Qualia Care Limited

Hillside Care Home

Inspection report

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Date of inspection visit:
09 November 2018
14 November 2018
16 November 2018
19 November 2018

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20 December 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 09, 14, 16 and 19 November 2018 and was unannounced on each of the four days. Prior to our inspection CQC received concerns regarding the safety of people and poor practice undertaken at the service. We inspected the service sooner than planned in response to the information we received.

This was the first inspection of the service since it was registered with CQC under the new provider Qualia Care Limited.

During this inspection we identified breaches of regulations 9, 10, 11, 12, 13, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Hillside is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hillside Care Home accommodates up to 119 people who require nursing and personal care. At the time of the inspection there were 66 people using the service.

The service provides accommodation in four separate units over two floors. At the time of the inspection three units were in use, the fourth unit was closed to admissions when the registered provider took over the service and they made the decision not to re-open it. Cedar unit is for people with nursing needs, Ash unit is for people living with dementia who also have nursing needs and Rowan unit is for young adults with a physical disability.

At the time of our inspection the service was not managed by a person registered with the Care Quality Commission (CQC). 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. There was a manager in post and they had applied to CQC to become the registered manager however their application remained pending at the time of this inspection.

The registered providers safeguarding processes and procedures were not followed to ensure people were protected from abuse. There was a delay in alerting the relevant safeguarding authority about an allegation of abuse made about a person using the service. A person was put at risk of harm because there was a failure to assess their mental capacity to consent in line with the Mental Capacity Act 2005.

Risks to people were not always identified and mitigated. We saw multiple examples on Cedar and Ash units were people were in bed and their call bells were out of reach. Risk assessments were completed for aspects of people's care, however care plans lacked information about identified risks and how they were to be

managed safely.

Some parts of the environment and equipment were unsafe and unhygienic. Rooms which were unlocked posed a risk to people's health and safety. This included a sluice room on Rowan unit where there was access to hot water which had the potential to scald, and store rooms on Cedar unit which contained items which posed a trip hazard. Some items of equipment used by people were unclean including crash mats, and hoist slings were unhygienically stored.

The number of staff across the service were maintained in line with the calculations worked out using a dependency tool. However staffing levels and skill mix on Ash unit were insufficient to meet the needs of people and keep them safe. We observed multiple examples where peoples call and requests for assistance were not responded to in a timely way and where staff lacked the skills needed to support the needs of people living with dementia. The deployment of staff on Cedar unit was not always effective in meeting people's needs at mealtimes.

A series of checks were carried out on applicants including a check with the Disclosure and Barring Service (DBS) to check on applicant's criminal back ground. However, references for some staff were not obtained from the applicant's most previous employer although the details were recorded on their application form, and there was no explanation for this.

Peoples needs were not always effectively assessed and planned for and people did not always receive care and support which was responsive to their needs. Care plans failed to identify people's needs and how they were to be met. There was no guidance available to staff on how to manage aspects of people's care such as dementia related behaviours.

Supplementary care records for monitoring aspects of people's care also lacked information and guidance for staff to follow and they had not been consistently completed to reflect the actual care and support provided.

Staff lacked the skills and knowledge about how to support to people when they exhibited behaviours which caused them distress. There was a lack of information for people on Ash unit about their hobbies and interests and how to keep them occupied and they were provided with little opportunity to engage in meaningful and stimulating activities.

Processes were not always followed in line with the Mental Capacity Act 2005 to ensure decisions were made in people's best interests. Care records lacked information around people's ability to consent and where authorisations placed restrictions on people to keep them safe, they were not understood and followed.

Parts of the environment were not suitably adapted to meet the needs of people. There was a lack of stimulus and wayfinding on Ash unit to help people living with dementia find their way around. There had also been a lack of consideration given to people's needs when colour schemes and contrasts were chosen prior to people moving onto Ash unit.

People were not always treated with kindness and compassion and their privacy and dignity was not always respected. Staff on Ash unit showed a lack of compassion towards people who were anxious and upset. Some terms used by staff on Ash and Cedar units when referring to people were undignified. Personal records were not always kept secure in line with data protection laws, putting people's confidentiality at risk.

The systems and processes in place for assessing, monitoring and improving the quality and safety of the service were not always effective. Risks to the health safety and welfare of people were not always identified and mitigated. Records were not properly maintained, accurate and kept up to date and there were many examples where records had not been signed and dated. The management of the service did not always promote an open and positive culture amongst the staff team. The registered provider's policies and procedures were not always followed to ensure people's health, safety and welfare.

Regular safety checks were carried out on equipment and utilities used at the service and a record of the checks were maintained.

People received the support they needed to maintain good nutrition and hydration. Meals and were modified in line with professional guidance for people who were at risk of choking and people were supported and encouraged to take prescribed food supplements when they needed them. People told us they got enough to eat and drink and that they enjoyed the food. Some meals however were not freshly prepared or served to people at the right temperature.

Not all people who used the service were able to comment about their experiences of using the service, however people spoken with told us they received the right care and support and that staff were kind and caring. Family members told us that they were happy with the care their relatives received and that they were made to feel welcome when visiting. Family members complimented staff for the high standard of care they provided people with and for love and excellent care they showed people.

Following the first and third days of inspection visit the registered provider shared details with us of the action taken in response to the concerns we raised during inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our findings below.

Is the service effective?

Requires Improvement

The service was not effective

Details are in our findings below.

Is the service caring?

Inadequate

The service was not caring

Details are in our findings below.

Is the service responsive?

Requires Improvement

The service was not responsive

Details are in our findings below.

Is the service well-led?

Inadequate

The service was not well led

Details are in our findings below.

Hillside 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 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 09, 14, 16 and 19 November 2018 and each day was unannounced. The inspection was carried out by; two adult social care inspectors on the first day, two adult social care inspectors and an inspection manager on the second day, one adult social inspector on the third day and two adult social care inspectors on the fourth day. The fourth day was an evening visit which commenced at 7pm.

Prior to the inspection, we reviewed information we held about the service and notifications we had received. A notification is information about important events which the registered provider is required to send us by law. We also reviewed the Provider Information Return (PIR). The PIR provides key information about the service, what the service does well and the improvements the registered provider plan to make. We contacted local authority commissioners, safeguarding teams and Knowsley Healthwatch for information about the service and used the information they shared with us to help plan the inspection.

During the inspection we spoke with ten people who used the service and seven family members. We used the Short Observational Framework for Inspection (SOFI) at different intervals throughout the inspection visit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the deputy manager, an area manager, registered provider, interim manager and interim clinical services manager, care staff and other staff who held various roles including kitchen staff and housekeeping staff. We looked at records relating to the care of seven people, four staff recruitment files, staff rotas, staff training records and quality monitoring records.

Inadequate

Is the service safe?

Our findings

The registered provider had systems and processes in place for safeguarding people from abuse, however they were not effective. On the first day of inspection we alerted staff to a potential safeguarding concern in relation to a person on Ash unit. We were assured by the deputy manager that they would, as a priority raise our concerns with the local authority safeguarding team. However, three days later when we followed up on the matter we were informed by the deputy manager that the referral had not been made. This put the person at risk of ongoing potential abuse. On the second day of inspection we were assured that a referral had been made to the local authority safeguarding team for their investigation. A safeguarding investigation into the matter is currently ongoing.

Arrangements in place at the service did not fully protect people who may lack the mental capacity to consent. One person often exhibited signs of pain but refused oral pain relief medication, however no steps had been taken in line with the MCA to establish if the use of covert medication was in the persons best interest to keep them safe from the risk of harm. There was conflicting information recorded in the persons care records with regards to their ability to consent to care and treatment. There was no capacity assessment completed for this person and no records to show that the best interest process had been followed in line with the Mental Capacity Act (MCA) 2005. Staff were of the view that the person had the mental capacity to make their own decisions and followed that principle when providing their care and support.

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

Risks to people were not always identified and mitigated. People's calls for assistance on Ash unit were not always responded to quickly. We saw examples where one person's calls for assistance were not answered in a timely way. In one instance It was over 40 minutes and in another over 20 minutes after the person activated their call bell before staff attended to them in their bedroom. In addition we saw multiple examples on Ash and Cedar units on the first day of inspection where call bells were out of reach of people in bed. For example, they were placed on bedside tables which were situated at the base of people's beds. We raised this with staff at the time and informed the deputy manager of this. Despite this we saw a further example on the second day of inspection where a call bell was out of reach of a person who we had previously identified on the first day of inspection. We raised this with staff at the time and the deputy manager. We were assured on the second day of inspection that regular checks would take place to ensure call bells were accessible to people. Call bells were within reach of people on the third and fourth days of inspection.

The environment was clean and hygienic and smelt pleasant throughout. However, there were some aspects of the environment which posed a risk to people's health and safety. On the first day of inspection a sluice room on Rowan unit was unlocked. The hot water to a hand basin in the sluice room exceeded 60 degrees, which posed a scald risk to people should they enter the room and use the sink. The door had a working lock however, the automatic closure device was not effective and required staff on leaving the room to manually pull the door tight into the recess to ensure it locked. On two occasions during our checks we

found the door unlocked because staff had failed to do this. We raised this immediately with the deputy manager and they arranged for the maintenance person to carry out the necessary repairs.

An out of use sign was displayed on the outside of a bathroom door on Cedar unit, however the door was ajar and packed with unused mobility equipment. This posed a falls hazard to people should they enter the bathroom. The door was locked after we raised this with staff. Hot water pipes were exposed in some bathrooms and toilets on Ash unit which had the potential to scald people. After we raised this with the deputy manager they arranged for the pipes to be covered.

Some items of equipment used to help people with their safety and mobility were unclean and unhygienically stored increasing the risk of the spread of infection. Crash mats next to some people's beds on Cedar and Ash units were heavily stained and a shower chair in a bathroom on Ash unit was rusty and stained underneath the seat. There were two hoist slings stored in a bathroom on Cedar unit. A member of staff removed the slings from the bathroom after we raised this with them.

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

There was a stock of personal protective equipment (PEE) and appropriate bins located across the service which staff used appropriately. For example, they wore disposable gloves and aprons when assisting people with personal care and they disposed of waste in dedicated bins. This helped to minimise the spread of infection.

Risk assessments were completed for aspects of people's care including skin integrity, moving and handling, nutrition and hydration. However, we saw examples where care plans lacked information about the control measures in place to minimise the identified risk and where information was inconsistent. For example, the identified risk section of one person's moving and handling care plan recorded that the person was at high risk of falls when moving around. The identified risk section in another person's care plan recorded; Refusing medication and the identified risk section on a wound care plan for a third person recorded; Skin breakdown. There was no information recorded on these care plans about how the identified risk was to be managed to minimise the risk of harm to the person. The outcome of a risk assessment for a fourth person identified that they were at high risk of falls, however their care plan recorded that they were at medium risk of falls. Whilst we did not see any evidence of negative impact for people, the lack of information recorded placed them at risk of not receiving safe care and support.

Accidents and incidents were recorded and analysed as they occurred in line with the registered provider's policy and procedure. Records evidenced incidents such as slips, trips and falls and any injuries sustained by people. The analysis of these incidents helped to identify any patterns or trends so that appropriate action could be taken to minimise the risk of further occurrences. The records included four incidents which had occurred during the month of November 2018, however there was no information recorded against the lessons learnt section for any of those incidents. We raised this with the manager at the time and they agreed to action this.

The registered provider had procedures in place for the safe recruitment of staff. A check with the Disclosure and Barring Service (DBS) was carried out on applicants before their employment was confirmed. A DBS check consists of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. However, recruitment records for a nurse employed did not include confirmation that a DBS check had been carried out. The nurse was not on duty when we checked recruitment records, however, we were assured the following day that proof of the check had been obtained and placed on the nurse's recruitment file. Reference checks were not obtained for

some staff in line with the registered provider's recruitment procedure. The procedure stated a minimum of two written references, one of which will be from the applicant's most recent employer, were obtained after a job offer, but before an appointment is confirmed and the person is allowed to commence work. Whilst two references had been obtained for staff we saw that they did not correspond with the previous employers detailed on the application forms of two staff. The interim manager agreed to action this. There was a process in place for checking that nurse's registrations were valid and up to date.

Some people were prescribed medication to be given 'as required' also known as PRN medication. These are items of medication were to be given to people when needed in line with the prescriber's instructions. However, on Ash unit there was no protocol in place for three people who were prescribed PRN medication. This meant staff did not have the information they needed such as why and when to administer the medication, maximum dose to be given at any one time and intervals between doses. In addition, there were no records maintained detailing when PRN medication was administered and the reason why. This made it difficult to audit how many tablets should be kept. We raised this with the nurse in charge at the time and they developed and put in place the required records for the administration of PRN medication. The medication room on Cedar unit was untidy and disorganised. We found it difficult to carry out checks on the stock of controlled drugs (CD) because the records and storage of them was disorganised. We did however evidence that the stock tallied with the records kept.

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

Staffing levels and skill mix of staff for each of the units were calculated using a dependency tool based on people's needs and occupancy levels. Staffing levels on the days of inspection were reflective of those identified through the dependency tool. However, our observations on Ash unit showed that people's needs were not always met in a timely way and by staff with the right skills. For example, calls bells were not responded to promptly and we observed examples where staff lacked the skills they needed to support people living with dementia. This is reported on further in the caring section of the report. We fed this back to the management on the first and second days of inspection and we were assured that an additional member of staff would be deployed on Ash unit each day. We were also assured that staffing skills on Ash unit would be reviewed and appropriate action taken to ensure people on Ash unit received care and support from staff with the right skills.

People on Cedar unit had their needs met in a timely way outside of meal times, however on the first day of inspection people were sat at dining tables for more than 30 minutes before having their lunch served. In addition, they waited up to 15 minutes after finishing meals before the next course was served. This was because the whole staff team were tasked with supporting people in their bedrooms with meals. We fed this back to the deputy manager on the first day of inspection and they agreed to review the staff deployment arrangements at mealtimes on Cedar unit.

We recommend that the deployment of staff is kept under review.

People commented that they felt safe living at the service, one person said, "I feel safe knowing there's always someone around" and another person said, "Yes, I feel safe and they [staff] treat me well." Family members told us that they thought their relative was safe and well treated. Their comments included, "I have no worries about [relative] safety, I'd let them [staff] know if I did" and "I think they [relative] is safe here."

The premises, equipment and utilities used at the service underwent regular safety checks. Records showed checks and tests had been carried out at the required intervals by a suitably qualified person. This included

checks on water temperatures and quality, fire alarms, call bells, bed rails and portable electrical appliances. The registered provider also had contracts in place for the routine maintenance and servicing of the main fire system, passenger lift and mobility equipment including hoists and slings.

Requires Improvement

Is the service effective?

Our findings

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 make 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met and we found this was not always the case.

DoLS applications for some people who used the service had been made to the local authority and authorisations were in place where a DoLS had been granted. However, some staff lacked understanding about what a DoLS meant for people and were unsure about which people had a DoLS authorisation in place. We saw two examples were a DoLS was in place for people however this was not reflected in their care plan records. In addition, there was no information about what the conditions of the DoLS were and no guidance for staff on how to ensure they were met.

Care files viewed included a document titled 'Consent to Care.' The documents were completed to indicate if a person had given consent for staff to manage aspects of their care and support such as medication, taking photographs, mail/post, and sharing of information with others. There was a note at the beginning of the document which stated,' A mental capacity assessment must be completed prior to gaining consent. However, there was no evidence in these care files to show that a capacity assessment had been carried out.

One person living on Ash unit had a DoLS in place which authorised staff to make decisions about the person's care and welfare which they deemed were in the persons best interest to keep them safe. However, staff were unaware of this and the person's care records stated that they had the capacity to make their own decisions. This resulted in the person not receiving appropriate care and treatment. We alerted the local authority safeguarding authority about this for their investigation.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) 2014.

People's needs were not always assessed and planned for in line with current best practise and evidence based guidance. For example, care plans in place for three people around managing their behaviour and mental health needs did not evidence that guidance from other health and social care professionals on how to effectively support the person had been obtained. Care records also lacked information about what was

the intended outcome for the person. Daily records for these people evidenced that they regularly displayed periods of confusion, upset and verbal and physical aggression. The records showed that on occasions staff offered reassurance to these people however there was no evidence of any other positive intervention and when reassurance was given what the outcome of that was for the person. Following the first day of inspection members of the community mental health team commenced visits to the service to review peoples mental health needs and provide input and guidance on developing effective care plans.

Some staff did not have the skills and knowledge to provide people with effective care and support. New staff were inducted into their roles and there was an ongoing program of training for all staff. The training matrix showed that training had expired for some staff however refresher training had been planned. Records showed that over 75 per cent of staff had undertaken dementia training, however this was not always effective as we saw many examples throughout the course of the inspection on Ash unit where staff failed to provide effective care and support to people living with dementia. For example, we observed that staff lacked knowledge and skills around dementia related behaviours such as aggression, agitation and anxiety and how to effectively support people when they exhibited these behaviours.

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

We saw some good examples on Rowan and Cedar units of staff effectively meeting people's needs and people living on those units told us that the staff provided them with the right care and support. One person told us, "They [staff] are brilliant," and "They [staff] do a great job" and "They've helped me every step of the way."

Parts of the environment were not adapted to meet people's needs. Ash unit lacked suitable lighting, decoration, signage and stimulus for people living with dementia. There were no focal points or items of stimulation to occupy people who spent their time keeping busy around the environment. Although some decoration had recently taken place no consideration had been given to choosing colours and contrasts to help people living with dementia to identify key features and rooms. Good use of colour and contrast can facilitate independent living, for example, by supporting people to find their way around and to use fixtures and facilities such as lighting, toilets and bathrooms unassisted. Bedroom doors on Ash unit were all painted in the same colour and there was no signage or items of memorabilia which could be used to help people identify their rooms.

The lighting along hallways leading to bedrooms on Ash unit were operated by motion detectors. Motion detectors identify when people are present and automatically activate lighting. However, the motion detectors were ineffective as there was a delay in lights turning on as people entered hallways. We raised this with the management and they assured us that they would arrange to have timing of the motion detectors altered so that lights were activated in a timely way.

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) 2014.

Communal lounge and dining areas on Cedar and Rowan units were decorated and furnished to a good standard and people told us they liked the décor and felt comfortable when occupying these rooms. Bathrooms and toilet doors displayed signage to help people on Cedar and rowan units find their way around.

People's nutritional and hydration needs were assessed and planned for using a nationally recognised tool. Care plans included information where people were identified as being at risk of choking and their food and fluids were modified in line with guidance from the speech and language therapist (SALT). Care plans also

detailed any support or assistance people needed to eat and drink and people's food likes and dislikes. Referrals were made in a timely way to dieticians where concerns were noted about people's weight. Nutrition and dietary supplements prescribed to people were given at the right times and people were encouraged to take them. Food was not always prepared in a timely way and served at the right temperature. This is reported on in more detail in the caring section of this report. People comment that they liked the food and that they got plenty to eat. Their comments included, "I enjoy the food, I like sandwiches at lunch time and have a hot meal at tea time," "The food is nice" and "We get plenty to eat and drink."

Care plans detailed people's physical healthcare needs and how staff were to support them. Details of primary healthcare services people were registered with were included in their care records along with the details of any contact people had with them. This included contact with GPs, dentists and opticians.

Inadequate

Is the service caring?

Our findings

People were not always treated with kindness and compassion. On the first day of inspection we observed that staff on Ash unit showed a lack of compassion towards people when they were anxious and upset. We heard one person from their bedroom continuously shouting out for help. When we visited the person in their room they pointed at their stomach and indicated they were in some pain. We alerted staff to this and their responses included "He's like this all the time," "He knows what he is doing", "Oh he's all there" and "He will refuse any painkillers." When staff attended to the person we heard them say things such as, "What do you want now" and "We can't help you if you won't take your medication." Staff spent no time with the person to reassure and comfort them.

Another person on Ash unit was visibly upset and a staff member told us the person regularly got upset. We asked the member of staff what emotional support they gave the person during these times and they shrugged their shoulders and replied, "This is just normal for him." A third person became upset repeatedly asking for family members, staff continuously replied by telling the person, "They will be here soon." Staff made no other attempt to reassure the person or to distract them away from their emotional distress.

Discussions staff held with people on Cedar and Rowan units showed they had good knowledge of people's personal histories and backgrounds and they used this knowledge to engage people in meaningful conversations. However, this was not always the case on Ash unit. Staff made little effort to stimulate people through meaningful conversations. We saw many examples on Ash unit where people constantly kept themselves busy by walking up and down hallways. One member of staff spoke about a person's background which could have explained why they liked to keep busy. However, staff failed to use this knowledge about the person to explore any other meaningful support which could be offered to otherwise occupy them.

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

We did however observe examples on Cedar unit when staff reassured people when they were upset. One person was visibly upset because they could not find a photograph, a member of staff sat close to the person, held their hand and reassured them that they would do their best to find it. Another example was when staff regularly checked on the wellbeing of a person who was anxious and confused after just moving into the service. Staff comforted the person, gave them lots of reassurance and encouraged them to socialise in the dining room with others. The person was later seen sat around a dining room table sharing laughter and banter with other people and staff.

People and family members commented that they thought the staff were kind. Their comments included, "They are marvellous, very kind to me," "Most [staff] are very helpful and caring," "I can't fault them [staff]" and "From what I see they [staff] are caring." The service had received a number of compliments. Family members complimented staff for the high standard of care they provided people with and for love and excellent care they showed people.

Language used by staff on Cedar and Ash units when referring to people was and undignified. Staff used task orientated terms during their discussions about people such as 'feeds' 'doubles' 'blends' and 'hots'. Conversations which took place amongst staff in front of people in dining rooms included; "Where are we up to with the feeds," "Have you seen to the feeds," "Which ones are you seeing to" and "I'll see to the hots." When asked what they meant by hots the member of staff told us, "Those who have a hot breakfast."

The preparation of food and meal time experiences were not always dignified. On the first day of inspection at breakfast time we observed staff scrapping plates of leftover food into a large bucket kept on a trolley in dining rooms. This practice was carried out in full view of people whilst they were dining and created a lot of noise. Two staff members described the buckets as 'slop' buckets. Breakfast items including toast, scrambled and poached eggs were made in bulk and left covered on hot trolleys in Cedar and Ash units. These items were served to people for their breakfast throughout the course of the morning. We sampled the food and found that the eggs were luke warm and the toast was cold and hard. Through discussions with staff we established that each unit has a toaster which should have been used by staff to make fresh toast for people when they were ready to eat their breakfast. Ash and Rowan units both had a toaster however we were told by the chef that the toaster on Cedar unit had broken in April this year and that it had not been replaced.

When we arrived on Ash unit we saw a person sat in a lounge chair with their breakfast of porridge and toast which was untouched on a side table next to them. The toast had been served on a paper napkin as opposed to a side plate. It was over 15 minutes after our arrival before staff approached the person to offer them with the encouragement and support they needed to eat their breakfast. People on Cedar and Rowan Units ate their meals at dining tables which were set with table cloths, napkins and condiments, however on the first day of inspection people on Ash unit were served their meals on bare tables which were uninviting. When asked about this a member of staff told us that the tables should have been set.

People's privacy was not always respected. On the first day of inspection we found multiple examples where people's personal care records were not kept secure and easily accessible to unauthorised people. On Ash unit files containing care records were left open on a table in the communal dining room. There were no staff present in the room at the time and the room was accessed by none care staff and visitors. Offices on Cedar and Rowan units where people's personal records were kept were unattended with the doors left wide open. On approaching an office on Cedar unit, we saw the door was wide open and overheard a member of staff sharing personal information about a person over the telephone. Although the information was being shared on a need to know basis our concern was that discussions of a personal nature about people could be overheard from the hallway used frequently by others, including none care staff and visitors. We raised our concerns with the management team at the time about the lack of confidentiality and security of people's personal records and they took immediate action to rectify this. This was a potential breach of the General Data Protection Regulation (GDPR) and relevant data protection law. Following the inspection, we were assured by the registered provider that appropriate action was taken to report our findings in line with the GDPR Regulation. Records were kept secure throughout the other days of inspection.

People were provided with personal care in their own rooms, bathrooms and toilets with doors closed and staff knocked on doors before entering rooms. We did however see examples across the service where bedroom windows which looked out onto public open spaces had no blinds or any other privacy screening. We saw an example on Ash unit where one person was awake in bed with their curtains open. The person's bedroom window overlooked the car park. We also saw examples on Ash unit where people in bed could been seen by others passing by because their bedroom doors where held wide open. We saw that a person being nursed in bed had removed their bed covers and was in a semi state of undress.

Bedrooms on Cedar and Rowan unit were personalised with items of furniture and other personal effects such as televisions, pictures, photographs, and ornaments. One person on Cedar unit invited us to view their room. The person proudly showed off their room that was personalised with may items which they told us were their own and helped them feel at home. However, we saw many examples on Ash unit where bedrooms had minimal items and lacked personalisation. Walls were bare making the rooms look sparse and uninviting. There was no evidence within people's care records to show that the lack of personalisation was either their choice or in their best interest.

This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) 2014.

Family members told us they felt welcomed when visiting their relatives and were offered refreshments. They told us they could spend time with their relative either in the privacy of the persons bedroom or in communal areas. There was a protected meal time policy operated at the service whereby visitors were asked out of respect for others not to visit communal dining areas during meals times. They did however have the option to wait in their relative's bedroom during meal times or if their relative agreed, accompany them to eat in their bedroom.

There was a range of information available to people and family members in and near to the reception area. This included leaflets and posters about things such as activities and advocacy services. The providers statement of purpose was also displayed and contained information about the provider and the service and standards people should expect. Other key pieces of information available included the procedures for safeguarding people and making a complaint.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care responsive to their needs. Through our observations, discussions with staff and on examination of daily records it was evident that one person living with dementia on Ash unit presented with behaviours that challenged, such as verbal and physical aggression. However, there was no care plan in place to instruct or guide staff on how to best support the person with this area of need. Despite this an Antecedent Behaviour Consequence (ABC) chart was implemented for the person in April 2018 and had been completed to date. However, there was no reason given for this and no guidance for staff on why, when and how to complete the ABC chart. The aim of using an ABC chart is to better understand what a person is communicating through their behaviours and what the triggers are so an effective care plan can be developed. Two staff members told us they didn't fully understand why the chart was in place and that they didn't always complete it. There was no evidence to show that the entries recorded onto the charts had been reviewed and used to develop an appropriate care plan for the person.

On the first and second days of inspection we regularly observed two other people on Ash unit visibly upset. A member of staff told us that both people often displayed these emotions and that it was usual for them. Despite this, care plans for both people did not reflect their emotional needs therefore there was no information or guidance available to staff on how to best support these people during periods of upset. We observed a lack of a consistent approach by staff when supporting these people which resulted in them not receiving the right care and support responsive to their needs.

Throughout the course of the inspection we observed very little activities taking place on Ash unit for people living with dementia. Some people spent their time keeping busy walking around the unit and others were sat at dining tables and in lounge chairs with no items of stimulation nearby, and no staff interaction. On the first and second days of inspection we noted that the TV was switched on in the lounge area on Ash unit with the volume turned down whilst people occupied this area.

Care plans for people living on Ash unit lacked information about people's hobbies and interests and ways in which staff could occupy people. People on Rowan and Cedar units told us that there were offered a range of activities facilitated by activity co-ordinators, and that they enjoyed them. Activities included, art and crafts, bingo and baking.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as people did not receive person centred care to meet their needs.

Food and fluid intake charts for people on Ash and Cedar units were not completed accurately. The British Dietetic Association (BDA) guidelines state that over a 24-hour period the average intake for adults including the elderly should range between 1600-2000mls. Charts did not provide the details of the actual amount of fluid the person was required to consume in a 24 hours period and this information was not recorded in their care plans. Staff were required to record onto charts the actual amount of food and drink the person had consumed throughout each day and night. However, we saw examples where the records had not been completed at all and examples where the actual amount of food and drink the person had consumed was

not recorded. One person's daily food and fluid intake chart showed no record of any fluids being taken over a 24-hour period and another example where a person had consumed just 600mls of fluid over a 48-hour period. There was a section on the charts titled ''Reason for poor oral intake' however this section had not been completed where people's food and fluid consumption fell below the recommended intake. Charts should have been reviewed and signed by nurses at the end of each day and night shift to assess whether people had received adequate food and fluids to prevent the risks of malnutrition and dehydration. However, most charts we reviewed had not been signed. Whilst we did not evidence any impact on people the lack of information and overview of the care provided placed them at risk of not receiving the right care and support responsive to their needs.

People at risk of developing pressure wounds slept on an air flow mattress. However, there was no information recorded in people's care plans about the use of airflow mattresses to reduce the risk of them developing pressure wounds. In addition, there was no information about the type of air flow mattress in use and what the setting should be. Whilst we did not evidence any impact on people, the lack of recording and overview of the care provided placed people at risk of not receiving the right care and support responsive to their needs.

Care plan records and supplementary care records for people across the service were not consistently signed and dated, including risk assessments and monitoring charts. This meant that there was a potential that records would not be able to be reviewed accurately in line with the registered providers monthly audits. We raised this with the management team who stated they would raise staff awareness regarding the importance of accurate and completed records.

Records for people across the service evidenced that care plan evaluations took place on a regular basis, however there was no evidence to show that people and relevant others such as family members were consulted and kept informed if a review of their relatives care and support needs had occurred. In addition, we saw examples were care plan records had not been updated to reflect changes in people's needs. For example, a wound care plan for one person had not been updated with instructions from the podiatry service about the use of pressure relieving boots. Another example was where a care plan had not been updated with details following a change in the frequency of wound dressings. Staff on duty knew about the changes in people's needs and provided them with the right care and support. However, the lack of maintaining accurate records put people at risk of not receiving the right care and support from staff less familiar with their needs. We raised this with the management team on the second day of inspection and the care plans were updated.

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

People and family members were provided with information about how to complain and those spoken with told us they were confident about complaining. A record of all complaints made about the service was maintained and showed that they were responded to and dealt with in a timely way.

Meetings were arranged to speak with people and relevant others about the service following recent concerns raised about the service.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection visit the service was not managed by a person registered with the Care Quality Commission (CQC). A person is showing on the CQC public website as being the registered manager, however they resigned from their post in November 2017. Since the inspection they notified us that they had put forward an application to CQC to deregister as the manager. The most recent registered manager left in April 2018 and de registered with CQC in May 2018.

There was however a manager in post who had applied to CQC to become the registered manager. The manager took up post in April 2018 and applied to CQC to become the registered manager on 16 September 2018, however their application was rejected and returned to them on 19 September 2018 due to missing and incorrect information. At the time of this inspection CQC had not received the manager's amended application. The manager was absent from work throughout the course of our inspection and the deputy manager had been appointed to oversee the day to day management of the service.

Prior to our inspection an area manager had been attending the service to provide additional managerial support. Both the deputy manager and area manager were present on the first day of inspection. Following feedback on the first day of inspection we were assured of the arrangements made to increase the management support at the service. An experienced manager registered with CQC and a clinical services manager, both who worked within the company were transferred to Hillside to manage the service and we were assured that this arrangement would remain in place to whilst improvements were made and sustained.

The registered provider had comprehensive framework in place for assessing, monitoring and improving the quality and safety of the service, however it was not always effective. Checks which had taken place failed to identify and mitigate risks to people's health, safety and welfare that we identified throughout our inspection. This included a failure to; assess and plan people's needs, monitor staff training, performance and attitude, maintain secure, complete and accurate records and maintain a safe and suitable environment to meet people's needs. We found examples were checks had not taken place at the required frequency including daily manager and clinical walk arounds. A falls audit for the service should have been carried out each month however records showed that the last audit was completed in July 2018. This was despite accident and incident analysis records showing that people had experienced falls at the service.

Each unit had a named manager responsible for the management oversight of their area of work. This included the completion and maintenance of records, supervision of staff including nurses and care staff and allocation of their work. A named nurse was in charge on each unit in the absence of the unit manager. Managers across the service were not always effective in recognising areas of poor practice and promoting good practise amongst the staff team. For example, managers were present when staff referred to people in an undignified way and they worked in areas where there was lack of security of people's personal records. In addition, managers regularly accessed people's care records but failed to identify that they were not always properly maintained, accurate and up to date. We identified multiple examples were care records were incomplete, lacked information about people's care needs and were not signed and dated.

The provider failed to share information in a timely way with the local safeguarding authority following information we shared with them on the first day of inspection. They also failed to access other relevant professionals to initiate a re-assessment of a person's ability to consent to their care and treatment. This exposed people to the risk of prolonged and unnecessary harm and demonstrated a failure to work in partnership with other bodies to mitigate risk to people and make improvements without delay.

Some staff told us that they felt that they didn't always feel confident about approaching managers to discuss any concerns they had or to make suggestions about improving the service. They commented that they felt it was a waste of time as nothing ever got done to improve things. Some staff expressed a lack of team work and felt this was an area that needed improving. Minutes following a staff meeting in May this year recorded that all staff in attendance agreed that there was a lack of team work, however no actions were set around how this could be improved. Minutes from other staff meetings, which had taken place over the last six months showed managers focused their discussions mostly around staff accountability. For example, what staff should and should not be doing. The records showed little discussion had taken place to increase staff morale, promote positive team work, or recognition of their work such as what they did well and their achievements.

The registered provider had a comprehensive set of policies and procedures for the service which were made available to staff and relevant others. Policies and procedures support effective decision making and delegation because they provided guidelines on what people can and cannot do, what decisions they can make and what activities are appropriate. However, people and others were put at risk because the registered provider's policies and procedures were not being followed as required. This included, safeguarding people, care planning, record keeping, staff recruitment assessing and monitoring the quality and safety of the service.

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

People and their family members told us that they had attended 'residents and relatives' meetings during which time they felt confident to share their views and opinions about the service. Topics of discussion held at the meetings included food, activities, the environment and fund-raising events. Family members told us they thought the management of the service had improved since the appointment of the manager in April 2018 and that they felt more involved through attending the meetings.

The service had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.

It is a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20A. that registered providers display their ratings from the previous inspection. However, this requirement did not apply now as this was the first inspection of the service under the registered provider Qualia Care Limited.

Within 48 hours of our first day of inspection we received an action plan from the registered provider confirming immediate actions taken and ongoing actions to improve the quality and safety of the service people received. We were also provided with an updated action plan following feedback we gave on the subsequent days of inspection and the registered provider committed to sending us regular updates of the action plan. We met with the registered provider at the service on the second day of inspection and provided our feedback to date. Based on our feedback the registered provider acknowledged the concerns we found on Ash unit and they agreed to suspend all admissions on that unit until the required improvements were made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always properly assessed and obtained for people in line with the Mental capacity Act 2005.

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 were not always provided with safe care and treatment.

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 always safeguarded from

abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Parts of the environment were not designed or adapted to meet people's needs.

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 in place for checking on the safety and quality of the service were not always effective. Records were not maintained, accurate and kept up to date.