Dr Htay Kywe

Hilldales Residential Care Home

Inspection report

10-13 Oxford Park
Ilfracombe
Devon
EX34 9JS

Tel: 01271865893

Date of inspection visit:
21 July 2016
27 July 2016

Date of publication:
15 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 21 and 25 July 2016 and was unannounced.

Hilldales Residential Care Home is a large three storey building, originally built as four houses around the turn of the twentieth century. Modifications have been made so that the properties are interconnected internally. There are communal areas on the ground floor and bedrooms on all floors of the building. Externally there is a paved area to the front of the houses and small yards to the side and rear which people have access to.

The home provides accommodation and personal care for up to 56 adults who have needs arising from drug, alcohol or mental health problems.

The service was previously inspected in September and October 2015 when the service was rated as inadequate overall. At that inspection we found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the provider not having adequately trained staff to protect people from the risk of fire; a lack of suitable systems in place to protect people from unsafe management and administration of medicines; a lack of systems to ensure people were protected from the risk of financial abuse; people's needs and risks had not been fully assessed and care plans did not describe how to support people; people who lacked mental capacity to make particular decisions were not protected, people were being deprived of their liberty without appropriate Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place. We also found some areas of the home and practices posed infection control risks and there were a lack of systems to assess and monitor the quality of the services provided. Although some improvements had been made, these were not sufficient to improve the overall rating of inadequate.

After the inspection, we reported that we were taking further action, which included placing the service in 'special measures'.

Following our inspection in September 2015, we imposed a condition on the provider to have a registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Following the September 2015 inspection, we also issued a warning notice in respect of Regulation 11 of the Health and Social Care Act (2008) Regulations 2014. This was because people's consent to care had not always been obtained before care was given. The warning notice required the provider to be compliant by 31 January 2016.

In March 2016, we undertook a focussed inspection to check whether the home was now compliant with

Regulation 11. Although some improvements had been made, we found the home was still in breach of the regulation and therefore the warning notice remained in place.

A new manager had been appointed by the provider and had registered with the CQC on 6 May 2016. However this registered manager was inexperienced in the role. They said they met with the provider most weeks to discuss issues. However they also said did not have any support or mentoring from anyone such as a more experienced registered manager. They described how they were learning 'on the job' but were aware that they "didn't know what they didn't know." This meant they did not have sufficient knowledge, skills and experience to carry out their role effectively and had not been supported to gain these as soon as they were appointed into post.

At this inspection 32 people were living at the home when we visited on the first day, but one person had moved to another home by the second day of inspection.

Staff and people said they liked the registered manager and other senior staff and felt supported by them. The registered manager was keen to improve the service and had been working on this with health and social care professionals including staff from the local authority's quality assurance and improvement team.

The registered manager had made changes to the way the service listened to people and staff. This had led to some improvements which people said they benefitted from. The registered manager was also adapting policies and procedures to meet the needs of the home, although this work was still in progress.

Some quality assurance systems were in place to monitor the care delivered as well as the building itself. Although some of these systems were an improvement, there were still concerns and issues which they had not identified or addressed. For example, care record audits had not identified that care plans and risk assessments were not updated to reflect people's current needs and risks.

Staffing levels were sufficient to meet people's needs. Staff had been trained and supported through supervision to support them with the skills and knowledge to undertake their role. This included understanding about how to ensure that they worked within the legal requirements of the Mental Capacity Act (2005). However, there was evidence that staff did not always put their training into practice. For example, staff did not consider a person's best interests when an issue arose. There was also evidence that staff did not fully understand the importance of maintaining accurate and up-to-date records which included the current risks and needs of people and how these should be addressed. Staff did not always use safe moving and handling techniques when they supported someone to transfer to a chair. Staff had received training to support them in their role, but there was some evidence that further work was needed to ensure that staff understood how to put training into practice.

People who had significant health needs, which required staff help, were not always supported to fully meet their needs. Risks to individual people were not always documented and did not fully describe what staff should do to minimise the risks. Although the service involved and worked with health and social care professionals, their advice was not always fully followed

There was a happy, friendly atmosphere in the home. Staff and people interacted with each other in positive ways. Staff clearly knew people well and were able to discuss their history and family with them. People appeared happy and relaxed throughout the inspection and said they liked living at Hilldales. Staff were trained how recognise signs of abuse and were able to describe what actions they would take if they had a concern.

There was a complaints policy and procedure. People knew how to complain, but said they had not needed to formally raise any concerns.

People were supported to have healthy balanced diets. People were able to access drinks and snacks at all times of the day. Comments included "The food is really good." and "I can get coffee whenever I want." People were involved in menu planning and choice of food.

There had been significant improvements to the premises which meant that it was comfortable and hygienically maintained. However, a new laundry area had not been environmentally risk assessed. Due to the limited space in this area for moving and handling, staff and people who used the laundry were at potential risk of injury.

We recommend the provider consider recording and analysing incidents when people were found to be smoking in their bedrooms to see if the risks could be further reduced. We also recommend that the provider clarifies the reason for the practice of searches of bedrooms including its purpose.

Medicines were administered safely by staff who had received medicine administration training. Medicine administration records were well maintained. Where people self-administered medicines, this had been risk assessed. Non-prescription, homely remedies were used by staff on occasions although the registered manager said he would advise staff to stop this practice.

At the last comprehensive inspection in September and October 2015, this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. We found breaches of the Health and Social Care Act (2008) Regulations 2014.

CQC met with the provider, the registered manager and other senior staff to discuss the findings and their action plan. Following this meeting, CQC decided to carry out another comprehensive inspection before the end of January 2017. CQC has told the provider that if there is not enough improvement and any domain is inadequate, we will move to close the service by cancelling the provider's 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

Not all aspects of the service were safe.

People's risk assessments did not identify all risks, and did not adequately assess and manage risks to reduce them as much as possible.

People were protected against the risk of abuse by staff who understood their responsibilities in relation to safeguarding vulnerable adults. However, there was still a lack of effective systems to safeguard people against the risk of financial abuse.

People received their medicines from staff who had been trained and who followed correct procedures when administering and recording them.

The systems to ensure people were protected from the risk of infection had been improved, although there were still some concerns relating to one person.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People were at increased risk because care and treatment plans were not adequate to meet people's identified health needs. This meant there was an increased risk people would not receive all the care they needed, or would receive inconsistent care.

Although staff had some understanding of their responsibilities in relation to the Mental Capacity Act (2005), there was evidence that further improvement was necessary to ensure they acted within the legal requirements.

People were supported to have a varied diet of their choice. People were able to access food and drink at times to suit themselves.

Staff worked with health professionals and helped ensure that people had access to healthcare services. However there was some evidence that care plans did not always reflect the advice given by health professionals.

The home was adapted to the needs of people living there. The premises had been improved through upgrading of flooring and redecoration. A new laundry area had not been environmentally risk assessed which meant people and staff using it could be at risk of poor moving and handling.

Is the service caring?

Good

The service was caring.

People said they liked living at the home. Staff were kind and compassionate towards people, and had developed warm and caring relationships with them.

Staff knew each person, and were able to talk to them about their life and what mattered to them.

Staff supported and involved people to express their views and make their own decisions, which they acted on.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

People were at increased risk because care plans lacked sufficient detail and were not being evaluated or updated when people's needs changed.

People needed more staff support to pursue their interests and hobbies and improve their independent living skills.

People were able to express their views about how the service was run.

There were systems in place for people to complain. People knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not completely well led.

A new registered manager had been appointed. However they were inexperienced and had not got a robust support system to help them develop in their role.

Staff and people knew who the registered manager was and said

they felt supported by them.

Some audits and checks were undertaken, but these did not always pick up issues which needed addressing.

Hilldales Residential Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 21 and 26 July 2016. On the first day of inspection, two adult social care inspectors visited the home. On the second day, one of the inspectors undertook the inspection.

The provider completed 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. We reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We also reviewed notes from a meeting held in June 2016 with two senior staff from the provider organisation.

During the inspection we spoke with the registered manager, six care staff, one administrator, two cleaning staff and two catering staff. We also met and spoke with over half the people living at Hilldales.

We reviewed five people's care records, three people's medicine administration records and two staff records. We also looked at information relating to the running of the service including medicine stock records, policies and procedures, training records for staff, audits and checks made. These included fire equipment audits and fire evacuation training records.

During the inspection, we spoke with a fire officer, a visiting community nurse as well as eight health and social care professionals, including local authority staff, staff from a mental health team and the police.

Inadequate

Is the service safe?

Our findings

At the inspection in September 2015, we found breaches of Regulations 12, 13 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which meant that people were not always cared for safely. We found ongoing concerns that people were not protected from the risk of financial abuse. We also found that there were risks associated with medicine administration. There were concerns relating to the building and equipment used in the home, including the laundry area. Although staff had received some training, we found that staff did not fully understand their responsibilities to ensure that people were cared for in a safe way, including reducing the risks associated with infection and with fire safety.

At this inspection we found a continuing breach of regulation 13, as well as a breach of regulation 18. We also found a continuing breach of regulation 12, although we found that improvements had been made to the administration of medicines, which meant the home now met this part of regulation 12. Improvements had also been made to the cleanliness of the home which meant the requirements of regulation 15 had been met.

At this inspection, people said they felt safe living at the home. We observed people in communal areas and bedrooms looking relaxed and comfortable in the environment. One person said "I feel safe; I've been here about 17 years." Other comments included "I like it here"; "Staff are friendly" and "It's OK here"

We observed examples of poor practice when staff were moving people. For example, on three occasions during the inspection, staff used a commode rather than a wheelchair to transport a person back to their room. As the commode had no footplates, the person's feet were not supported and trailed along the floor. This poor moving and handling practice increased the risk of injury for that person. On one occasion we observed staff not applying the brakes on the commode before the person was transferred from a chair to the commode. This meant the commode could move during the transfer, causing an injury to the person. We also observed two staff supporting a person to get up from a chair. Although a transfer belt was put round the person to support them to stand, staff also put their arms under the armpits of the person. This put the person at risk of having their shoulder joint damaged in the move. On another occasion we observed two staff supporting a person to move from a prone position on a bed. Although staff used a transfer belt, they did not ensure that both of them and the person were aware of when the move was about to happen. For example by stating the move would happen on the count of three. As the person was being moved, it was clear they were in some pain. As they tried to stand, the two staff were unable to support them, which meant they then had to be laid back on the bed in a hurry and which put the person and staff at increased risk of injury. The poor moving and handling practices considerably increased people's risk of injury.

We discussed these concerns with the registered manager, who said they would arrange for an occupational therapist assessment to be undertaken to ensure the correct techniques and equipment were used to support this person when moving.

After the inspection, the registered manager informed us that a physiotherapist had assessed the person. They said that there were new risk assessments and a change to the care plan for this person in respect of their risks when being moved and in bed. Equipment including a hoist had now been put in place to support this person when being transferred.

We checked whether staff had been trained in how to move people safely. 16 of the 20 care staff, including the registered manager and senior staff, had completed moving and handling training in August 2015. This included staff who were not using safe moving and handling techniques. The registered manager said he would raise the issues with the staff concerned and identify what actions needed to be taken.

A dedicated laundry area had been created in the home since the last inspection. Within the laundry, a narrow area with shelving had been created for staff to sort people's laundry into individual piles. We asked a member of staff how they worked in this restricted space, and they said it was quite a difficult space to work in and they only spent small amounts of time in this room. The lack of space increased the risk of injury to staff due to the additional bending, twisting, stooping and carrying movements necessary in the limited workspace provided.

We asked the registered manager whether an environmental risk assessment had been undertaken for the new laundry area. This would have included the risks of moving and handling inanimate objects. He said this had not been done. This meant those risks had not been identified.

An assessment of each person care needs was made using evidence based assessment tools. For example, staff assessed people's risks in relation to falls, moving and handling and whether people were at increased risk of developing pressure ulcers due to their frailty or reduced mobility. However, where risks were identified for people, clear plans were not in place to communicate and instruct the staff team on how to reduce people's individual risks as much as possible.

For example, a pressure ulcer assessment which had been completed in October 2015 showed a person was at low risk of skin breakdown. In April 2016, the person's risk level had changed, their skin had broken down and they were receiving care and treatment for this. The pressure ulcer risk assessment tool used by the home was supposed to be updated monthly to highlight and monitor any changing levels of risk. This person's risk assessment had not been updated at all in the intervening nine months. When we spoke with two staff about this person's care, they were aware of these risks. The person had been seen regularly by health professionals and had the appropriate pressure relieving equipment in place. However, the out-of-date information and lack of detail in their care plan about this risk, increased the risk they would not receive all the care they required.

During this inspection, a person was on their hands and knees cleaning a downstairs shower and toilet. They described how they liked to help staff with the cleaning. The person was wearing their own clothes covered by a disposable apron and rubber gloves, although these were not one-time use, disposable gloves. The person was using cleaning products, which if used incorrectly could be hazardous. During our discussion, the person touched their face and hair with their gloves on several occasions. Cleaning staff said they did check that the person was using apron and gloves. However we asked the registered manager whether a risk assessment had been undertaken to ensure the person was supported to undertake cleaning safely. We also asked whether they had been given any training, for example in infection prevention and control and the safe use of cleaning products. The registered manager said they had not completed a risk assessment or provided training to the person to reduce the risk for the person in undertaking this activity. This meant the person was at risk of injury and cross-infection. The registered manager said they would complete a risk assessment and invite the person to join the next infection control training being run for staff

due in the next month.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

The home had one washing machine and one tumble drier. We discussed whether the home had considered whether there was sufficient this equipment for the size of home. We asked what happened if there was a breakdown of laundry equipment. Staff said there was a 24 hour service arrangement in place so repairs would be carried out quickly. Staff said the washing machine and tumble drier were in constant use. These arrangements meant people who wished and were able to do their own laundry, as part of their rehabilitation, would have difficulty doing so. Staff said two people did their own laundry, but acknowledged that this had to be managed carefully to enable them to do so.

Soiled laundry was appropriately segregated and laundered. Each person's laundry was washed in personalised net bags which helped to prevent laundry being mixed up. There were colour coded cloth bags for separating laundry and contaminated laundry was washed in red soluble laundry bags which reduced the risk of infection. There were regular checks made of the laundry area including a check on the filter in the tumble drier. The registered manager explained that another home had had a fire caused by a tumble drier, so they were very aware of the need for checks to reduce a similar event happening at Hilldales.

Staff had not always been recruited safely. For example, the staff record for one member of staff who had been recruited in December 2015 contained a Disclosure and Barring Service (DBS) check dated June 2014, which was 18 months prior to their appointment. There was no evidence of a DBS check having been applied or received subsequent to the offer of a post at Hilldales to the person. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The staff record did contain references from the person's last two employers. The registered manager said they would ensure that they received an up-to-date DBS check for this member of staff.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

A second person had been appointed in May 2016. Their staff record contained an application form which showed gaps in the person's employment record. Although there were no notes of the interview, the registered manager and another member of staff were able to describe how they had followed the gaps with the interviewee. The registered manager said that in future they would ensure they recorded and kept details of the interview process. Checks on the suitability of this candidate had been undertaken prior to their appointment. These included references from previous employers and a Disclosure and Barring Service (DBS) check. As the DBS had not been received prior to the person starting work, a risk assessment had been undertaken. This risk assessment documented how the person would be supervised at all times when working at Hilldales. During the inspection, we saw this person always working alongside other staff.

People were cared for in a clean, hygienic environment. One person described the home saying "it's spotless here." There were no unpleasant odours in the home. Designated smoking areas were well ventilated which meant the smoke did not invade other communal areas and bedrooms. Staff had access to hand washing facilities. Gloves and aprons were available for staff to use in all areas of the home. This helped to prevent the risks of cross infection. The provider had increased the number of cleaning staff to four. A member of staff said this had really helped to improve the cleanliness of the home. Another member of staff said the new laminate flooring which had been laid in communal areas had helped to ensure they

could be cleaned easily. Daily, weekly and monthly cleaning schedules had been introduced and were being followed by cleaning staff. Colour coded equipment such as cloths and mops had been introduced for cleaning different areas, such as communal areas and bathrooms. These helped to prevent the risk of cross-infection.

Checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken on a regular basis. Records showed escape route lighting had been checked each month and had been last checked on 19 July 2016. People and staff had regular fire drills so they could practice how to respond in a fire. Fire evacuation training had been undertaken the day before the inspection. This showed improvement in fire safety had been made.

People received their medicines safely and on time. There was an up-to-date medicines policy and procedure to guide staff. There were robust systems in place to check when medicines arrived at the home, and when unwanted medicines were returned to pharmacy. Medicines which required stricter control were managed in accordance with the legislative requirements, and all doses were accounted for. Medicines were stored safely, in a secure treatment room and were checked regularly. Any medicines which required cold storage were kept within a monitored refrigerator to ensure their effectiveness.

The service used a monitored dosage system on a monthly cycle for each person. Medicines administered were documented accurately and completely in people's medicine administration records (MAR), as were records of prescribed creams applied. Staff were trained, and assessed, to make sure they had the required skills and knowledge to administer medicines safely. There were arrangements in place to for people to take their own medicines, where they wished to and were assessed as able to do so safely. At the time we visited, three people were administering their own inhaler medicines, which were stored securely in a locker in their room.

We observed medicine administration and saw people received their medicines appropriately. Where the dosage of a person's medicine had to be adjusted dependent upon blood test results, staff ensured their prescription was updated accordingly and the correct dosage used. Records of MAR sheets were checked and action taken to follow up any discrepancies or signature gaps. However these checks were not documented. A senior member of staff who was responsible for audits, said checks would be documented in future.

The service had a homely remedies policy, so people could have over the counter non-prescribed medicines if needed, such as antacids. Records of the use of those medicines showed homely remedies were mostly used by staff. This was not in accordance with the homely remedies policy. We discussed this with the registered manager who said homely remedies would no longer be used by staff.

Each person had a personal emergency evacuation plan (PEEP). This took into account the individual's mobility and showed the support they would need from the emergency services if they needed to be evacuated in the event of a fire. However the list of people living in the home was not up to date as there were 32 people on it, whereas we had been told that there were only 31 people living at the home. The registered manager said he would ensure the list was updated to reflect the current occupancy.

An alarm system had been installed which activated if anyone smoked in their room. The alarm alerted staff and people living in the home by issuing a voiced instruction to inform people not to smoke. We heard the alarm on one occasion and saw staff attend and ask the person to extinguish their cigarette. Staff then advised the person to use one of the designated smoking areas. These measures had improved fire safety in the home. The registered manager said people had responded well to not smoking in their room and now

normally used either one of the two designated smoking lounges or went outside.

We recommend the provider consider recording and analysing incidents when people were found to be smoking in their bedrooms to see if the risks could be further reduced.

Accidents and incidents were reported and individual reports showed actions had been taken in response. In two areas of the home, there was visual information about the number of occurrence of falls and pressure sores which had occurred in a month. This information was displayed on staff notice boards. Senior staff and the registered manager said this was to raise awareness of the risks of falls and pressure sores. However, they were not able to describe whether any analysis of incidents of the data was undertaken or how the information was used to reduce the risks of pressure sores and falls.

We followed up actions taken to improve systems to manage and audit people's monies effectively.

Although the registered manager and staff had taken action to address some of the concerns, there was evidence that new systems had not been fully implemented. For example, although people had been supported to have bank accounts set up, their income was still not being directly paid into these accounts. Money in respect of people's care fees and personal allowances were still being paid into the provider's business bank account. There were no clear audit trails to show how that money was then distributed to each person. Some people were charged for items such as cigarettes and toiletries. However there was no system to ensure that they had signed to say they had received what they had been charged for. Staff withdrew money from ATMs on people's behalf. However there was no reconciliations system to evidence the withdrawal on the bank statement matched the amount given to the person. Income that was received from the local authority in advance was paid to people in arrears, without any consideration of interest being paid to people. The systems used to record each person's income and expenditure were not reconciled over the same period and therefore at times, people appeared to be 'in debt' to the home, when actually income they received had not been taken into account. A £10 Christmas bonus for some people which had been credited to the provider's bank account had not been transferred to the people concerned. This meant that people were still at risk of financial abuse.

Therefore there was a continued breach of Regulation 13 of the Health and Social Care Act (2008) regulations 2014.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They had a good awareness of the signs of abuse and were able to describe what they would do if they had concerns about suspected abuse. Staff said they would discuss this with the registered manager or senior staff. Staff said they would be taken seriously and action would be carried out to address the issues. Staff were also able to describe who they would report concerns to outside the home, for example the local authority and the Care Quality Commission.

Records showed staff had reported to, and worked with, the local authority where issues of possible abuse were suspected.

Staffing levels were sufficient to meet people's needs. Staff were very visible around the home throughout both days of the inspection. Staff responded to people's requests quickly. Staff worked without rushing people and had time to stop and talk with people during the day. Where people requested staff to do something for them, staff were able to respond to the request in a timely manner.

Requires Improvement

Is the service effective?

Our findings

At the inspection in September 2015, we found breaches of of regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people's capacity to make decisions had not always been assessed and staff had not met the requirements of the Mental Capacity Act 2005 (MCA). We also found staff had not been provided appropriate training and support to ensure they were able to carry out their role effectively

At this inspection we found continuing breaches of regulations 11 and 18, as well as a breach of regulation 9. People had not always been care for effectively when a Deprivation of Liberty Safeguards authorisation had been put in place. Improvements had been made to the training and support provided to staff, although we did have concerns that staff had not had sufficient time to embed the learning in their practice.

People were not always supported to make choices about their care and treatment. There was little evidence people's individual preferences had been explored with them and activities arranged to suit their preferences. Although we found some evidence that there had been some improvements since our inspection in September 2015, this was still not sufficient to meet the requirements of the regulation.

People were at increased risk because care and treatment plans were not adequate to meet people's identified health needs. Where health risks were identified, care plans lacked detail about how to reduce those risks and meet people's care and treatment needs. This meant staff did not have the information necessary to deliver effective care.

Although staff reviewed people care plans monthly, this review did not capture recent advice from health professionals or evaluate whether the care and treatment provided was effective. This meant there was an increased risk people would not receive all the care they needed, because staff did not have all the information they needed to take preventative measures or implement the required care and treatment. Where a review of a care plan had taken place and changes identified, the information was stored in a separate part of the care record. The care plan had not been updated to reflect the findings of the review which meant staff did not have all the current information reflected in the care plan at the front of the care record. However, staff were knowledgeable about people's needs and able to describe the current care needs of people they were supporting.

For example, on the first day we visited, staff had asked the district nurse to see a person because they were concerned the person had swollen legs, the dressings on their legs were leaking and both legs were discoloured. When we looked at this person's care plan, it had been completed on 15 October 2015. The care plan stated, 'I have no issues with my skin integrity and have a valid pressure sore assessment." However, in another part of their care record, an undated risk assessment showed the person was at risk of skin breakdown on their legs due to their poor circulation. This risk assessment instructed staff to monitor the person's feet daily and contact district nurse if they had any concerns. The person's monthly care plan review page was dated April 2016. This showed the skin on the person's legs had broken down and the nurses had been contacted to visit and review the person. Entries in the person's daily records showed staff

were in regular contact with the district nurses about this issue. District nurses were visiting the person several times a week to dress the person's leg wounds and were happy with the person's care. Their ongoing feedback and instructions were recorded in the daily records. However this information was not being used to update their care plan, skin risk assessment and pressure ulcer risk assessment.

We followed up the care of this person with two staff who demonstrated a good knowledge about the person's care and treatment needs. However, they had additional information about the person which was not captured anywhere in the person's care records. For example, they described how the person had a medical condition which was affecting their circulation and was on prescribed medication for this. They said the person needed to have their feet elevated as much as possible to improve their circulation. They also said the district nurses had recommended the person should be given regular pain medication following today's visit. None of this information was in the person's current care plan. The gaps and out-of-date information and lack of detailed care plans meant we could not be assured this person received all the care they needed in a safe way.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 provides the legal framework to assess people's capacity to make certain decisions at a certain time. When people are assessed as not having the capacity to make a decision, a best interests decision is made involving people who know the person well, such as relatives or friends, and other professionals, where relevant.

At this inspection, we found staff had a better understanding of the Mental Capacity (MCA) 2005, but still did not fully understand their role in supporting people to make decisions. Staff had completed some training in MCA and further training was planned for senior staff in relation to its application to people.

The registered manager and senior staff had worked with the local authority to assess people's understanding of receiving care at the home and also their finances. This had led to some people being supported to move to managing their own money and having their own bank account.

However during the inspection, the registered manager and two senior staff discussed a person who had been taken to the dentist to have dentures fitted. The person had refused treatment, staff said this had included being aggressive towards the dentist. The three staff discussed taking the person to their GP for a referral to a maxilla facial specialist to have the dentures fitted. We asked whether a capacity assessment had been undertaken to see if the person had capacity to understand the issues if they did not have dentures fitted, for example they may possibly need a softer diet. Staff said no capacity assessment had been made with respect to this issue. We also asked whether any consideration had been given to have a best interests assessment and meeting with the person, their family, staff and health and social care professionals to discuss the issue. Staff said this had not been considered. They said they would now consider doing this.

Where people are deemed to not have capacity to make a decision about a particular issue, it may be necessary to consider whether they are being deprived of their liberty in relation to the issue. If this is found to be the case, an application for a Deprivations of Liberty Safeguards (DoLS) authorisation must be made. In these circumstances the provider must do all they can to find the least restrictive ways to meet the person's needs. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best

interests.

The registered manager identified three people they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body, all of which had been authorised. One of the people who had a DoLS authorisation was moving from the home on the first day of inspection. Since DoLS authorisations are specific to a person at a particular location, the registered manager said they would be notifying the local authority DoLS team.

We reviewed the care record of one person, who had a DoLS authorisation, which related to their capacity to remain safe when away from the home. Staff explained that at times the person would become quite agitated if they were not able to go out. We asked staff how they ensured the person was safe and not able to leave the home without staff knowledge. Staff explained that all external doors, with access to the road had a keypad entry system. Staff said the person was able to go outside to smoke cigarettes in the grounds of the home if they chose. We asked how the person was supervised if they went outside for a cigarette. A member of staff described how they would check, from time to time, where the person was. We asked what systems were in place to ensure the person was safe. Staff said although they checked from time to time there was no formal system to check the person was still there. Staff said if the person left the grounds, they would go out looking for them. However it was unclear how long they would wait or how long they would search before calling the police to report the person missing. We saw details in daily notes that the person had left the home unaccompanied in the last month on more than one occasion. This meant that the person was not being supervised in accordance with the DoLs requirement to ensure they remained safe.

We reviewed the DoLS authorisation for this person, which had been authorised in June 2016. A condition of the authorisation required staff to undertake a capacity assessment and best interests assessment within two weeks of the authorisation. We discussed with the registered manager whether this had been undertaken. They said they it had not been completed yet although the period of time since the authorisation was over two weeks. They did not have an explanation why this had not happened.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily records described the choices people were given on a day to day basis. There was evidence that people were consulted and involved in decision making. There were positive examples of how staff could help people make as many decisions as possible for themselves. For example one record described how the person got agitated sometimes. Staff were advised to 'Approach sensitively and speak to him clearly, explain things in a straightforward manner. Sit down and take the time to talk to him face to face.'

People were supported to access healthcare services such as attending regular appointments with their dentist, optician and any hospital appointments. Staff worked closely with local healthcare professionals such as the GP, community nurse and members of the local community mental health team. Health professionals said staff sought advice appropriately about people's health needs and followed advice. Some people were encouraged to take responsibility for their own health needs, for example independently visiting their GP at the surgery. One person who was a diabetic monitored their own blood sugar levels.

There was evidence that staff had received a significant amount of training to address previous concerns about staff training. This included regular fire drills so they understood what to do if there was a fire. Staff had also completed other training including health and safety. There were more robust systems in place for monitoring who had done training. This helped senior staff to identify when training needed to be refreshed.

However, there was some evidence that not all the training had been effective. For example, although staff had completed moving and handling training, they did not follow safe moving and handling advice when supporting a person to move. We observed four occasions when staff did not use the right equipment and techniques to support a person to move safely.

We asked the registered manager what training staff had received in moving and handling. They said staff undertook a three hour face to face training session provided by an external training provider. They also said that staff completed an in-house training course whicn involved watching a video and completing a booklet.

We also asked the registered manager what training staff were provided in record keeping. They said no formal training was given in this. However they said a senior care worker oversaw the care planning process, including checking care plans and any updates made. However, staff were not updating and maintaining care records so that they reflected people's care needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Actitivities) Regulations 2014

One member of staff said they had received "lots of training, almost overwhelming." Another described training about the Mental Capacity Act (2005) as "really helpful so I understand about asking to go into people's rooms."

Some adaptations to the environment of the home had been made to meet the needs of people who lived there. Corridor areas were kept clear so people with mobility equipment could move around the home more easily. A stair lift had been fitted which enable people with limited mobility to go up and downstairs. Wheelchair users lived downstairs, and had access to two wet room facilities.

Further improvements to the environment had been made since we last visited. A new laundry area had been constructed, flooring had been replaced and some communal areas had been decorated. On the first day of inspection, an entrance door was being replaced with a more secure door. There was a programme of redecoration underway, and new flooring had been fitted in a dining room area. A new extractor fan had been installed in one of the designated smoking areas, which made this environment much better for people. Further improvements to the outside space were needed to make this a more pleasant environment for people to spend time in. The registered manager described the plans for one external courtyard, where there were plans to introduce garden furniture and pots with plants to improve the look and feel of it. He explained that this area was also more secure as there was a gate to prevent people coming in or going out, without the knowledge of staff.

Good

Is the service caring?

Our findings

There was a relaxed family atmosphere at the home and staff had developed positive and caring relationships with people. Staff were interested in what people had to say and spoke about the people they cared for with fondness, caring and compassion. Several people who lived at the home had developed friendships with one another and enjoyed spending time together. People wandered around the home, using various seating areas including the two smoking lounges, a non-smoking lounge and the dining room. A reception area was also used by people throughout the day. People sat here and were able to chat to other residents, visitors and staff. People were able to make themselves, and others, drinks which provided an opportunity to develop and sustain relationships. People chatted to one another and to staff about what they wanted to do and common interests. Other people watched TV in the lounge; there were lots of jokes and laughter. Staff had encouraged one person who was in a choir. The choir had been invited to perform at the home which staff and people said had gone down "really well."

People were supported to express their views and be actively involved in making decisions about their care. Staff were involved people in developing and reviewing their care plans, they said changes were often made in response to people's feedback. People signed to confirm they had read and agreed with them. Each person had been allocated a key worker who worked with the person to identify what they would like to do and what support they needed.

People's privacy was promoted because each person had a key to their own room, so they could lock their door when they came downstairs or went out. Staff had a pass key which they could use to access people's room in the event of an emergency. Staff were discreet when supporting people with personal care, respected people's choices and acted in accordance with the person's wishes. They knocked on people's door and waited for a response before entering. Where people wanted to discuss issues with staff, they were able to discuss them in private.

However, when chatting with a member of cleaning staff, they said they went through people's drawers and wardrobes each time when they cleaned their room. They explained this was because sometimes people put things in drawers, which needed to be removed, such as soiled pads or wet clothing. We followed this up with a senior member of staff and the registered manager. They said this should only take place when the person is in the room. They described other items which had been found in the past, including spoiled food, alcohol or other banned substances. The searching of people's rooms without their consent or agreement is a breach of their privacy.

We recommend the provider clarifies the reason for this practice and its purpose.

People religious preferences were documented in their care records, for example, whether a person liked to visit church, but would need staff transport to do so. Any specific wishes such as the person's views about resuscitation in the event of unexpected collapse were documented as were advanced directives. For example, one person wished to have 'the last rites'. The last rites are the last prayers and ministrations given to many Catholics shortly before death.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in September 2015, we found breaches of of regulations 9 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not always supported to receive care which reflected their personal needs and preferences. We also found complaints were not always dealt with in a timely way and resolved to the person's satisfaction.

At this inspection we found a continuing breach of regulation 9, as well as a breach of regulation 17. Care was not always delivered according to the person's current needs. We also found that care records did not provide an up-to-date record of the person's risks , needs and wishes.

People's care plans and risk assessments lacked detail although daily records included details about people's physical and mental wellbeing and how they had spent their day. However, where significant entries were made which suggested the person's care plan or risk assessment might need updating, this had not occurred. This meant relevant information was not always being used to inform updates to care plans and risk assessments. Although people's care records were reviewed regularly, these reviews rarely resulted in any significant changes to the care plan. This meant care plans did not always reflect the care people were receiving.

For example, one person said they had recently spent six weeks in hospital. Their care records showed they had recently been discharged from hospital following surgery. Prior to this discharge, their records showed the person was reasonably independent and mobile. It described how they could manage their own daily living needs and move around without staff assistance. The person's hospital discharge letter showed their care needs had changed. However their care plan had not been updated to reflect those changing needs. For example, the person now needed help to mobilise, with personal care and relied on staff to get them food and drink. Although staff we spoke with were able to describe the care and support they provided this person, we did not feel assured that all staff would have this knowledge. This was because some aspects of the care described by staff were not recorded in the care plan at all. They said they had been told this information by visiting community nurses. However there was no evidence that this had informed changes to the care plan. This meant that some staff were at risk of not having all the information needed to support the person with their increased needs.

When we spoke with the person, they were sitting in their chair near their bed and had a drink beside them. The person said they were unable to move from the chair without staff assistance. However, they had no call bell to alert staff when they needed anything or wanted to use the toilet. We asked the person how they alerted staff when they needed help. The person said they shouted out when they heard a member of staff passing by, which we heard them do. We followed this up with a senior member of staff, who said they would arrange for the person to be given a call bell.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our discussions with staff about people care records, it was clear staff did not always understand how to use the care plan and risk assessment documentation provided and were unclear where things should be recorded. For example one person's record contained a letter from a health professional which stated 'behaviour is becoming increasingly more unmanageable'. It also advised that staff should 'keep a diary of his outbursts'. However there was no evidence in the person's care record of any record being kept which would allow staff to evidence whether there was a change.

We discussed this with the registered manager and showed them examples of two people's care records we had looked at. They confirmed staff were not using the care plans and risk assessment tools, as they were intended to be used. This was putting people at increased risk and suggested further training on record keeping was needed.

People's care plans and risk assessments did not include any agreed goals the person was working towards. This was despite the fact several people were receiving support and rehabilitation to regain their independence. For example, one person had gained in confidence and was becoming increasingly independent, and another had giving up alcohol completely. This suggested some people could be encouraged to further develop their independent living skills and may be suitable to progress towards moving to a supported living type service with support.

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

However, staff knew people well, understood their needs and cared for them as individuals. People were relaxed and comfortable with staff that supported them. Staff knew what mattered to people, about people's lives and their interests. A staff member chatted easily to a person asking about their sisters. People who needed help with personal care confirmed staff supported them.

There was no personalised activity plan to meet people's individual needs for socialisation. However, some progress had been made in developing activities for people. A noticeboard showed a range of activities on offer in the home, these included board games, quizzes, a raffle and regular trips out. An activity book showed activities which had been undertaken. One staff member we spoke with was particularly interested in supporting people with activities in the home. Equipment and supplies for activities were stored in a dining room area for this purpose. Staff spent time playing a game of cards with one person and supporting another person with an art activity. They also involved people in choosing a number to enter a raffle, where the prize was a bowl of fruit. Another person was enjoying listening to their favourite folk music. Staff showed us personalised place mats people had made. One person described how they liked to be left alone, playing their music. However they said this was their choice and they liked to do this in communal areas rather than their bedroom so they could still socialise.

A number of more able people went out and socialised in the local town and had friends there. One person told us about their weekly walking group, where they had trained to be the walk leader and they were a member of a choir which they really enjoyed. However, where people were less able, they lacked stimulation and were not supported to undertake meaningful activities for them. Staff told us about one person who had previously enjoyed doing some gardening but had lost interest more recently. Other people were at increased risk of social isolation because they chose to remain in their room or were confined there because of their health or mobility needs. This meant they spent a lot of their time sitting around not doing much.

People had been asked to complete a questionnaire about their interests and hobbies. However, where

their responses showed they had expressed interest in pursuing particular hobbies and interests, no specific actions had been taken to address this. This was because the home did not allocate any dedicated staff time for activities; instead staff fitted it in around their other care duties. This meant they were not able to consistently support people. For example, one person had said they enjoyed dancing and gardening. However there was no evidence that the person had been supported with either of these hobbies.

We followed this up with the registered manager who said they had identified this need and were considering developing a dedicated activity co-ordinator post. They planned to discuss this with the provider. There was some evidence that the registered manager was trying to 'match' staff to people. For example they described how one person had played the guitar in the past and consequently, a member of staff who was a keen guitar player was working with him to support his interest.

Some people but not everyone had 'All about me' documentation which provided personalised information about the person, their family and their life history before they came to live at the home.

Resident meetings were arranged and people were encouraged to attend them. The registered manager kept minutes of these meetings which showed what people had said and what had been done about it. There were also regular meetings to discuss the food provided in the home. These had led to changes to the menus which people said had been really appreciated.

At this inspection, we found improvements had been made in relation to complaints. There was a complaints policy and procedure. People were encouraged to raise concerns and complaints, although the registered manager said some people were resistant to this. The registered manager said therefore they also had a 'grumbles' log in place so that people could raise issues without having to formally document them. They said this had led to them being able to deal with issues as they arose. People said they knew how to complain and felt able to do so. However, there had not been any formal complaints since the inspection in September 2015.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in September 2015, we found a breach of of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that quality assurance systems and governance did not demonstrate that the quality and safety of the care provided was monitored effectively. We also found a breach of regulation 18 of the Care Quality Commission (registration) Regulations 2009. This was because the provider had not displayed the previous inspection ratings as is legally required.

At this inspection, we found some improvements however there was a continuing breach of regulation 17. However, although some audits had taken place, these had not always been effective. For example, care plans had been reviewed but there was evidence that changes to people's risks and needs had not been resulted in alterations to people's care plans. There was no evidence that this had been identified in any audit.

The registered manager had been working with the local authority quality monitoring team to improve their quality assurance arrangements. This included improving the medicines administration audits. However, some of these arrangements were not fully effective because they did not identify the breaches of regulations found at this inspection. For example, people's care records lacked details about each person's current care and treatment needs. Care plans and risks assessment were not reviewed and updated in response to people's changing needs. This meant they could not be relied on as an accurate, complete and contemporaneous record of people's care and treatment needs.

Issues about updating care plans and record keeping had not been identified. This was because care records audits were not carried out effectively to monitor the quality and standard of record keeping.

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

The service promoted a positive culture which was open and honest. Staff worked well together as a team and felt supported and valued for their work. They had a set of values which included compassion, dignity and respect for people. However, there was no clear vision for the home which described the purpose of the service.. For example it was unclear how the provider was supporting people with addiction problems to overcome their issues. Although the registered manager said some people were on external addiction reduction programmes, there was no clear guidance on how the home itself were involved in supporting people to this end.

The registered manager was newly appointed on 6 May 2016 and had experience of previously working in the service as a senior care worker. However this was their first appointment as a registered manager. The registered manager was not fully conversant with current practices, legislation and national guidance in respect of the management of a care home. They said they planned to do a level five qualification, commencing in September 2016 to support them to develop their skills and knowledge. We asked the registered manager how they were currently supported in their new role. They said the provider did visit

most weeks, but was not experienced in the role of being a registered manager. We asked whether the provider had enabled the registered manager to be mentored or supervised to support them in their role. They said this had not happened. This meant that there were gaps in the registered manager's knowledge and skills where they did not have any support. The registered manager said he would raise this with the provider so that it could be addressed.

The registered manager valued people's feedback and acted on their suggestions. For example, minutes of a resident meeting held in May 2016 showed that action had been taken to provide a suitable store for mobility scooters owned by some people living at Hilldales. The next scheduled resident meeting was planned for August 2016. The registered manager was also very visible around the home and would stop and talk to people about how things were going and what help they might need. The registered manager explained that they and another senior member of staff would speak every day to every person living at Hilldales to ensure they were happy. They described how they would take action if there was a concern.

Although the registered manager showed us an electronic set of policies and procedures, which had been purchased, these had not been fully reviewed or adapted to ensure they met the needs and systems of the home. We discussed one policy with the registered manager which contained a procedure staff should follow. However when we asked the registered manager for the evidence that this was being followed they were not able to provide it. They said they were working through each of the policies in turn to adapt them to the needs of the service.
At this inspection we found the registered manager had notified CQC about significant events that had happened, including deaths of people using the service and safeguarding incidents in accordance with the regulations. We used notifications and other information to monitor the service and ensure they responded appropriately to keep people safe.

Staff had a handover meeting each day to communicate any changes in people's needs. Regular staff meetings were held so staff were consulted and involved in decision making and kept up to date with changes. Asked about the changes, one staff said the increase in staffing had helped with cleanliness. Other staff said having a registered manager had provided clear leadership, and staff better understood their roles and responsibilities.

At this inspection the assessment and ratings from the previous inspection of the home was displayed, in accordance with the regulations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were at increased risk because, where individual health needs were identified, there was a lack of detailed care plans about how their care and treatment needs were being met. This is a breach of regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Conditions of people's DoLS were not being met. This is a breach of regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks assessments were not detailed and did not identify all risks. They were not reviewed and updated as needs changed. This meant there was an increased risk people would not receive all the care they needed. Some moving and handling risks for staff were identified in the laundry. Risk assessment was needed to identify further action to reduce those risks.

This is a breach of regulation 12 (1) (2) (a), (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were not effective systems in place to ensure people were protected from the risk of financial abuse This is a breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected because the quality monitoring systems in place were not fully effective. People's care records lacked detailed about each person's care and treatment needs. They were not reviewed and updated in response to their changing needs so could not be relied on as an accurate, complete and contemporaneous record. This is a breach of regulation 17 (2) (a), (b), (c), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at increased risks because staff had a poor understanding about how to use the provider's risk assessment and care plan records. People were at risk because staff used poor manual handling techniques to transfer people This is a breach of regulation 18 2 (a) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.