Methodist Homes

Hillside

Inspection report

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Date of inspection visit:
01 March 2016
02 March 2016

Date of publication:
19 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 01 and 02 March 2016. It was an unannounced visit to the service.

We previously inspected the service on 22 July 2014. The service was meeting the requirements of the regulations at that time.

Hillside provides nursing care for up to 67 people, including older people and younger adults. 54 people were living at the service at the time of our visit.

The service did not have a registered manager in post. The previous registered manager left the service in May 2015. 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. A new manager started at the home on 7 March 2016.

There were safeguarding procedures and training on abuse to provide staff with the skills and knowledge to recognise and respond to safeguarding concerns. Individual risks were managed well at the service but we found people had not been protected from hazards they may come into contact with around the building. For example, clinical waste was accessible in a sluice room as the door was not always kept locked. Standards of food hygiene and general cleanliness also needed attention to prevent the spread of infection.

Staff were recruited using robust procedures to make sure people were supported by workers with the right skills and attributes. Staff received appropriate support through a structured induction, regular supervision and an annual appraisal of their performance. There was an on-going training programme to provide and update staff on safe ways of working.

People told us it took a long time for their call bells to be answered when they rang for assistance. A typical comment was "It takes them 20 minutes or more to come, not good at all." We checked the call bell log and did not find evidence of this. However we have asked the service to monitor this and make further investigations.

Care plans had been written to document people's needs and their preferences for how they wished to be supported. These had been kept up to date to reflect changes in people's circumstances. Staff were able to tell us about people's needs and how they supported them. Referrals were made to external agencies where people needed specialist support.

Systems were in place to monitor the quality of the service. Some staff were fully aware of the values and visions of the provider.

Staff did not always respect people's privacy and dignity as staff did not always knock prior to entering a

person's room.

We found whilst there was a process for recording formal written complaints, no record was kept of any day to day concerns and complaints raised by people who live at Hillside. We have made a recommendation about the recording of complaints or any issues raised by people who live at the home.

Mental capacity assessments took place where needed. Deprivation of liberty safeguards (DoLS) applications had been approved by the local authority and had been reported to CQC as required. However consent and user involvement was not routinely recorded. People told us they did not feel involved in decision about their care and treatment. We have made a recommendation about seeking and recording consent from people or their legal representative.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to processes about medicine, infection control practice and risk management. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

People were not protected from hazards around the premises as these had not been identified so that action could be taken to reduce the risk of injury or harm.

People were not protected from the risk of infection because the provider had not always followed safe infection control practices.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures for staff to follow in the event of any abuse happening.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not routinely encouraged to make decisions about their care and day to day lives.

People's experience of the food was not always positive

People received the support they needed to attend healthcare appointments and keep healthy and well.

People received safe and effective care because staff were appropriately supported through a structured induction, regular supervision and training opportunities.

Is the service caring?

Requires Improvement

The service was not always caring.

There was limited engagement between staff and the people they supported. They did not provide people with explanations on their care and did not promote their involvement.

People privacy and dignity was not always respected as staff did not always knock on doors prior to entering a room.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were procedures for making complaints about the service. However, there was no system for capturing and logging day to day concerns and complaints raised by people who lived at the home.

People were supported by staff who knew about their care needs and the level of support they needed.

People's preferences and wishes were supported by staff and through care planning.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had not had stable management in post. This led to inconsistences in support for staff.

Systems were in place to monitor the quality of the service.

Hillside

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 01 and 02 March 2016 and was unannounced; this meant that the staff and provider did not know we were visiting. On the first day of the inspection, the inspection team consisted of two inspectors, a specialist advisor within nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the visit the inspection team consisted of the same two inspectors

Prior to the inspection we reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Instead, we gave the manager an opportunity to share with us any information about what the service does well and any improvements they intended to make.

We spoke with 18 people who lived at Hillside who were receiving care and support and four relatives. We also spoke with 10 staff members including qualified nurses, care staff, non-care staff and the two managers. We reviewed five staff files and eight care plan files. We looked at incident reports and complaint records within the service and cross referenced practice against the provider's own policies and procedures. We spoke with two healthcare professionals and made contact with the local authority prior to visiting.

Requires Improvement

Is the service safe?

Our findings

People were not protected from hazards around the premises. We found risks to people's health and safety had not always been assessed so that action could be taken to prevent harm. For example, on two occasions we found a sluice room was open and unattended. This meant there was access to soiled and hazardous waste material. We found two potential hazards which had been subject to national safety alerts. Disposable gloves used in the provision of people's care were freely available in bathrooms and on trolleys around the building. The risks of people with cognitive impairments ingesting these had not been assessed. We also saw thickening powder was available alongside tea and coffee making facilities in kitchenettes. The risks of people who either had cognitive impairments or did not know what the powder was for and the harm it could cause if over-used had not been assessed. We had pointed out the access to thickening powder on the first day of the inspection. It was still accessible on the second day.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risk assessments had been written to reduce the likelihood of injury or harm to people. For example, to assess the likelihood of developing pressure damage, supporting people with moving and handling and the risk of developing malnutrition. We saw action plans were put in place where people were assessed as being at high risk. These identified measures to reduce risks, such as regular repositioning and use of pressure relieving mattresses to prevent tissue damage. These actions were being taken where necessary.

People were not adequately protected from the risk of infection. This was because there were inconsistencies in standards of hygiene around the building. We noted concerns about how food was kept in four kitchenettes. For example, in a freezer we saw a therapeutic ice pack (cold compress) was stored alongside a frozen dessert. The frozen dessert was not properly wrapped and some of it had melted at some stage and was smeared on the freezer door. We found foods in fridges with no dates of opening. Breakfast cereal had been decanted into plastic boxes with no date of opening. We found condiments stored in cupboards after opening, contrary to instructions by the manufacturers to keep them refrigerated. We also found flooring in two kitchenettes was sticky underfoot. A drawer storing cutlery and drinking beakers was found to be dirty.

There were unpleasant odours in some people's bedrooms on the first floor, stained carpets and spills that had not been cleaned up. Stairwells had not been kept clean. For example, we saw an apple core left on a radiator in a stairwell, dead insects behind hand rails and dirty and stained carpets.

In the laundry, both sinks needed cleaning. We found crockery and a bottle of water which may indicate staff had been eating in there. There were dirty splash marks on the walls by the sinks. A tea towel waiting to be washed had been placed on the floor where it could come into contact with contaminants.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We found mixed practices regarding medicine administration and storage. Medicines were not always administered in a safe way. On day one of our inspection we observed the nurse on duty being disturbed whilst administering medicine. This meant there was a risk of mistakes occurring. Medicines were stored in a lockable movable cabinet; we observed the cabinet unattended on two occasions. We checked if the cabinet was locked and it was. When not in use the cabinets were stored in a lockable 'clinic room'. The room was locked on each check. On day one of our inspection we found a storage cupboard within the 'clinic room' was unlocked, this cupboard stored medicine which were not in use. This meant there was a potential for stock to be mislaid or not accounted for.

Medicines no longer in use and pending disposal were stored in a pharmacy supplied disposal bucket. This was so full that medicine was protruding from the top. This meant there was a risk of contamination. Used sharps were not stored in line with best practice. We found one sharps bin which was full beyond the recommended amount and did not have an assembly date on. This meant that it may have been in use for the more than the recommended timescale.

Medicines were not always stored safely. We found a strip of approximately thirty paracetamol left on the side, we asked the nurse about this and they were unable to explain why they were there and stated, "Oh they should be disposed of, I don't know why they are there."

One person had been assessed as being able to administer their own medicine. At the time of the inspection we did not see any evidence that any stock control was recorded for this. However we have since been provided with evidence that the service ensured people were taking medicine as regular stock checks were made.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels had been determined from carrying out dependency level assessments for each person. Staffing rotas were maintained and showed shifts were covered by a mix of nurses and healthcare assistants. Although the home had several empty beds, it was staffed as though it were at full occupancy.

People told us it could take a long time for their call bells to be answered when they rang for assistance. We heard an example of this when a bell rang 51 times before it was switched off. Comments from people included "I don't use it (the call bell) often, but they take ages to come so I go and get someone instead," "It takes them 20 minutes or more to come, not good at all" and "I think they must be busy because it does take a long time for them to come. They come when they can." Other people told us "When they are not short staffed they come fairly quickly, they can be very busy and a long time before they come to you" and "It takes them a long time at night, usually more than 15 minutes. Daytime it's not too bad if they are fully staffed which is not often." One person said "They take ages to come in the day time. I go in my wheelchair and get them myself from the nurses' station. At night they don't come at all quickly. If they do come they switch off the bell and say to me things like 'don't play with that bell, it's not a toy.' I want my pad changed, they don't listen to me." Some people told us they found it more effective to shout to attract staff attention. For example, one person told us "I shout as they walk past, like just now I shouted (name of staff). They told me they would be five minutes. They did come back, but not in five minutes."

We asked the manager for a copy of the call logs. We looked at these in detail; we found no evidence that people were left for a long time after the call bell was activated.

The feedback from people using the service was described to the manager so they could investigate this further.

The service had procedures for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff had also undertaken training to be able to recognise and respond to signs of abuse. Staff told us they would not hesitate in reporting any concerns about people's well-being. This included escalating concerns to external agencies, if necessary.

People were cared for in safe premises. There were certificates to confirm it complied with gas and electrical safety standards. Appropriate measures were in place to safeguard people from the risk of fire. We saw emergency evacuation plans had been written for each person, which outlined the support they would need to leave the premises. Equipment to assist people with moving had been serviced and was safe to use.

The service used robust recruitment processes to ensure people were supported by staff with the right skills and attributes. We looked at the recruitment files of five staff. These contained all required documents, such as a check for criminal convictions and written references. Staff only started work after all checks and clearances had been received back and were satisfactory. The manager was advised photographs were needed to complete staff files.

Accidents and incidents were recorded appropriately at the home. We looked at a sample of recent accident and incident reports. These showed staff had taken appropriate action in response to accidents. Actions had been taken to prevent further injury to people. For example, sensor mats had been provided where people had a high incidence of falls. These alerted staff to when people got up, so they could check they were safe.

The manager took action where staff had not provided safe care for people, such as where errors had occurred. We looked at a recent example where an agency member of staff had signed to say they had given four people their medicines. However, this was still in the blister packs. The manager made a safeguarding referral to the local authority to alert them and contacted the agency to let them know what had happened and to ask them not to send that worker again.

Twelve of the people we spoke with said they felt safe at the home. When asked if they felt safe, one person said "Yes I do, but the lack of staff is a concern. I did not get my medication yesterday afternoon, they don't seem organised here." Another person told us "Yes I do really. It's just the carers. Sometimes they are good to me sometimes they are not. Lots of changed staff who don't know me." One person told us they felt safe and added "This is a wonderful place. I would not go anywhere else. You see I have made lots of friends in this home. I have company here." The relatives we spoke with felt their family members were safe at Hillside. Comments included "I feel she is safe here – yes, she seems happy enough," "We feel he is safe here really" and "I think so yes, but we have had lots of staff changes recently. Not sure they know Dad well."

Requires Improvement

Is the service effective?

Our findings

In the main people were supported by a service that was mostly effective, however we heard negative comments around the provision and quality of food. We found gaps in evidence demonstrating the service gained consent from people regarding care and treatment.

We observed a number of lunchtime meal times at the home. People shared their experience of meal times with us. We heard some mixed responses. Positive comments included "The food is ok. They do come and ask me about the food if I like it or not – I don't have any complaints about the food," "We do get a choice but the quality of the food varies quite a lot. Plate is hot but the food isn't. The pudding varies as well –we do usually get a choice" and "It's just alright it varies. It usually is hot. We do usually get a choice of food."

Negative comments about the food included "The kitchen is a nightmare really – you never get what is on the menu. For example you get curry and mash. Not rice, no sugar in the custard today or yesterday. Food is diabolical at the moment to be honest," "I couldn't eat the food today – I am not good with food –so she sent up this pudding for me. No I don't really like the food" and "What shall I say – I won't say its brilliant but I can't make out its terrible now either. They come around asking you what you want but that doesn't mean a thing. You seem to get a random serving of food. I can't manage chips or new potatoes, I ask for mash – now I get mash and new potatoes on the same plate – something seems to have got lost in the translation of my request. I have no teeth you see." Where people had been dietary requirement due to medical conditions, for instance the requirement of a pureed diet or additional calories this was clearly recorded in care plans and staff had knowledge of the requirements.

People had a choice of where to have their meal. Where it was identified that people required assistance with their meal this was provided on a one to one basis. However this meant that staffing levels in communal eating areas was minimal. One dining area was occupied by four people who appeared familiar with each and relaxed in each other's company. Two people were discussing a television programme they had watched the previous night.

We spoke with the manager about the comments from people. They advised us that a new chef had been recently appointed and was confident that improvements would be made.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found inconsistencies in the recording of consent. This had been identified by the service and was an action on their improvement plan. Some files contained clear evidence that people or their representative had been involved in decision making. However in other files we found labels which indicated that a signature from a representative was required.

Where required we found that assessments were undertaken regarding people mental capacity with regards to decision making, however these were not always detailed. The service had made appropriate referrals to the local authority.

We recommend that the service seek advice and guidance from a reputable source about supporting people to consent to care and support.

People generally felt staff had the skills to care for them well. Comments included "The regular staff know me well and are good," "The girls are just wonderful, just not enough of them" and "Some are well trained but I won't say all of them. I get tired of having to struggle to tell the new staff my needs and what I like in my care. It's hard work for me to talk you see." One person told us "They have had to replace a few (staff) with agency staff. They don't seem too bad but you do get one or two who don't know what to do." Some people felt communication was an issue. For example, one person told us "Lots of girls who can't speak English well, they come but not necessarily quickly and some don't know what we like. They are all too new so they don't know us."

People received their care from staff who had been appropriately supported. New staff undertook a structured induction to their work. This was cross-referenced to the nationally-recognised Care Certificate. The Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way.

There was a programme of on-going staff training to refresh and update skills. We saw staff had completed courses on topics which included safeguarding, nutrition awareness, dementia, infection control and diversity and inclusion. They had also completed training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to help them understand these important pieces of legislation.

Staff met with their line managers for supervision, to discuss how they were working and ways to develop their practice. Appraisals were undertaken annually to assess and monitor staff performance and to look at any training needs.

People were supported with their healthcare needs. Care plans identified any support people needed to keep them healthy and well. We saw people were referred to appropriate healthcare specialists when needed. For example, speech and language therapists, dieticians and tissue viability nurses. Notes were maintained of visits by healthcare professionals and the outcome of these, to provide a record of any advice or areas to follow up.

We heard mixed responses from people about how their healthcare was met. Positive comments included "They were very good here in sorting out my sore when I arrived, generally they are ok with that. The nurses are very good and kind," "They do get the doctor for me if I need one. They do look after me" and "They do dear – they look after my health very well indeed." Negative comments included , "I have not had my eyes tested since I have been here – I should do really" and "The regular nurses are a lot better than the agency

staff – you don't catch them rushing about. I sometimes have to ask and ask for someone to look at something for me but they do look after my health. I am overweight and they don't help me with that."

We received positive feedback from a healthcare professional about how the home managed people's healthcare needs. A visiting GP told us they thought Hillside was "A good nursing home." They said staff made appropriate referrals to them about people's health and well-being. They added any recommendations or actions they requested to improve people's health were always followed by the staff team. Another healthcare professional told us that the service made appropriate referrals to them and following treatment plans provided.

Requires Improvement

Is the service caring?

Our findings

We observed and heard mixed evidence regarding how caring the service was. People's privacy and dignity was not always respected. On day one of our inspection we observed three separate occasions when staff walked into people's rooms without knocking. On one occasion the manager was with us when we observed this. The manager advised us that this would be addressed with the member of staff.

One person told us they were concerned about how their privacy was respected, "I can be being washed and undressed and they come in and take my carer away so that they can double up to hoist another resident. I think there should be another floating carer so that this intrusion into my privacy does not happen. When my door is shut it should be respected. I am important too."

We observed complex manual handling being carried in one of the lounges. Staff undertaking this did not communicate with the people throughout the movement. This meant the person was not involved in the process and was not kept up to date with what was happening. This could have led to emotional distress.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that most of the time, staff are kind and caring. People and their relatives felt that permanent staff provided a better service than agency staff. Comments included "They are generally good," "They are wonderful, just wonderful girls" and "The carers are all kind and patient –but they are short staffed with carers at the moment and some are on holiday. The regular staff are better than the agency staff."

Relative's comments included "The carers are all kind and patient –but they are short staffed with carers at the moment and some are on holiday. The regular staff are better than the agency staff" and "There are some of the carers who go above and beyond but there are not enough of them."

We observed some positive interactions between staff and people. A newspaper session was being facilitated by the activities co-ordinator, people who attended were relaxed in the staff company and we could see that they were enjoying the session as there was laughter and smiles.

We observed two people being supported with a meal the member of staff sat near to them and was at eye level. The staff did not rush the person and engaged with them throughout the meal. General interaction between staff and people was task focused. However we did see one member of staff who was very well known by people who lived at Hillside engaging with people on an individual basis. It was clear from the interaction that a good working relationship had been developed.

We spoke with staff and they all were knowledgeable about people they were looking after. The service collected information about people and their likes and dislikes. It was clear when talking to permanent staff that they were aware of people's likes. For instance one person was a keen artist and staff engaged in conversation with them. Another person had expressed an interest in supporting senior staff with

interviewing new employees.

We found some evidence that people were involved in decisions about their care, however there was inconsistences in the recording of this. Some people were not able to tell us they were involved in decision making. We did see review meetings which had included the views of people and their relatives when discussing care and treatment provided.

People were asked about how they would like to be cared for towards the end of their life and information about people's religious beliefs and sexuality were recorded. One person who was in a same sex relationship told us that their sexuality had been respected by staff.

Requires Improvement

Is the service responsive?

Our findings

People were supported to maintain their independence and access the community. People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the care plan.

Care plans outlined the support people needed with areas such as their health, dressing, washing and bathing and mobility. We saw some evidence where people or their relatives were involved in developing their care plans. There was a 'My Life Story' document which provided a format for useful information to be recorded about people's lives and what was important to them.

Care plans were personalised and detailed daily routines specific to each person. Staff were able to explain to us how they were meeting people's needs and that people had been referred to health and social care professionals where this was required. For example, to dietitians where weight loss was evident.

In the main, information in people's care plans had been kept under review to make sure they reflected people's current circumstances. This helped ensure staff provided appropriate support to people. We noted some gaps in recording of wound dressings. This appeared to be around a bank holiday period where staffing levels were low for permanent staff. Staff we spoke with confirmed that agency nursing staff had been used a lot in recent times.

People were able to see their visitors as they wished. One person told us they saw their family regularly and had been into town recently for lunch with them. Relatives said they did feel welcome, but struggled to get up to date information from staff or management about their family members.

We heard one person speaking with staff about arranging some flowers for Mothering Sunday. The member of staff checked how much money the person had and asked what colour and type of flowers they would like to be sent and made the appropriate arrangements on their behalf.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Daily progress notes were also kept up to date about each person's health and well-being.

Where people required support with their personal care they were able to make choices and be as independent as possible. For example, we saw one person went out for the day to a club. Another person told us "I go out every day on the bus to the shops and to run my own errands."

People's cultural and religious needs were taken into consideration. For example, we saw a church service took place. These were held each week. There was also a bible and prayer meeting once a week. Staff said they would facilitate visits from other denominations or for other faiths, as required.

The service supported people to take part in social activities. There was a weekly programme of activities.

The activity organiser had maintained a photo album to show some of the events organised at the home. In the past year these included visits from singers, a harpist, an Elvis tribute act, a Stars and Stripes show and a ventriloquist. Themed events had also taken place for occasions such as Saint Valentine's day, Ladies day at Ascot, Saint Patrick's day and harvest festival. Animals were invited into the home, such as a Pets As Therapy dog and a company providing exotic animals and owls for people to touch. We asked one person about the visit from the exotic animals and they said it had been "Lovely."

Occasion trips out had been organised. For example, to the theatre and lunch out at a nearby pub. We saw one person was supported to go into town to do some shopping. The activity organiser told us there were seven or eight volunteers who helped people with going out into the community. One person felt more could be done to support people in going out. They told us "They don't take us out anywhere. We never go out even in the summer on a nice day."

We asked people whether they had made any complaints or knew how to. Comments included "I have not made one. I would speak to one of the nurses," "I haven't made a complaint. I just tell the carers, they usually do something about it but it has to be one of the regular carers" and "I have made a complaint in the past but nothing happened as a result. My daughter has also complained." Relatives told us "No complaints really. I would go to those in charge if needed"
and "We feel a bit detached from who to complain to at the moment with all the changes in staff and management. We don't have a relationship with anyone to have a quiet word with."

There were procedures for making compliments and complaints about the service. We looked at how a recent complaint had been dealt with. There was a record which showed the manager had met with the complainant to listen to their concerns and answer their questions. This was the only complaint recorded for the past year. We discussed with the manager about day to day complaints and concerns raised by people who lived at Hillside. We were told there was no process for recording anything other than formal, written complaints. This meant that some people's views may not be listened to at the home.

We recommend staff follow good practice in the recording of any complaints or issues raised by people living at the home, to show what action was taken.

Requires Improvement

Is the service well-led?

Our findings

People were supported by a service that was not always well led. There was no registered manager in post at the time of our inspection. However the service was being supported by a peripatetic manager from the same provider and had successfully recruited to the permanent manager post. At the time of our inspection it was their second day of employment. The previous registered manager left in May 2015, since then the service had a number of senior staff. People and staff commented about the lack of stable management. One relative told us "We feel a bit detached from who to complain to at the moment with all the changes in staff and management – we don't have a relationship with anyone to have a quiet word with." One staff member told us "X has been stabilising, it had been quite disturbing, different managers wanting to make change, you have to manage change."

Systems were in place to monitor the quality and effectiveness of the service. Regular audits were undertaken by the staff. Topics included falls and pressure area to name two. These audits fed into a service 'value assessment' which was monitored and signed off by a member of the quality team from the provider. We looked at the audits completed. We found it difficult to understand how the service ensured actions identified had been completed as there was no pulling together of themes from each individual audit. For instance a monthly medicine audit identified a number of issues regarding signatures. But there was no overall action plan to address this shortfall. We spoke with the manager about this. They advised us that if shortfalls are noted in audits, the audit is given back to a member of nursing staff and there is an expectation they will ensure remedial action is completed. A signature is then added on the front page of the audit.

The provider had a number of expectations laid out to ensure quality monitoring of the service. The manager of Hillside was expected to complete monthly, quarterly audits and was responsible for completing a document called 'Time critical recording'. This tool recorded important events like when a safeguarding concern was raised. This document also prompted the manager to complete any required notification to CQC. In addition to this the provider made regular visits to the service to monitor effectiveness. An 'observation checklist was completed at the visit; actions and a responsible person were identified to drive improvement.

The manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. For instance we had received information when a safeguarding referral had been made to the local authority.

The manager informed us and staff corroborated this, that they undertake a weekly stand up meeting with staff. This provided them with an opportunity to drive improvements in practice. Regular staff meetings and resident meetings were held to share communication. Some relatives told us that communication to them could be improved and a number wanted to have email contact.

The service sought feedback from people using the service, their relatives and stakeholders. The questionnaires received were analysed by an external agency who produced a report and the service work

with the quality team to devise an action plan.

We found the management open and receptive to change. Some feedback provided on day one of our inspection had been acted upon by day two. Some staff we spoke with were aware of the vision and values of the provider. The newly appointed manager told us "the company invests in residents and staff, that's what I wanted from a new company." Staff we spoke with stated they felt valued by the provider, and were enthusiastic to help change the service and help it improve. One member of staff told us "I am passionate about my job, you have to help to improve the situation, it is disappointing when staff phone in sick, they let us all down" another member of staff told us "I am open to change."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always provided with privacy and dignity as staff did not always knock prior to entering a room. Staff did not always talk to people are they were providing care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from hazards around the premises. Standards of hygiene around the home varied. Medicines were not stored safely and there was poor practice around the administration.