Hillgay Ltd

Hilgay Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 26 September 2017 and was unannounced. Hilgay Care Home provides residential care for up to 35 older people. There were 28 people living at Hilgay Care Home 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.

The registered manager had left in June 2017 and at the time of the inspection there was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was in the process of applying to become the registered manager.

At the last inspection on 19 and 20 July 2016 we found breaches of four regulations relating to inadequate levels of staffing, lack of support at meal times, lack of person centred care and poor management oversight. The provider sent us an action plan on 4 October 2016 explaining what they would do to ensure that they were meeting the regulations by the end of November 2016. At this inspection on 26 September 2017 we found that some improvements had been made but there continued to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because there were not sufficient numbers of suitable staff employed. We also identified other areas of practice that needed to improve.

People, their relatives and staff all told us that there were not enough staff on duty. People were having to wait for their care needs to be met. One person said, "I always have to wait a long time for my call bell to be answered." During the inspection we observed that people's call bells were not always answered promptly and one person waited for 30 minutes. One person said, "Sometimes I wait so long for staff to come I wet myself." A relation told us, "They (staff) try their best, but they are always short staffed." Staff members we spoke with were all clear that there were not enough staff on duty. One staff member said, "The care gets done but people have to wait for it." The provider was using high numbers of agency staff to cover for vacant posts over a sustained period of time. Staff told us that agency staff were not always available. Records showed that staff numbers had not remained consistent with the provider's dependency tool which identified how many staff were needed to care for people's needs safely. This meant that the provider had not fulfilled their plan to improve staffing levels following the previous inspection in July 2016 and it remained that there were not always enough staff on duty to care for people. Following this inspection, we received further information about staff working at night who were not trained to administer medicines. This showed that the provider had not ensured that the skill mix of staff was always suitable to meet the needs of people. This was a continued breach of the regulations.

The provider had put an action plan in place following the last inspection on 19 and 20 July 2016 to address

the breaches that were identified. Whilst they had followed their plan in most respects and met the previous breaches, there had been a failure in management oversight to ensure that improvements needed were effectively identified and sustained. This was identified as an area of practice that needed to improve.

People's social needs were not always being met. The number of organised group activities had improved since the last inspection and people told us that they enjoyed the organised activities provided. However at other times people did not have enough to do. One person said, "There is nothing for me to do here, what can I do?" Consideration was not always given to people's gender, their individual needs and preferences. People told us they were bored and our observations confirmed that people had little access to activities or occupations that were stimulating and relevant. This was identified as an area of practice that continued to need improvement.

Risks to people were being identified, monitored and managed. People told us they felt safe living at the home. One person said, "Staff help me when I get anxious." Risk assessments and care plans guided staff on how to provide care to people safely. People told us they received their prescribed medicines when they needed them and we observed that staff were managing the administration of medicines safely.

Staff understood their responsibilities to safeguard people and knew how to report any concerns. There were robust recruitment procedures in place to ensure that staff were suitable for their roles.

People had confidence in the skills of the staff. One person said, "I can't fault the staff they are all good." A visitor said, "The staff are very clued –up, they definitely know how to care for people." Staff told us they were supported and had opportunities for training and records confirmed this. Staff had received training in the Mental Capacity Act 2005. They understood their responsibilities regarding gaining consent from people. One staff member said, "We need to get people's agreement for things, if they don't consent we have to accept their decision."

People told us they enjoyed the food at Hilgay Care Home and they were receiving the support they needed to have enough to eat and drink. The chef had good knowledge of people, their needs and preferences. One person said, "We have lovely food here, yes very good." People told us they were supported to access health care service when they needed them. A visiting health care professional told us that staff made appropriate referrals in a timely way.

Staff had developed positive relationships with people and knew them well. One person said, "They are all caring and kind. Not a bad one amongst them, including the agency girls." Staff were kind and caring in their approach and respected people's dignity. People were supported to make decisions about their care. One person said, "They are always asking me for my views. I tell them I don't mind." A relative said, "We are here today to discuss how things are going."

Care plans were well personalised with details that supported staff to provide care in a person centred way. We observed that staff were familiar with people's chosen routines and noticed changes in their needs. Care plans were reviewed and updated regularly and gave an accurate description of the care provided.

People told us they knew how to complain and would speak to the manager or a member of staff if they had any concerns. The provider had a complaints system in place and this was visible in the home.

There were a number of management tools used to monitor standards and quality of the service. The management structure was clear and staff understood their roles and responsibilities. Staff and people said that they had a visible presence in the home, one person said, "The owner is here most days now." The

provider demonstrated their commitment to making improvements and told us, "This care home is my passion, I will not fail, there are too many people relying on me."

We identified two continued breaches of the regulations because the provider had not ensured that there were sufficient numbers of staff to care for people safely or that the skill mix of staff was suitable to meet people's needs. 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?

Requires Improvement

The service was not consistently safe.

There was not always enough staff on duty to care for people safely.

Risks to people were managed with clear plans to guide staff.

People's medicines were managed safely and staff understood their responsibilities with regard to safeguarding people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had the training and support they needed to be effective in their roles.

People were supported to have enough to eat and drink and were able to access the health care services that they needed.

Staff understood their responsibilities with regard to the Mental Capacity Act.

Is the service caring?

Good

Staff were caring.

Staff knew people well and treated them kindly.

People were supported to express their views and be involved in decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's social needs were not always met because there was a lack of social stimulation.

Care was provided in a person-centred way and care plans reflected people's wishes and preferences.

There was a robust complaints system in place.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Lack of management oversight meant that there had been a failure to improve and sustain improvement in some areas of practice.

There was a clear vision for the service and the provider was committed to making improvements.

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 26 September 2017 and was unannounced. The inspection team consisted of 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 service.

Before the inspection we reviewed information we held about the service including 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. This included some concerns that we received about staffing levels at the home and the use of high number of agency staff on a regular basis. The provider had submitted a Provider Information Return (PIR) before the inspection. A PIR 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 that we were addressing any potential areas of concern at the inspection.

We spoke to 12 people who used the service, four relatives, three visitors and two visiting health care professionals. We interviewed six members of staff and spoke with the provider. 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 also 'pathway tracked' three of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the provider's information systems.

At the last inspection of 19 and 20 July 2016 we identified four breaches of the regulations. The overall rating for the service was Requires Improvement.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 19 and 20 July 2016 there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of suitable staff to meet people's needs and to keep them safe. The provider submitted an action plan in October 2016 that detailed how they would meet the legal requirement by the end of November 2016.

At this inspection on 26 September 2017, we found that staffing levels remained a concern for people, their relatives and staff. One person told us, "There are not enough staff and sometimes I wait so long for staff to come I wet myself." Another person said, "I always have to wait a long time for my call bell to be answered." A third person said, "There are not enough staff on, they don't have time to talk." A relative said, "It's a nice home and generally ok but there are definitely staffing issues." Another relative told us, "They (staff) try their best, but they are always short staffed." Seven of the people that we spoke with told us they usually had to wait "a long time" for their call bells to be answered. We observed that call bells were ringing during the inspection and on some occasions it took staff a long time to answer them, for example one call bell was ringing for 30 minutes.

Staff told us that they were "stretched" because there were not enough staff on duty. One staff member said, "There are lots of people here who need two carers to give them care and we're really stretched. The care gets done but people have to wait for it." Another staff member said, "There's just not enough staff at the moment." We looked at staff rotas and found that the number of staff on duty varied. The provider used a dependency tool to calculate how many staff were required to meet the needs of people. This showed that six staff members were required during the day to care for people safely. The rota documents that we examined showed that there were not always the required numbers of staff on duty. We noted that numbers varied and had worsened within the period examined. For example, on the morning of our visit, there were only three care staff present. Staff told us this was due to sickness, annual leave and because there were not always agency staff available to cover shifts.

Staff members told us that one staff member had been asked to come in that morning although they were taking a week's leave. They said it was not unusual for staff to change their leave when agency staff were not available. Staff told us that high numbers of agency staff were used regularly and this was confirmed in the records we looked at. One staff member said, "We are using loads of agency staff. Although some are good, it still makes it even harder because they need support, we have to show them what to do." Another staff member said, "It's got much worse lately." A third staff member said, "I've been on when there have been just two of us. It's not safe." A visiting health care professional commented on staffing levels, saying they often had to wait for staff to answer the front door when they came to visit people at the home. They said that this was a particular issue at the weekend. "It's because they haven't got enough staff on duty, people's needs have increased over the years but they just haven't got enough staff."

We asked the provider about staffing levels and they acknowledged that there were difficulties. They explained that a programme of recruitment was underway and we noted that some interviews were taking place on the day of the inspection. They told us that they were doing all they could to improve the situation

and they were regularly covering shifts, including night shifts themselves. Although recruitment was a priority for the provider, they acknowledged that it would be sometime before the new recruits had completed their recruitment checks and induction training to enable them to begin work. The provider remained reliant upon using agency staff to ensure adequate cover in the meantime. Changes to the staff team had been planned following the last inspection on 19 and 20 July 2016. However, since that time, the provider had failed to oversee the recruitment and retention strategy and this meant that planned improvements had not been implemented, embedded and sustained and people's needs continued not to be met in a timely way. Following this inspection, further concerns were received regarding the deployment of staff at night who did not always have the skills needed to administer medicines to people. The provider told us that arrangements were in place to ensure that people would have access to their medicines if they needed them, however this meant that additional staff would be brought in if the need arose and there was a risk that there would be a delay in people receiving their medicines when they needed them. This meant that there continued to be a lack of sufficient, suitable staff to care for people safely. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 19 and 20 July 2016 we found that risks to people were not being consistently managed and care plans lacked sufficient detail to guide staff on how to provide care safely. This was identified as an area of practice that needed to improve. At this inspection on 26 September 2017, risk assessments had been completed and care plans had improved and were more detailed. For example, two people had been assessed as being at high risk of developing a pressure sores, their risk assessments had been regularly reviewed. We noted that staff had contacted the district nurse when they noticed that one person was developing a pressure wound and the nurse had left information for staff about actions they should take. Records demonstrated that staff were encouraging the person to comply with the nurse's recommendations for bed rest.

People were living with a range of care needs, including arthritis, diabetes and some people were living with dementia. Most people needed some support with their personal care, eating, drinking and mobility. Staff were using validated tools to assess risks to people and care plans provided guidance for staff on how to support people safely. For example, one person had sensory loss and a risk assessment highlighted the importance of ensuring that they were wearing their hearing aid before assisting them to move. We noted that a staff member checked that the person had their hearing aid in before they supported them to move, giving clear verbal guidance and encouragement. This showed that risks to people were being effectively identified, monitored and managed.

People told us they felt safe living at the home. One person said, "The staff are here for us." Another person said, "Staff come with me in the lift and I feel safe." A third person said, "Staff help me when I get anxious." Environmental risk assessments were in place and regular checks ensured that the premises and equipment were safe. There were Personal Emergency Evacuation Plans (PEEP) in place for each person which outlined how they could be supported to evacuate or be kept safe in the event of an emergency, such as a fire or flood. Some people had difficulties with mobility and there were manual handling risk assessments and care plans to guide staff on how to support people safely. Mobility care plans identified specific equipment that should be used, such as a stand-aid, and the type of sling that was suitable for the person as well as identifying the number of staff required to support the person during the manoeuvre. This ensured that staff had clear guidance when supporting people to move safely.

A record was kept for any incidents or accidents and the provider had oversight of this. We noted that appropriate actions had been taken to reduce the risk of further incidents. For example when someone had a fall the accident was investigated to identify possible causes or reasons and care was reviewed to avoid reoccurrences.

People were receiving their medicines safely. Medicines were stored securely and there were daily checks in place to ensure the fridge and room temperatures were within recommended ranges to help keep medicines safe for use. Medication Administration Records (MAR) were accurate and up to date. Some people were receiving PRN or 'as required' medicines. There were clear protocols in place to guide staff in how, when and why they should be taken and included maximum doses over a 24 hour period. One person living at the home received medicines covertly, that is without their knowledge or consent. We noted the care plan contained a mental capacity assessment, evidence of 'best interests' decisions and a referral for Deprivation of Liberty Safeguards (DoLS) authorisation. This was consistent with the law. People told us that they received the medicines they needed. One person said, "They are very conscientious about the medicines, there's never a problem.

There were robust recruitment procedures in place, and appropriate checks were undertaken before staff began work. This meant that the provider had ensured that staff were suitable to work with people. People were cared for by staff who understood their responsibilities with regard to safeguarding people. They were able to identify signs of abuse and understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would speak to a staff member who wasn't treating someone right and tell my senior (care staff member)". Another staff member told us, "If the manager didn't do something (about an abusive situation), I would let you (CQC) know".

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that they had confidence in the staff. One person said, "They are very good, they know what they are doing and pay close attention to what we need. I think they are well trained." Another person said, "I can't fault the staff they are all good." A visitor told us, "The staff are very clued –up, they definitely know how to care for people." Despite these positive comments were found that not all staff had the skills they needed to be effective in their roles.

The provider was using a high proportion of agency staff to cover for vacant posts at the home on a regular basis. Not all the agency staff had the skills and knowledge they needed to meet people's needs. Following the inspection we received information that agency staff , who were working on night shifts, were not able to administer medicines. The provider confirmed this but said that they had made arrangements for people to receive their medicines if they were required. The provider had failed to ensure that the skill mix of staff was always suitable to meet the needs of people. This was a breach of Regulation 18 of the Health and Social Care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had opportunities for training and development. One staff member said, "I have done quite a lot recently." Another said, "We are being supported with more training now." Staff told us that there was a robust induction process for new staff. One staff member told us, "I did get an induction. I shadowed other staff until I felt okay. There was a lot of training too." Training records confirmed that staff were able to access training in subjects relevant to the care needs of the people they were supporting such as dementia awareness, nutrition and health and pressure area care. We observed staff supporting one person who was living with dementia and who had behaviour that could be challenging to others at times. Staff were calm and confident in their approach, using appropriate techniques to reassure the person when they showed signs of becoming distressed.

Staff were receiving regular supervision. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Staff described their supervisions as "open and honest," and said they had the opportunity to address issues with managers both in the supervision process and day to day.

At the last inspection on 19 and 20 July 2016 there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always receiving sufficient support at meal times. The provider submitted an action plan in October 2016 that detailed how they would meet the legal requirement by the end of November 2016.

At this inspection on 26 September 2017 we found that the provider had followed their action plan and this breach of the regulations had been addressed. People told us they enjoyed the food at Hilgay Care Home. One person said, "The food is usually good, and there is a choice." Another person said, "We get two choices at lunch time one is meat and the other is usually you know, no meat." A third person said, "It's nice food, not like being at home, but plenty of it," and another person told us, "We have lovely food here, yes very

good."

We observed the lunchtime meal. People were encouraged to sit where they wanted to, staff members supported people to engage with other people during the meal. One person told us, "I like to sit with my friends at lunch time," we noted that staff ensured they were able to join the table of their choice. There was a calm and pleasant atmosphere throughout the meal time with music playing quietly in the background and people chatting with each other and with staff. Throughout the meal staff were checking that people had what they needed and were topping up people's drinks, offering support to cut up food and to eat when needed. People were offered second helpings and staff noticed when one person had not eaten much food. They checked if there was anything else they would like to eat and offered to make a sandwich.

The chef had a good understanding of people's nutritional needs and their preferences. They were able to tell us about people's particular needs and knew who had a good appetite and who needed smaller portions. During the morning the chef was chatting to people in the lounge and dining room. People were asking what was on the menu for lunch and the chef was explaining that one option was a chicken curry. One person said, "I love curry," and the chef replied, "I know you do, I'll make sure there's mango chutney to go with the curry, you like that don't you?" The person smiled and nodded their agreement. Another person told us, "He (chef) knows I like custard, he always gives me extra."

Some people were assessed as being at risk of malnutrition and/or dehydration. Risk assessments had been completed and care plans identified the support that people needed. A Malnutrition Universal Screening Tool (MUST) was used to assess the risk and people had their weight monitored regularly. We noted that one person had been losing weight previously but this had now stabilised and their risk of malnutrition had reduced. Another person had been assessed by a Speech and Language Therapist (SALT) following difficulties with swallowing and they now needed to have a soft diet. Staff were aware of this and we saw that was being provided. People were offered drinks regularly through the day and records confirmed that drinks and snacks were being offered. One staff member told us about the introduction of a "mocktail morning" where fruit cocktail drinks were offered made with fresh fruit to increase people's nutritional intake. People told us they enjoyed this, one person said, "It's a bit of fun, we all have a laugh."

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 we spoke with had not received recent training in the MCA or DoLS however they demonstrated a good understanding of their responsibilities with regard to the legislation. They understood the rights of people with mental capacity to take risks. One staff member gave an example, saying, "We need to get people's agreement for things, if they don't consent we have to accept their decision" Another staff member said, "We can't force people to do something against their will, they have the right to refuse." DoLS authorisations had been grated for some people; staff knew this and were aware of their responsibility to comply with these authorisations when providing care.

We observed staff checking with people and gaining their consent before supporting them with care. For

example, staff were heard asking people, "Would you like some help to stand up now?" and, "Can I cut that up for you?" They waited for a response from the person before commencing to assist them. Some people who were living with dementia lacked capacity to make specific decisions and had appointed representatives or advocates to deal with their affairs. The provider had checked that representatives had the legal authority to make decisions about the person's care and welfare.

People were supported to access the health care services that they needed. People told us that staff were proactive in making referrals when needed. One person said, "If I'm ill the staff pick up on it and call the doctor." Another person said, "I needed anti-biotics, the staff soon had it all organised. I don't have to worry." A visiting health care professional told us that staff were quick to contact them if people needed support, for example if they noticed changes or deterioration in their health. Another health care professional said the staff were knowledgeable about the people they were caring for. They confirmed that staff referred to them appropriately and they managed people's care safely and effectively. Records confirmed that people were supported to attend hospital appointments, and had interventions with a range of health care professionals including, dieticians, opticians, chiropodists and nurses.

Good

Is the service caring?

Our findings

At the last inspection on 19 and 20 July 2016 we found that people were not always supported to maintain their self- esteem, dignity or respect. This was identified as an area in need of improvement. At this inspection on 26 September 2017 we found that there had been improvements and throughout the inspection we observed positive interactions and conversations being held between staff and people. The provider told us that staff were receiving regular supervision, training and support to ensure that they understood the importance of maintaining people's dignity. Throughout the inspection we observed that staff were encouraging and respectful when supporting people.

People and their relatives told us they were happy with the care that was provided. One person said, "All the staff are lovely," another person said, "They are all caring and kind. Not a bad one amongst them, including the agency girls." A relative told us, "We think the home is great, we give it 9/10." Another relative said, "The staff always give 100%." People had developed positive relationships with the staff, one person said, "They are very kind." Staff knew the people they were caring for well and could tell us about people's needs and their individual traits and preferences. One staff member said, "We get to know and understand people very well." We observed staff interacting with people throughout the day. We noted staff were respectful and kind to people living at the home. We observed many instances of genuine warmth between staff and people. One person told us, "I would say the staff all get along with us very well. It's more of a friendship really, we pull each other's leg sometimes."

Staff told us that they supported people to be as independent as possible. One staff member told us, "It's important to support people to do as much as possible for themselves, it's a case of use it or lose it." One person said, "They are very encouraging, they know I can be anxious about walking so they stay behind me but they support me to keep going. It's so important." Another person said, "I still like to be independent, I can't go out alone but I do what I can." A relative told us, "My (relation) loves the freedom here, she can do what she wants." We observed staff supporting people to remain independent, for example one staff member was heard encouraging someone to use their walking aid. The staff member was giving the person clear instructions to guide them and encourage them to maintain their balance before taking another step. They remained attentive and patient with the person until they had achieved the manoeuvre. Another person was eating independently with the use of a plate guard, a staff member noticed them struggling and supported them discreetly to enable them to finish their meal independently.

People and their relatives told us that they had been included in making decisions about their care. One person said, "They are always asking me for my views. I tell them I don't mind." A relative said, "We are here today to discuss how things are going." Another visitor said, "They make sure I know what's going on, there is a legal representative as well and they always involve us in decisions." Care records showed that people had been involved and developing care plans. Some future care plans were in place with details of people's wishes for care at the end of their life.

People were supported to maintain their personhood. For example, one person told us that they enjoyed having their nails painted in bright colours, they said, "I've always painted my nails, one of the girls (staff)

does it for me now." Another person told us that they regularly had their hair done and we noted that a number of people had visited the hairdresser on the day of the inspection. Staff members was heard complimenting people on their appearance. One staff member said, "Your hair looks so nice, you have a lovely head of hair." The person, who was clearly pleased with the compliment, smiled and thanked them. Many of the female residents had their handbags with them and some were wearing jewellery. This showed that people were being supported to maintain their dignity and their personal identity. We noted that some people had diverse cultural and religious needs. Their care plans identified this and included specific details to address their cultural needs with regard to end of life care.

People's confidential information was kept securely in a locked cabinet. People and their relatives told us that they were confident that staff respected their privacy. One person said, "They always close the door to give me privacy."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 19 and 20 July 2016 there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always receiving care and treatment to meet their assessed needs or which reflected their preferences or wishes. The provider submitted an action plan in October 2016 that detailed how they would meet the legal requirement by the end of November 2016. At this inspection on 26 September 2017 we found that the provider had followed their action plan and improvements had been made in developing person centred care plans. However planned improvements to address people's social needs had not been fully implemented and sustained. This meant that whilst the breach of regulations had been met, the provision of meaningful occupation for people remained an area of practice that needed to improve.

People's social needs were considered within their care plans and information about their preferences and interests were included. Some care records contained information about people's life histories this meant that it was possible to 'see the person' in care plans. Details about their past experiences, and things they had previously enjoyed doing were included. For example one person's life history showed they had previously enjoyed arts and crafts, another person had liked to travel and a third enjoyed music. The activities co-ordinator had included some of these pursuits, such as music, and arts and crafts within the activity programme. We noted that there were more events and activities available to people then at the previous inspection in July 2016.

Since the previous inspection the provider had employed an activities co-ordinator who told us that the activities programme was based upon feedback from people about what they enjoyed. They told us that there was a music session once a fortnight with an external entertainer and an arm-chair exercise session once a week. Most people told us they enjoyed the organised activities. One person said, "I enjoy the crafts we make," another person said, "I made a bird box, we make them up and paint them." We noted examples of people's art work were displayed in the lounge area. The activities co-ordinator described arranging board games, quizzes and bingo sessions during the week and this was identified on an activities plan. On the day of the inspection we observed people joining in with the Bingo session. The chef told us they sometimes arranged cooking sessions and described having recently made pizzas with people that were then cooked and served for tea. One person told us how much they had enjoyed this and told us, "The chef is lovely."

Organised activities were happening on some days of the week. We noted that there were no activities planned for three days of the week including the forth coming weekend. When organised activities were not happening, there were few opportunities for people to engage in a meaningful occupation. Most people told us they enjoyed the organised activities but at other times they were bored and had nothing to do. Some people told us they didn't join in because the activities provided were not of interest to them. Their comments included, "There isn't much to do, I get very bored," and, "The staff are too busy to take us out or anything like that." Notes from residents and relative's meetings showed that people had been disappointed that they could not access the garden more often during the summer. One person told us, "I would love to get out there, but we need staff to go with us and they are too busy." We asked a staff member

about this and they told us that there were plans to redesign the garden to improve safety and enable more people to have independent access to the garden.

Not everyone at the home felt that there were activities available that were meaningful or relevant for them. For example, some men living at the home told us there were no specific activities available to support their interests. One man said, "There is nothing for me to do here, what can I do?" He pointed out that, for example, there were plenty of magazines in the conservatory area for people to look at however, these were specifically aimed at women. The activities co-ordinator told us that they did not provide specific activities for men, this means that consideration was not given to people's gender.

During the morning of the inspection no activities were planned. Some people were able to amuse themselves by reading a newspaper of magazine. However there were no other resources within reach for people to use independently. Staff were noted to be around to offer drinks and biscuits to people but no staff were spending time with people or engaging with them. This meant that some people were sitting with nothing to do and no stimulation for long periods of the day. This is an area of practice that needs to improve.

Care plans were personalised and included details about how to support people with their daily routines. This included details that were important to people such as, "Likes to have jumpers and blouses done up, but doesn't like tight clothes." Another example described a person's particular routine, describing the tasks that they were able to complete independently and what they needed support with. People's preferences were noted for example, one care plan included that the person, "Likes to sleep on top of the covers and does not like wearing pyjamas." Staff told us that the detail in care plans helped them to provide care in a more person-centred way. The staff we spoke with were knowledgeable about people and the care they received.

Care plans contained relevant and up to date information. For example, a person was living with diabetes and there was clear guidance for staff on how to support the person to manage their condition. This included regular eye checks and foot care as well as having blood glucose levels monitored. Records confirmed that staff were following the care plan. There was clear guidance describing the signs and symptoms that might indicate that something was wrong and the actions to take in an emergency. Staff we spoke with were able to tell us in detail the care this person required to keep them safe and to promote good health.

People's needs were regularly reviewed and their care plans updated to reflect changes. For example, one person was assessed as being at risk of developing pressure sores. Staff had noticed changes in the condition of their skin, and had made an appropriate referral to the district nurse. The risk assessment and care plan had been updated and staff were following the guidance of the health care professional to support the person's skin integrity.

Another person was living with dementia and had visual sensory loss. They needed support to manage anxiety and their care plan described their need for a calm and quiet environment. There was clear guidance for staff in how to support them if they became anxious saying that they, "Like to touch and be touched, hold hands for reassurance and talk calmly and slowly." During the inspection we observed staff members successfully calming the person when they showed signs of becoming anxious with gentle touch and reassuring words. They told the person what was happening, ensuring they were included in what was going on around them, and held their hand as described in the care plan. This showed that staff had considered the person's sensory needs and were supporting them in an inclusive way.

The provider had a complaints system in place and it was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. People told us they knew how to complain. One person said, "I would talk to the manager," another said, "Any of the staff would help." Staff were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures and where to find them. One staff member said, "If we can deal with things before they become a complaint, that's better for everyone". The provider kept a log of any complaints and this included details about actions taken to address any concerns that had been raised.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 19 and 20 July 2016 there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of management oversight and failure to maintain accurate, complete and detailed records in respect to each person using the service. The provider submitted an action plan in October 2016 that detailed how they would meet the legal requirement by the end of November 2016. At this inspection on 26 September 2017, we found that the provider had made improvements to systems for care planning which were more person centred and comprehensive. Record keeping had also improved and this meant that records provided a clear and accurate reflection of the care being provided to people. This meant that the provider had addressed the previous breach of the regulations.

Some systems for assuring the quality of the service had improved however, there remained concerns about the lack of management oversight in some areas of practice. The registered manager had left the home in June 2017 and at the time of this inspection on 26 September 2017 the provider was in the process of applying to become the registered manager. They explained that the recruitment process was underway for a permanent manager but this position had not yet been filled.

The provider told us that a number of planned improvements had not yet been implemented, including recruitment to vacant posts within the staff team as detailed in their action plan following the previous inspection on 19 and 20 July 2016. The provider explained that they had not been aware that some planned improvements were not progressing until the previous manager had left. Some actions had been completed and there had been improvements in the quality of care plans, the accuracy of recording, and the support provided to people with food and drink. However in other areas of practice, lack of management oversight had resulted in a failure to improve and sustain improvement.

The provider had a system in place to assess the number of staff required to safely meet people's needs. The provider used agency staff to cover a significant proportion of hours each week to ensure that sufficient staff were on duty. However records showed that there had been a failure to ensure that all shifts were covered with the required number of staff as determined by the provider's dependency tool. Staff told us that it was difficult to keep up with booking the number of agency staff required in advance and at times agency staff were not available. The sustained dependency on agency staff was due to a number of vacant posts. The provider had identified the need to recruit more permanent staff following the previous inspection in July 2016, however there had been a failure to improve and sustain improvements in staffing levels.

We asked staff to tell us about morale at the home. All the staff we spoke with were concerned about staffing levels and spoke about the impact that the on-going high use of agency staff had on their morale. One staff member said they were tired because there was pressure to cover additional shifts due to staff shortages. Another staff member said that working with inexperienced or unfamiliar staff put additional stress on the existing staff group. They told us that they had spoken to the provider about their concerns and that they were aware that the provider was in the process of recruiting more staff. One staff member said, "We've been promised more staff. I'm hoping things will get better". Another stated, "We've been told lots of new staff

have been taken on and are waiting for their DBS's. It's not just about the numbers. They (management) need to make sure they get the right people as well." A lack of management oversight meant that there had been a failure to recognise and address the impact upon staff morale and well-being during the continued period with poor staffing levels. This was an area of practice that needed improvement.

Staff concerns were reflected in the notes of a recent staff meeting and the provider had acknowledged that recruitment was their main priority at the moment. One staff member said, "I think they are doing everything they can at the moment. This showed that staff felt able to raise their concerns with the provider and had confidence that the provider was now taking action to address the issue.

Systems had been put in place to assess people's needs and to develop holistic care plans which included people's social needs. There had been improvements in the organised activities programme but this had not addressed the social needs of all people at the home. The provider's quality monitoring systems had not identified that people did not always have access to meaningful activities or occupations that were stimulating and relevant for them. This meant that there had been a failure in management oversight to evaluate, improve and sustain improvements in providing personalised care that met people's social needs.

The management structure was clear and staff understood their responsibilities and what was expected of them. Although staff reported low morale because they felt stretched and pressured they demonstrated commitment to providing good standards of care to the people they were supporting. One staff member said, "I believe that things will turn round, in the meantime we are all doing our very best for the people living here." The provider had employed a consultant to assist with some elements of the management of the home. They reported that this had been helpful in identifying areas for improvement and they had also provided practical support such as providing supervisions for staff members.

Quality assurance systems were in place and a recent survey showed that people were satisfied with the care they were receiving. Actions were identified to drive improvements such as, including people in care plan development in a more meaningful way. Incidents and accidents had been analysed to look for trends or patterns and to check that appropriate actions had been taken to address identified issues. A number of audits were in place to monitor quality, for example, a health and safety audit gave the provide assurance that the required checks were being carried out regularly.

The provider did not have a documented development plan in place for the service. However when asked, they were able to list a range of actions that were planned with expected dates for achieving these. This included introducing a new call bell system and improving access to the garden. The provider had made links with external agencies to support them with developing the home, including the Local Authority Contracts Department, and Skills for Care who provided advise about training for care staff.

The provider had a clear vision for the home and described their commitment to making improvements and developing the service. They said, "This care home is my passion, I will not fail, there are too many people relying on me." Staff and people said that they had a visible presence in the home, one person said, "The owner is here most days now." Another person said, "She is very nice and easy to talk to." A relative told us, "At first we weren't too sure, but generally I think the changes will be for the best in the long run. They try and keep us up to date with everything." One staff member said, "There has been a lot of change and I think that will continue, but it is positive and I believe the owner (Provider) is totally committed." People also spoke positively about the changes, one person said, "The manager often comes in to give updates on what is happening, she told us about new staff coming and the garden is going to be changed too."

The provider understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. They were aware of the requirements following the implementation of the Care Act 2014. For example, they were aware of the requirements under the duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.

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 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to care for people safely. Regulation 18 (1)