Hillgay Ltd

Hilgay Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8 and 10 January 2019 and was unannounced. Hilgay Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can provide accommodation and personal care for 35 people in one detached building that is adapted for the current use. The home provides support for people living with a range of complex needs, including people living with dementia. There were 18 people living at the home at the time of our inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider of Hilgay Care Home was also the registered manager and they were present throughout the first day of the inspection and part of the second day.

At the last inspection on 23 April 2018 we rated the home as Requires Improvement. This was the third occasion that the home had been rated Requires Improvement. Following the last inspection, we met with the provider to confirm what they would do, and by when, to improve the key questions of is the service safe and well led to at least Good. The provider submitted an action plan which detailed how they planned to make the required improvements.

We received information from the local authority about a number of safeguarding concerns at the home. This indicated potential issues with the management of risks of people falling. We examined these risks as part of this inspection.

At this inspection the registered manager had not maintained improvements seen at the last inspection and standards at the service had deteriorated. We identified serious concerns which put people's health and well-being at risk.

There were not enough staff to care for people safely. Staff did not all have the training that they needed to be effective in their roles. Some staff had been deployed to work with people during their induction period without having received the training they needed to assist people to move safely.

Risks to some people were not being effectively managed. When people had falls, systems for reviewing their needs were not robust and adjustments were not always made to mitigate risks. Some people needed support to move using equipment. Assessments and care plans did not provide clear guidance for staff in how to support people safely. Some assessments were completed by staff who did not have the necessary training and experience. We raised a safeguarding alert with the local authority following the inspection.

Incidents and accidents were recorded. The registered manager had oversight of these records but had failed to identify patterns and trends. They had not taken all reasonable steps to prevent further occurrences or to mitigate risks to people.

Systems and processes for management at the home were not effective and there was an over reliance on the registered manager. There were not sufficient trained staff willing to administer medicines to people. This had resulted in the registered manager working an unsustainable number of hours over an extended period. Suitable contingency plans were not in place which put people at risk of not receiving their prescribed medicines when the registered manager was unexpectedly away from the service. A safeguarding alert was raised by the deputy manager during the inspection.

The system for managing complaints showed that two complaints had been received since the last inspection. However, people, their relatives and staff told us about a number of other complaints that had been raised but were not recorded. People told us they had no confidence that their concerns were taken seriously and addressed by the registered manager.

There was a lack of strategic management and oversight which meant that there had been a failure to make improvements following the last inspection. The registered manager had failed to ensure that incidents were reviewed and considered in line with the provider's safeguarding policy.

Records of staff rotas were not always accurate and this meant we could not have confidence that staffing levels were being maintained as described by the registered manager.

There was a widespread lack of confidence in the registered manager. This was expressed by staff, people, their relatives and health and social care professionals. One staff member said, "The manager doesn't listen, we have all said the staffing levels are too low and nothing changes."

People and their relatives told us that staff were usually kind and caring. A person told us that some staff were "A bit snappy." One person told us they thought this was because staff were under pressure.

People were supported to have enough to eat and drink but risks associated with choking were not always identified and acted upon. We asked the deputy manager to assess one person who we observed to be coughing at meal times during both days of the inspection.

Staff checked with people before providing care. Care plans showed that decisions made in people's best interests were recorded and relatives had been included in the process. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

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

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

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

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

Risks to people were not always assessed and managed effectively to keep people safe.

Potential safeguarding alerts had not always been made in line with local safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not all received the training and support they needed to care for people.

People were supported to have enough to eat and drink but risks were not always identified and assessed. People were able to access health care services when they needed to.

Staff sought consent from people before providing care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were not consistently kind in their approach.

Staff were task focussed and had little time to spend with people. People had to wait for their needs to be met.

Staff supported people to be independent. People's privacy was respected and information was kept confidential.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints were not always recorded, responded to and resolved.

Care was not always person centred and people's social needs were not always met.

Is the service well-led?

Inadequate

The service was not well- led.

Systems and processes were not effective to ensure the service was safe.

There was a lack of management oversight. Shortfalls were not identified and addressed to drive improvements.

There was a lack of confidence in the registered manager expressed by, health and social care professionals, staff, people and their relatives.

Hilgay Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 10 January 2019. The first day of inspection was unannounced.The inspection team consisted of three inspectors on the first day and two inspectors on the second day.

The local authority had informed us of a number of safeguarding concerns. The information shared with CQC indicated potential concerns about the management of the risk of people falling. This inspection examined those risks.

On this occasion we did not ask the provider to submit a Provider Information Return (PIR) before the inspection. 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. This was because we were responding quickly to information and concerns that had been raised with us. Before the inspection we looked at information we held about the service. This included any complaints we had received and any notifications. Notifications are changes, events or incidents that the service must inform us about.

During our inspection we spoke with seven people and four visitors or relatives. We spoke with eight members of staff, and the registered manager. We observed staff interactions with people. We reviewed a range of records about people's care and how the service was managed. These included the care records for seven people, medicine administration record (MAR) sheets, staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

The service was last inspected on the 23 April 2018 and was rated Requires Improvement at that time.

Inadequate

Is the service safe?

Our findings

At the inspection on 26 September 2017 we found a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of suitable staff deployed. We issued a warning notice requiring the provider to become compliant with the legal requirements by 31 January 2018. At the last inspection on 23 April 2018 we found that the provider had made improvements. However, at this inspection on 8 and 10 January 2019 the improvements had not been sustained and there was a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were not sufficient numbers of suitable staff to care for people safely.

People and their relatives told us that there were not always enough staff around. Their comments included, "They are always busy, I don't like to bother them." "A lot of the good staff have left, there are lots of agency staff now, they don't always know what to do." "The staff seem very stressed sometimes." A relative told us they visited more often because they were concerned about the lack of staff." Another relative said, "Most of the staff are lovely but you can't always find people to talk to if you need to."

Staff told us that there were not always enough staff on duty. Their comments included, "We have lots of people who need two carers now, we just haven't got enough staff." "We have told the registered manager that there's not enough staff on but nothing changes."

The registered manager used a tool known as a 'dependency tool' to calculate how many staff were needed to support people according to their level of need. However, staff told us that the tool did not accurately reflect people's needs. We noted that some people were assessed as being at high risk of falling and needed support from two carers but the dependency tool identified them as medium dependency. We asked the registered manager how they ensured there were enough staff on duty. They said they continued to use the dependency tool at present. However, the registered manager told us told us that the tool was being reviewed because they were not confident that it was reflective of people's needs but that they would continue to use it in the meantime.

We examined staff rotas for the previous six weeks. This showed a heavy reliance on agency staff to provide the number of staff indicated by the dependency tool. For example, staff told us that there should be at least five staff on duty in the mornings according to the dependency tool. We noted 14 occasions when the rota showed that four staff were working at 7am. Staff told us that each morning two care staff were deployed in the kitchen until the kitchen staff arrived between 8.30 and 9am. This meant that on some occasions only two staff were covering the home in the early morning. We asked staff what happened if people wanted to get up early. They told us, "They can't, we don't have enough staff on to help them even if they wanted to."

Our observations on both days of inspection showed that there were not always enough staff to keep people safe. For example, during the morning on 8 January 2019 there were periods when no staff were in the lounge, dining room and conservatory area. A person needed urgent assistance and was calling for staff to help them, they began walking with their frame across the room and overbalanced. The inspector who

was present intervened to prevent them from falling and assisted them until a staff member arrived to help. A second person was also supported by an inspector because there were no staff around to support them.

We asked a staff member if there were usually staff deployed in the lounge area and they replied, "There should be but they are all busy with other people at the moment." "Another staff member told us, "Since the activities co-ordinator has left there isn't always someone in here every day." Three of the people in the lounge area had been assessed as being at risk of falls and needed support from staff to move safely. One person had a sensor mat in the bedroom to alert staff if they were moving around without support at night. Although this supported the person to be safe at night, during the day the risk of falls was not effectively managed because there were not enough staff around to support them to mobilise when needed.

People told us that they often had to wait for their call bells to be answered. One person told us that they could wait up to twenty minutes saying, "The staff are so busy, it's not their fault." We checked the call bell system on the day of the inspection. We noted that on two occasions at 6:45am and 00:41 a person had waited for more than 18 minutes and at 08:42 another call bell had not been answered for more than nine minutes. A staff member said that they knew this was not acceptable.

There were not sufficient numbers of suitable staff on duty to care for people safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risks to people were identified but assessments and plans were not always effective in keeping people safe. Reviews did not always address changes in people's needs and not all assessments were completed by people who had the skills and competency to do so.

Some people had been assessed as being at high risk of falling. Risk assessments and care plans had been reviewed following such incidents. However, it was not always clear for staff what changes had been made to help prevent further incidents. For example, one person had difficulty with remembering to use their walking frame, and forgot to call staff when they needed help to mobilise. Their mobility care plan reflected these needs and noted that their mobility worsened when they were tired. The care plan guided staff to remind the person to call for support and to use their walking frame. The person had fallen on four occasions in a four-week period. After each incident their care plan and risk assessment had been reviewed but no changes were made to reduce the risk of further falls. One review noted that staff should remind the person to call for help but also stated that the person didn't usually do this. Each incident recorded that the falls had been unwitnessed. There was no evidence that there had been an analysis to identify measures that might reduce the risks of further falls including whether additional staff support was required.

Another person was assessed as needing support from one staff member when walking, but two staff when being supported with personal care. They had a fall and their mobility care plan and risk assessment were reviewed. The person was identified as having an infection and this was noted as the reason for the fall. They were prescribed antibiotics for the infection but no changes were made to their care plan and risk assessment to reduce the risk of further falls while they were unwell. The person had another fall seven days later and their care plan and risk assessment were again reviewed but no changes were made to the care provided. The person's mobility declined and they had a third fall the next day resulting in an admission to hospital where a fractured bone was identified. The risk faced by this person had not been effectively assessed in order to try and prevent further occurrence.

Following the inspection, we received information of concern from the Local Authority regarding this person's return to Hilgay Care Home as to whether the service could meet their needs. We asked the registered manager for additional information. A risk assessment was completed by two staff on duty when

the person returned to the home. The risk assessment identified equipment that should be used to support the person with moving around. However the staff who completed this assessment were not qualified to prescribe this equipment. There was no documented assessment which took into account any specialist advice on how to support the safe movement of a person with this type of injury.

The risk assessment identified two types of equipment that should be used but did not specify when or how each piece of equipment should be used. One piece of equipment required the person to be able to support their own weight, however the assessment had identified that they were not able to do this. There was not clear guidance for staff in how to support the person safely with the injury that they had sustained. This meant that staff were not provided with the information they needed to provide care safely. A safeguarding alert was raised with the local authority and at the time of this report's publication the outcome of safeguarding enquiries was not yet known.

One person's nutritional care plan noted that they were diabetic. However there was no risk assessment or care plan to guide staff in how to support the person with this need. The registered manager said that this was because the person's diabetes was well controlled and therefore "not an issue." This meant that there was no guidance for staff in how to identify signs or symptoms that might indicate that the status of the person's diabetes had changed and what actions to take. There were high numbers of agency staff working at the home who did not know the person well. This increased the potential risk to the person because staff did not have all the information they needed.

Incident and accident reports had been completed following incidents such as falls. The registered manager had oversight of these. Records were kept showing what had occurred and when, including the time of each incident. This enabled the registered manager to look for patterns and trends. However, the registered manager said they had not found there to be any patterns to the falls. The incident and accident record in November 2018 identified six falls had taken place and a further seven falls were reported in December 2018. Of the 13 falls, six had occurred at weekends. We noted that at least eight of the falls were unwitnessed falls and five unwitnessed falls had occurred at times when there were less staff on duty, before 9am or after 3pm. The registered manager had not used this information when considering staffing levels at the home or made any adjustments to the deployment of staff to prevent further incidents. This meant that the registered manager had failed to do all that was reasonably practicable to identify and mitigate risks.

The registered manager failed to ensure that risks to people were effectively assessed, reviewed and managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff could describe signs that would indicate that people were being abused and told us that they knew how and when to report any concerns. At the previous inspection on 23 April 2018 the registered manager had not always ensured that potential safeguarding concerns had been alerted to the local authority in line with local safeguarding procedures. We identified this as an area that needed to improve and the provider took immediate action to make the required alerts. Since the last inspection the local authority informed us of further incidents that they had identified, which had not been reported by the registered manager in line with safeguarding procedures. This included a number of unwitnessed falls which may indicate that peoples mobility needs were not able to be met safely. Following this feedback from the local authority the registered manager reported such incidents. We raised a further safeguarding alert and prompted staff to raise another during this inspection. It remained that there had been a continued failure in the provider's systems to ensure that incidents were reviewed and considered in line with their safeguarding policy. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. The provider had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form.

People were receiving their medicines safely from staff who were trained to administer their medicines. Records were completed consistently and any medicine errors were addressed through the provider's incident and accident process. Some people were receiving PRN (or as required medicines). There were clear protocols in place to guide staff in how and when to administer PRN medicines. The provider had systems in place to ensure that medicines were ordered, stored and disposed of safely.

The home had staff dedicated to maintaining the cleanliness of the environment. The registered manager said that plans were in progress for refurbishment of the kitchen and this was due to be completed in the coming months. Staff were seen using appropriate personal protective equipment and demonstrated a clear understanding of infection prevention and control procedures.

Requires Improvement

Is the service effective?

Our findings

People were not always receiving effective care that promoted a good quality of life.

Staff had not always received the training and support they needed to be effective in their roles. The provider had not put in place a clear system for the induction of new staff when they started working at the home. Some staff told us they had received an induction. One staff member said, "I did do some training and then some shadowing when I started." Other staff had not received an induction. One staff member told us, "I didn't have an induction, I just had to get on with it." Staff records did not contain information about the induction process. We asked what the procedure was for introducing new staff and were shown a document which identified key policies that staff were required to read and a second document that included orientation to the home. Staff told us, there was no system in place to ensure that staff received training before they began working with people. One new member of staff had completed four shifts shadowing staff but had not yet completed training, including manual handling training, before they were deployed to work with people. We asked the registered manager about this and they confirmed that the staff member had now completed their manual handling training. There was no process in place for the registered manager to assure themselves that new staff had the skills and competencies they required to carry out their role.

The staff training plan showed that not all staff had received the training they needed to care for people safely. Apart from manual handling, less than 50% of staff had received training in categories identified on the training plan. This meant that there was a risk that staff did not have the skills and knowledge to care for people safely. The deputy manager told us that staff take-up of training was low and staff did not always attend training sessions that were booked. We asked what the provider's policy was about staff attendance at training that they considered essential for their roles. The registered manager said that there was no current policy on this. Only six staff had completed training that was relevant to the needs of people they were supporting such as dementia care. The registered manager said that some training, including safeguarding training, had been provided to staff but did not appear on the plan and certificates had not yet been received from the training provider. There was a lack of clear systems and processes for arranging, monitoring and reviewing the training needs of the staff.

Staff told us they received regular supervision with a consultant who was supporting the registered manager. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Staff told us that they felt able to raise any concerns and did so. However, they did not feel supported because they had little confidence that their concerns were addressed. One staff member said, "I tell them my concerns about staffing levels, they tell the manager. I never hear anything else." Another staff member said, "I can say whatever I want but I'm not sure what good it does. Nothing changes." Staff described feeling stressed and under pressure due to lack of staff on duty. They told us that working with agency staff, who were unfamiliar with people and the home, increased their stress and made their job more difficult. One staff member said, "I just feel that we cannot go on like this, we tell the manager but nothing changes."

The registered manager could not be assured that staff had the skills, knowledge and competencies needed to meet people's needs and staff did not feel supported in their roles. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were being supported to have enough to eat and drink. However, risks associated with eating and drinking were not always identified. Since the last inspection a health care professional had raised concerns that staff had not noticed signs that a person was at risk of choking. A referral was subsequently made to a speech and language therapist (SaLT) by a health care professional. Following this inspection, the provider informed us that they had also made a referral and the SaLT guidance was included in this person's care plan. We observed that staff were following the guidance at mealtimes. During both days of the inspection we observed the lunchtime meal. We noted that one person appeared to be coughing when they were eating and drinking but not at other times. A staff member had noticed this on one occasion and offered a drink to the person. We could not see that any other incidents of coughing at meal times had been noted in their records and a referral had not been made to speech and language therapist. Following the inspection, we asked the deputy manager to assess the person for risks of choking, in case a referral to SaLT was appropriate. They subsequently confirmed that a referral had been made.

Failing to identify and assess risks associated with eating and drinking is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We received a mixed response from people about the quality of the food provided. One person said, "It is lovely food, always nicely cooked." Another person told us, "It's not always the best quality I don't feel that we get value for money." A third person said, "I can't always eat it, for example, the beans were stringy today." Most people we spoke to were happy with the food they received and said that they were included in discussions about what should be on the menu. We heard people being offered a choice before the meal. When one person requested a different dessert, it was changed straight away.

Assessments of people needs and choices had been completed in a holistic way and included their physical health, mental health and social needs. Technology was being used to support some aspects of care. For example, sensor mats were in place for some people who had fallen or had been identified as being at high risk of falls. Staff were using evidence based tools to assist the assessment process. For example, a Malnutrition Universal Screening Tool (MUST) was used to assess if people were at risk of malnutrition.

Systems were in place to enable effective communication between staff. Handover meetings happened regularly to pass on information to staff coming on duty. Staff explained that this helped them to be aware of any changes in people's needs.

People were supported to access health care services. Records showed that people had received regular visits from health care professionals including the GP, District Nurse and Physiotherapist. One person told us, "They call the doctor if they are worried." A relative said, "They ring 111 if they need advice." We saw health care professionals visiting people during the inspection.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles

of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Not all staff had received training in MCA however staff were able to describe the principles of the act and understood their responsibilities. They described people's right to make decisions and said that they always checked before providing care. We observed staff members asking people's consent before supporting them. Where people did not have capacity to make certain decisions records documented decisions that had been made in their best interest and recorded who had been consulted, including family members. DoLS applications had been submitted to the local authority where appropriate.

People who were able to move around independently could access all areas of the home safely. A lift connected all floors and we saw people using the lift with support and independently. Some people were able to access the garden independently. The garden was not accessible to all people without support from staff due to people's needs. One person told us, "I would love to go out there more often." Bathrooms were adapted to support people with physical disabilities.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff were mostly kind and caring but some people expressed some concerns. Their comments included, "When you ring the bell they say, "What is it now? Not how can I help?" Some people told us that staff could be "a bit short" with them sometimes. One person said, "I think it's when they are tired, they can sometimes be a bit snappy." We observed most staff interactions to be kind and caring throughout the inspection. Staff spoke to people with warmth and kindness. However, following the lunchtime meal we observed a person being given a cup of tea. They thanked the staff member and asked for a biscuit. The staff member dismissed their request saying, "You've only just had your lunch." Another person called out to a staff member to request help but they were busy supporting someone else. They were heard to reply, "You will just have to wait a minute." This did not support a respectful and compassionate approach.

Most of the time staff were showing concern for people and responded to their needs. However, staff were task focussed and not always able to ensure that people's needs were met in a timely way because they were supporting other people. One person wanted to move from the meal table to a comfortable seat but there were no staff around to help them. They had to wait for staff to be available to support them. A visitor was heard asking a staff member to support their relative but the staff member apologised and said, "I'm afraid I can't help until someone else comes in here." This meant that sometimes people were having to wait longer then they should expect for their care needs to be met. This had a negative impact on people's dignity.

Staff we spoke with knew the people they were caring for well and could describe their needs and preferences. However relatives told us that agency staff were not always familiar with people's needs. One relative said, "Sometimes, at weekends particularly, there are lots of agency staff on duty and they don't know people at all." A staff member described working with agency staff who were all unfamiliar with people and said, "None of them knew what to do." A relative described the impact on their relation saying, "They just don't relate well to the agency staff because they don't know them." A relative described how agency staff did not always know how best to support their relation with their continence needs. They described how regular staff used strategies to support them but some agency staff didn't know them well enough to understand their preferences.

Not all staff were communicating with people in a respectful way. Staff did not always know or respect people's preferences or choices. People sometimes had to wait longer then they should for support because staff were busy. People were not always being treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and where appropriate their relatives, were supported to express their views about their care and support. For example, one relative told us that they had been invited to a review of their relation's care plan. This had been recorded and included the person's views. One relative told us, "The staff are good at letting us know what's going on and asking for our input." Relatives told us they could visit at any time and that staff were welcoming to them.

Staff were aware of the importance of maintaining people's privacy. Personal information was kept securely and staff were mindful to speak quietly when discussing personal matters. One staff member was seen supporting someone in a discreet way to ensure their comfort and dignity was maintained. Staff understood the importance of people maintaining their independence and we observed staff supporting and encouraging people to do things for themselves, where they were able to.

Some people had communication needs and care plans guided staff in how to support them. For example, one care plan guided staff to ensure the person was wearing their glasses before supporting them. We observed that staff were following the care plan for this person.

Requires Improvement

Is the service responsive?

Our findings

People's complaints and concerns were not always listened and responded to. The provider had a complaints system and kept records of complaints they had received. Two complaints had been recorded and a written response to one complaint showed that the registered manager had addressed the concerns raised. However, some people and their relatives told us about complaints that they had raised which were not recorded in the provider's system. One person told us that they had complained about staffing levels and not being able to go out. They said, "It's not taken seriously, we are told they are getting more staff but it doesn't happen. I am giving up now." A relative told us that they had raised issues about the increased costs of some external services provided at the home such as hairdressing and chiropody . They told us that they did not feel their concerns had been listened to. Another person had raised a concern about difficulties with contacting the home because the answer phone was full and did not allow people to leave a message. They told us that they were concerned that they would lose contact with their friends because they might stop ringing if they couldn't get through.

We asked the registered manager why not all complaints had not been recorded. They said that they had not received any other complaints but when we described the detail of the issues they were aware of the concerns but had not considered them as formal complaints and had not recorded them.

Failure to fully consider, investigate and address people's complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff told us that they did not have time to just spend with people and we observed this to be true during the inspection. Staff were very task focussed and people's social and emotional needs were not always being met. Some people spent most or all day in their rooms and were at risk of social isolation. One person told us that the staff did check them regularly but they didn't have time to spend with them. They explained, "Staff say, 'I'll be back later', and then they're not seen again."

People told us they did not have enough to do and we observed that there were few activities or opportunities for social engagement during the inspection. A relative told us that an activities co-ordinator had left the home before Christmas and they had noticed a difference. They said, "There is just very little going on now, we have noticed that people are choosing to stay in their rooms more and more because there is nothing to come down for."

A new activities co-ordinator had been employed and we saw them talking to people and encouraging them to join in a planned activity. We observed that some people were engaging in a craft session. An external entertainer also visited the home and some people enjoyed the music session in the conservatory with some visitors from the local college. However, in between these organised activities people had little to occupy them. There was little evidence to show how people's individual interests and preferences were supported. Ensuring that people's social needs are met in a personalised way is an area of practice that needs to improve.

The registered manager said that they had not supported anyone with end of life care at the home since the last inspection. We noted that records of some people's preferences and requests for end of life care were recorded with their care records.

Inadequate

Is the service well-led?

Our findings

At the last inspection on 23 April 2018 there was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because governance systems and process were not operating effectively to ensure the health, safety and welfare of service users. At this inspection on 8 and 10 January 2019 it remained that there were failures in the governance of the home.

Following the previous inspection, the provider had worked with a consultant to make improvements and to develop an action plan. This consultant was no longer working with the provider at the time of this inspection. Another consultant was supporting the registered manager in maintaining care plans and records. This meant that progress in making improvements identified in the action plan had been limited and positive improvements to staffing, that had been identified at the last inspection, had not been sustained. Since the inspection the registered manager told us that they have asked the consultant to work with them again to find a suitable manager.

People spoke well of the registered manager and described them as being "very hardworking," "kind," "helpful" and "friendly." However, some people and relatives expressed concerns about the management of the home. Their comments indicated a lack of confidence in the skills and experience of the registered manager and concerns about poor administration, the lack of staffing and the general running of the home.

Staff told us they had concerns about how the home was run. Staff comments included, "It's chaos most of the time. The manager doesn't listen, we have all said the staffing levels are too low and nothing changes." "We can't carry on like this, the manager changed the dependency tool and now it shows we need less staff than we do. We have a lot of people who need two carers and staffing levels don't reflect that at all." "It's not a well-run home. Everyone here feels the same." One staff member said, "The manager is here day and night, they take so much on themselves."

Health and social care professionals also expressed concerns about the ability of the registered manager and described a lack of confidence in their knowledge, skills and experience. Social care professionals expressed concerns about the registered managers level of understanding about their responsibilities for reporting safeguarding concerns in line with policy. The registered manager told us that some staff at Hilgay Care Home were not prepared to administer medicines even though they had received training. This was due to their concerns about the safeguarding process in the event of any errors in administration of medicines. A staff member confirmed that this was due to the way that previous safeguarding alerts had been dealt with and staff were now frightened to make mistakes. The registered manager confirmed that this was the case but said they were not sure what more they could do to relieve staff anxieties in this area. This showed a failure in leadership as a culture of mistrust had developed where staff felt they would not be treated fairly and supported if errors were made.

Our observations throughout both days of the inspection confirmed what people had told us. The management arrangements were chaotic and disorganised. For example, when asked to provide clarification the registered manager struggled to find documents because they had been updating them and

they were not yet filed or training certificates that had not yet been received. Records of staff rotas were not fully completed and it was difficult to determine whether staffing levels had been maintained according to the rota. Some information received following the inspection showed that not all the shifts allocated to agency workers had been covered. This meant that we could not have confidence that staffing levels were maintained.

The registered manager had been staying at the home for some months and according to the rota they were consistently working 14-hour days, and had worked for 26 days without a break. They were also on hand during the night to ensure consistency if people needed PRN medicines because not enough staff were trained or willing to administer medicines. We asked the registered manager whether they felt this was sustainable and they said that they felt fine. However, staff reported concerns about the health of the registered manager.

Some systems and processes at the home could not operate without the registered manager. They had not recognised this shortfall in governance and there was no clear contingency plan in place if they were not able to work at the home. For example, there were not enough staff who were trained and willing to administer medicines to people, including at night. When the registered manager was unexpectedly unavailable there was no contingency plan in place and this put people at risk of not receiving their prescribed medicines. The deputy manager was able to make arrangements at short notice for trained agency staff to be available. Whilst people did not come to harm, they had been put at risk of not receiving their medicines, and a safeguarding alert was raised before suitable arrangements were put in place. This showed that the registered manager had failed to recognise that arrangements for administering medicines was unsustainable and had failed to ensure that suitable contingency plans were in place.

The registered manager was the only person who had access to certain information and files at the home. For example, they had access to reports from the call monitoring system that were not available to other senior staff. This meant that systems and processes to support the safe running of the home were not effective when the registered manager was absent.

Some quality monitoring systems were in place but were not effective in driving improvements. For example, audits of files had been completed and identified gaps in records that required attention. No actions had been taken to make the required amendments and there was no plan in place for when this would be addressed. We asked the registered manager about this and they were aware of the shortfalls that had been identified but told us they hadn't had time to address these issues.

Checks were undertaken regularly to ensure the safety of the home including weekly fire checks. However, records showed some weeks when these checks had not been completed because the staff member responsible was away. We asked them what arrangements there were to ensure these safety checks were completed in their absence but the staff member was not aware that any arrangements were in place.

There had been multiple failures and a lack of effective systems and processes to ensure the safe operation of care at the home. This is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with dignity and respect.

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 had been a continued failure in the provider's systems to ensure that incidents were reviewed and considered in line with their safeguarding policy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Failure to fully consider, investigate and address people's complaints

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager failed to ensure that risks to people were effectively assessed, reviewed and managed.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had been multiple failures and a lack of effective systems and processes to ensure the safe operation of care at the home.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitable staff on duty to care for people safely. The registered manager could not be assured that staff had the skills, knowledge and competencies needed to meet people's needs and staff did not feel supported in their roles.

The enforcement action we took:

Warning notice issued