a Notice of Decision to impose positive conditions on the provider's registration to ensure risks were addressed.