Dr Htay Kywe

Hilldales Residential Care Home

Inspection report

10-13 Oxford Park
Ilfracombe
Devon
EX34 9JS
Tel: 01271 865893
Website:

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 11 and 23 December 2014 and the 13 January 2015 and was unannounced.

The service was previously inspected in July 2013 when it was found some records had not been fully and accurately maintained so people were not always protected against the risk of unsafe or inappropriate care. A follow up inspection on 20 November 2013 found this standard was being met.

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.

Summary of findings

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

Most people had lived at Hilldales Residential Care Home for a number of years, but the home also provides short term respite care. At the time of our inspection, there were three people who were staying at the home for respite and 48 people living there permanently. Staff support was provided at the home at all times; some people did not require staff support when away from the home.

We found the service was not safe in some aspects as the provider had not taken steps to ensure people were safe from the risk of fire. People were only allowed to smoke in two lounges in the home, but we found some people also smoked in their bedroom. However there had not been an assessment of the risks and personal evacuation plans had not been developed to ensure staff and people knew what to do in the event of a fire. Wheelchairs were left in areas which obstructed fire exits and routes.

Hilldales Residential Care Home did not have 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.

Although the home was owned by a single provider, he did not manage the service on a day-to-day basis and had not appointed a registered manager to take charge as required by the Care Quality Commission. Staff did not receive adequate supervision and appraisal and there were no systems in place to monitor who had received them. Whilst staff had received some training, the systems to record and monitor this were not robust or well maintained.

People were not fully involved in decisions about their care and the staff did not understand the legal requirements to make sure people's rights were protected. For example, people had restrictions placed on them which they had not agreed to. There was no evidence that the home had undertaken an assessment of people's capacity or made any applications for a Deprivation of Liberty assessment to take place, which is a legal requirement where a person is restricted in particular aspects of life.

The provider did not have systems in place to systematically monitor the quality of the service provision. Although the provider said they asked people what they thought of their care, there was no evidence of these discussions or of improvements being implemented following these discussions. The provider did not review incidents, accidents and complaints to support improvements to the service.

People were not involved in their care planning and reviews, although some people said they would like to be. People were not supported to become as independent as possible. While there was some evidence of risk assessments and care plans, these did not fully reflect the needs of the person. Daily notes did not contain evidence that all aspects of the care plan had been delivered by staff.

Staff were caring and kind to people, taking time to talk to people about what they wanted and supported them in their needs. People said the manager and staff were friendly and always available. Health professionals said staff were proactive about ensuring that people's health needs were met by liaising with them when necessary. The provider had a system in place to monitor who had appointments each day and would offer to accompany them if they wanted support.

However, people's privacy and dignity was not always respected as we observed people having chiropody treatment in an open area on the first day of inspection. We also found that the doors to bedrooms on a busy corridor were left ajar when people were asleep in bed during the day.

We found breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Inadequate

The provider did not have suitable systems to ensure that people were safe from the risk of fire, particularly as people were allowed to smoke in the home.

Medicines were not always administered safely.

Some people said they did not feel safe from the risk of abuse by others living in the home, although there was evidence that staff would support people if they were verbally abused. There was also evidence that police were called when staff had concerns about aggression.

There were adequate numbers of staff to support the people living at Hilldales and staff recruitment processes included appropriate checks on their suitability.

Is the service effective?
The service was not effective.

Inadequate

Staff did not have an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. This meant that some people had had restrictions placed upon them without their consent or the appropriate authorisation being in place.

People were provided with a balanced diet which some people said was "very good". People could access food and drink at all times of the day and night and were also able to bring their own food into the home.

People were supported to access health and social care services, which helped to ensure they remained healthy.

Is the service caring?
The service was not always caring as it did not fully respect people's right to privacy and dignity.

Requires Improvement

Staff showed compassion and were caring of people. Staff talked kindly to people living at Hilldales and supported them in their care.

Is the service responsive?
The service was not responsive.

Requires Improvement

People had not been involved in developing and reviewing their care plans. Care plans did not always reflect all aspects of people's assessed needs and risks. Daily notes did not always reflect what care had been provided to a person or significant events that had occurred to them.

Summary of findings

People's complaints about the maintenance of the building were not responded to in a timely manner.

Is the service well-led?

.The service was not well-led. There was not a registered manager in post. There was a lack of systems in place to ensure that staff received supervision and appraisals. There was not an effective system in place for monitoring staff training.

The provider had not submitted statutory notifications to the Care Quality Commission for significant events that had occurred.

The provider had not undertaken any surveys of people or staff opinion to support quality assurance. Incidents, accidents and complaints were recorded but there was no evidence that the provider analysed these to see if there were any patterns or ways to prevent them reoccurring.

Inadequate

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.

The inspection took place on 11 and 23 December 2014 and 13 January 2015 and was unannounced. The inspection team consisted of two inspectors on the first day and one inspector on the second and third days. On the first day we focused on looking at care records, medicine administration procedures and speaking to people who lived in the home. During the second day, we looked in more detail at care records, staff records and records related to the running of the service. We reviewed five care records and medicine administration records for people at the home. On the third day, we focussed on the management of finances for people living at Hilldales and attended a staff hand-over meeting.

Before our inspection we reviewed the information we held about the home, including the 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 also reviewed notifications of incidents the provider had sent us since the last inspection. A notification is information about important events which the service is required to tell us about by law.

During the inspection, we spoke with the registered provider, the manager, three care staff, two domiciliary staff and eight people living at Hilldales. After the inspection, we spoke with a GP, an occupational therapist, a community health assistant and two community police officers who have worked with people living at Hilldales. We spoke with a social worker who supports people at Hilldales and a Fire Officer who carried out a visit after our inspection. We also discussed and were provided information by a senior procurement and contracts officer at a local authority about payments and allowances for five people living at Hilldales.

Inadequate

Is the service safe?

Our findings

People were at risk because adequate fire safety precautions had not been undertaken. The manager said smoking was permitted in two lounges at Hilldales or people could smoke outside, but people were not allowed to smoke in their bedrooms or in other indoor areas. However, in most of the bedrooms we visited, there was evidence of people having smoked there and there were occasions when people were smoking in corridors. The manager did ask one person not to light a cigarette in their bedroom while showing us around the home, however there was no other evidence that staff enforced the rule or undertook routine checks. Staff said it was difficult to ensure people did not smoke in restricted areas as often they wandered through with a lit cigarette forgetting it was lit.

Neither people's risk assessments or care plans considered the possible risks of people smoking. Some people used a wheelchair to move around the home. Because there was not a lift in the building, people needed to use different wheelchairs on each floor of the building. We found on the first day of our inspection, some wheelchairs were left in areas near staircases which impeded access to corridors and fire exits. The manager said they would address this when we told them on the first visit day. However on both subsequent inspection days, there were occasions when we found routes and fire exits were still partially blocked by wheelchairs.

There were no personal evacuation plans for people in case of a fire at night, although some people who required a wheelchair occupied bedrooms on upper floors. The manager said they would develop plans for people to address these risks.

Because of the concerns raised, we asked the manager to contact the fire service so they could discuss the concerns with them and identify how they could reduce the risks. The fire service confirmed that they visited the home after the inspection. They said they had raised their concerns with staff about fire risks, in particular the risks of people smoking in their bedrooms and in the lounges as well as the lack of personal evacuation plans for people. They also said that the staff they spoke with did not have sufficient knowledge and understanding about how to keep people safe in the event of a fire, for example by "using a horizontal evacuation plan". The fire officer who undertook the visit said that in the event of a fire "there was a high probability that people would be injured or die" and they would be taking further action to ensure that the provider addressed their concerns.

The manager said an external organisation undertook checks of fire equipment and provided a demonstration of how to use equipment. We saw a certificate stating the last check had been in August 2014. The fire officer stated that they had found only minor concerns which included maintenance required on some of the fire doors in the home.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were protected from the risk of abuse as staff take appropriate action when a concern is raised. The manager said there had been occasions when people living at the home had been abusive to each other. They said that when this happened, they would talk to both parties to try to resolve the issues.

One person said they did not feel safe living at Hilldales as other people living at the home had been verbally abusive. Another person said they "feel safe the majority of the time, one person gets stroppy about it, staff tell him off." Another person said "don't feel safe, people can turn on you - [the manager] will call the police." However other people said they felt safe living at Hilldales and that staff ensured they were not abused.

The police confirmed that they had been called to Hilldales on occasions to deal with incidents involving people showing aggression. They said they had a good relationship with the manager and staff at the home and staff involved them appropriately when there was a situation they needed support with.

Medicines were not always administered and managed safely. All staff undertook medicines training and their competency was assessed. One care worker explained the content of their training and showed they understood how to administer medicines safely. They explained that they always asked the person if they wanted their medicines, and if they refused they would sign on the medicines chart using the correct code. However, we witnessed one care worker signing the medicines records before they gave medicines to people. On the second day of the inspection, a senior care worker had met with the relevant staff member to discuss their medicine practice.

Inadequate

Is the service safe?

There were some discrepancies in the numbers of tablets that should have been available against what was recorded in the medicine administration records. This indicated that people may not have received their medicines as prescribed, which might be detrimental to their health and wellbeing. The senior care worker said they did carry out audits of medicines but that these were not recorded. The controlled drugs register had been completed incorrectly on the day of the inspection, although there were the correct amount of medicines in the controlled drugs cupboard.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff said they were kept busy, but they felt there were enough staff to support people safely. During our visit there appeared to be sufficient staff although this was difficult to ascertain fully due to the size and layout of the home. Staff rotas for the previous week showed there were usually five care staff on duty during the day and three or four staff on duty each evening and night. In addition, there were two kitchen staff, two cleaning staff, an administrator and the manager during the day.

One person said there had been some recent weekend nights where only two staff had been available for duty. The manager confirmed this had been the case as they had been unable to get staff cover to meet the shortfall. Although we did not see any evidence that this shortfall in staff had been formally risk assessed, the manager said, because of the staff shortage, they had arranged to be on-call to support the two night staff. The manager also said they had now appointed staff to the vacancies and one of these staff was due to start before the end of December 2014. We saw records showing that the person had attended an induction session and was due to start work on the following weekend.

Recruitment checks had been undertaken to ensure staff were only employed if they were suitable and safe to work in a care environment. We reviewed the records for the new member of staff, which showed all the checks and information required by law had been obtained before they commenced working in the home.

People were protected by the prevention and control of infection. Some people said that on occasions, toilets and communal areas were not clean and there was faeces on the floor. However, when asked what they would do about it if they discovered it, one person said it was not their responsibility to let staff know if they found an area which needed cleaning. One member of staff said they always checked toilet and bathroom areas as soon as they started work and would deal with an area at once if they were told about it. During the inspection, we found all areas of the home were clean and hygienic. We also observed staff cleaning areas both as part of a routine and when a specific infection problem had been identified.

Food hygiene safety was monitored at the home to ensure people’s safety from the risks of consuming food that was not fit for consumption. Some people had a refrigerator and/or microwave in their bedroom. Staff said some people chose to eat food from the kitchen or food they had purchased in their bedroom and that this was allowed. However, they said staff did routinely check on food stored in bedrooms and they worked with people to ensure it was fit for consumption or was thrown away.

Inadequate

Is the service effective?

Our findings

Staff did not understand the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. Staff were unsure what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. The MCA 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 interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

People's liberty was not promoted. For example, Closed circuit TV monitored the home's exits and staff confirmed this enabled them to stop one person leaving the building. However, that person had not agreed to the restriction, there was no assessment of their mental capacity to make the decision and there had been no DoLS application to restrict that person of their liberty. The home was therefore acting illegally in holding the person without their consent or a DoLS authorisation.

On all three days of inspection, we raised concerns that some people had not had their capacity to make decisions about various aspects of their care assessed and that staff were restricting them without a DoLS authorisation (or an application for one) in place. A visiting health professional said that they had also advised the manager to apply for a DoLS application for one person as they had had concerns about the person whohad said they were unhappy and wanted to leave the home. On each of our visits, the manager said that they would apply for DoLS authorisation for individuals where they were restricting them. However, no applications had been made by the end of the last inspection day.

People's finances were not protected. Staff said they managed the money for 28 people living at Hilldales. Each person was given a fixed sum of 'pocket money' each week as otherwise, staff said, the person might spend the money on alcohol. Other people had their own bank accounts and managed their own money. Where people had their money managed by staff at Hilldales, the money was paid into the providers business account. The provider sent an envelope for each with the amount the person should receive written on the envelope together with a cheque which office staff cashed. Office staff then added money to each envelope. People come to the office and are given money from their envelope.

A senior procurements and contracts officer advised "Money should go into each person's personal account not into a central business account even if the provider is a signatory on the personal account. There should be clear auditable trails for income and expenditure."

Some people had an arrangement to receive tobacco products, toiletries and other small items from the office. Office staff maintained a spreadsheet recording what people had received and a balance of their income. Some elements of the spreadsheet were also input by the provider. However there was no evidence that people signed to say they had received these goods or were kept informed about their monetary situation.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the first day of inspection, there were no formal documents to show people had agreed to have their money managed by the home. However, by the second day of inspection, we were shown agreements signed by twenty-three of the residents, although some of these were not witnessed or dated. No assessment of people's capacity had been undertaken to ensure that they understood what they were signing. One person said that they had refused to sign the agreement, although their money was still managed by the home. The manager said that this person had agreed verbally to the arrangement as a condition of being allowed to remain in the home, although this was not documented in their care plan.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had not received training in MCA and DoLS, although the person responsible for arranging training said they would arrange for staff to have this training in January 2015. The training had not been arranged by mid-January 2015 although some enquiries to a training provider had been made.

Staff did not receive adequate support and training to ensure that they were able to carry out their roles effectively. A senior care worker said staff were expected to undertake training in five areas when they joined. These

Inadequate

Is the service effective?

included protection of vulnerable adults, infection prevention and control, health and safety, challenging behaviour and dementia awareness. We were told the training packages were on a DVD and staff had to complete a workbook which was then checked by a senior care worker. However there were no systems to confirm when staff had completed this training.

Three new staff had received safeguarding vulnerable adults training during the last year. A senior care worker said all staff received this training when they first started working at the home, but there were no records showing that other staff had undertaken this training. Staff said they recognised signs of abuse and knew what action to take if they had a concern.

Staff said they had completed some face to face training with an external training organisation. Records showed 16 staff had undertaken training in fire safety during 2014 and seven staff had completed diabetes, hydration, flu and pneumonia care, pressure damage and last days of life training during the year.

The provider said he supervised the manager every two to three weeks, but did not keep paper records of this. A senior care worker said they supervised staff in a group normally on a monthly basis although sometimes it was not as frequent. However there were no records showing when supervisions had taken place or who had attended the group supervisions.

Most people said the food was really good and plentiful. People were offered a choice of food and drink. However, some people said that they did not like the food and that there were no special diets provided for their particular conditions. The catering staff said most meals were cooked from fresh ingredients rather than being pre-prepared meals and menus were rotated every three weeks. Menus showed people were offered choices including a full cooked breakfast in the morning, a light lunch and a main evening meal, which was served at 4pm. In the evening a selection of snacks, such as sandwiches were available. If people did not want to eat their meal at the given time, they were able to have it stored in a refrigerator so they could eat it later. On the first day of inspection, lunch was a home-made mushroom soup with bread and on the second day of inspection, there were chicken and salad wraps on offer. Both of these options were fresh and tasty. During our visit, the staff were preparing for Christmas; special food had been bought and was being prepared for a Christmas lunch and buffet in the evening.

Healthy option alternatives, including food appropriate for people with conditions such as diabetes, were available, although these were not always clearly indicated. Catering staff said they would offer alternatives if people did not like the meal options available. People could access food and drinks throughout the day from an area off the kitchen, although the main kitchen was not available to people living in the home. There was a microwave and refrigerator in most of the bedrooms we were invited into. The manager said these were provided for people if they wanted them, so they could store and cook food for themselves.

The manager and staff responded to people's health needs quickly and effectively. Staff discussed one person who required an appointment at their GP. This was arranged and a member of staff accompanied the person to the appointment. Another person told staff they were concerned as a prescribed medicine had been decreased which was making them anxious. Staff contacted health professionals and arranged an appointment for the person to be reviewed. A community health care assistant visited on the first day of inspection and said the staff were very good at communicating any concerns they had, so that they could arrange to visit the person. This demonstrated staff supported people to maintain good health and involved health care professionals when necessary.

Appointments with external health providers including dentist, GP and optician were usually organised by staff. These were recorded on a central computer system in the office, to ensure they were attended, as often people required a member of staff to accompany them. During the inspection a member of staff arranged to take a person to their appointment. A GP said the staff were "proactive calling if they had concerns about someone." Staff contacted other health professionals when they had concerns about a person's health, including paramedics when a person complained about chest pain.

People’s needs were not always met due to the layout of the home. Several people living at Hilldales were not fully mobile. A stair lift had been installed in the home to support people who were unable to manage the stairs. However some people were accommodated in upstairs

Inadequate

Is the service effective?

bedrooms although they needed a wheelchair, which made it difficult for them to move around all parts of the home. Staff could not identify how many people in the home did not smoke, but said most people did. Both the lounges in the home were areas where people could smoke if they wanted. Whilst there were areas other than these two lounges where people who did not smoke could sit, these were not dedicated lounge areas. One was an area around a pool table and the other was a small area called the library. Both of these areas were also thoroughfares and on the first day of inspection, the library area was being used by the visiting chiropodist for people to have foot treatment. This meant people did not have a smoke-free communal lounge area to relax in.

The manager showed us three newly converted bedrooms and a large wet room which they were expecting to be able to use for people who were not fully mobile. The provider said they were planning to apply to the Care Quality Commission to increase the number of people they could provide care for to 59 using these rooms in addition to the rooms they already had. We contacted the provider after the inspection to explain that the rooms could be used immediately so long as they met the required standards and the home only accommodated up to 56 people until the registration change had been approved

Requires Improvement

Is the service caring?

Our findings

The staff were caring, but people's dignity and privacy was not always respected. For example, some people were having chiropody treatment. Staff said this was available every month to support people with diabetes foot care. The treatments were undertaken in a small annex off a main corridor, which did not provide privacy and dignity for people. We raised this with the manager, who said usually the area was screened off but, in future, people could have the treatment in their own bedroom if they preferred. However, the fire officer informed us that on the day of their visit, they had observed people receiving chiropody treatment in one of the lounges whilst other people were present. There was no evidence that this had been discussed with either the person receiving treatment or with other people sat in the communal areas to see whether they felt it was acceptable.

People were asleep in bed during the day with their doors open on busy corridors where staff and people frequently went past. Staff said that people liked to have their doors open but there was no evidence in care records that this had been discussed with them.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People gave a varied view of their experiences of living at Hilldales. Some people said staff were very kind and would always help them, but other people living at the home said they did not think the care was good. One person said they were "very happy" and they had lived at the home for a number of years and loved living there. Another person said the home "gets better and better, great food. Staff treat me well". However other people said they were not happy at the home and did not enjoy living there. Although some people said they were unhappy and they would prefer to live elsewhere, when asked where else they would like to move to, they said they did not know. One person said they had moved into the home a number of years ago expecting to be there for a limited time, but they were not being supported to move to other accommodation where they could be more independent. A visiting health professional commented "Staff very helpful, it's a lovely home, very caring."

The manager and staff listened to people and tried to support them to do what they wanted. This included helping people to attend appointments and visit the shops. Staff were knowledgeable about people's likes and dislikes and worked with them to undertake activities either on their own or accompanied by staff. An example of this was staff doing some shopping for one person who was unable to get out.

The manager said they supported one person to attend court after they had been arrested and had accompanied them as they found it stressful. One person said they enjoyed the activities that were laid on which included Karaoke evenings, bingo and trips to a local pub, although they said they were not sure when these activities occurred as they did not occur every week. Another person said they worked as a volunteer at a local hotel at weekends. However there was no schedule of activities and events that people could get regularly get involved in.

People were encouraged to personalise their rooms if they wanted to with furniture and personal ornaments. One person said they had chosen all the artwork on their walls and another person described how staff had put up Christmas decorations in their room which they were really pleased with as they enjoyed the festivities.

People said their friends and relatives could visit whenever they wanted to, but one person commented that their family had stopped coming because they were unhappy with some of the hygiene standards in the communal areas which they had to pass through when getting to the person's bedroom.

There were records of resident meetings held in the last twelve months with people living at the home to discuss issues including activities and outings. Staff said these meetings were not generally well attended, but they encouraged people to attend and get involved if they wanted to.

A GP said staff "seem to have a good relationship with clients. Some are hard to relate to but staff are skilled at managing a difficult client group." A police officer said the staff supported people well and this had reduced the number of incidents, although there were still occasions when there were problems. The police officer added that they had a good working relationship with the staff at the home who would always keep them informed about any concerns which arose.

Requires Improvement

Is the service responsive?

Our findings

People were not always involved in developing or reviewing their care plans. Care plans are a tool used to inform and direct staff about people's health and social care needs. In some records, an initial assessment had been completed by a staff from social services, which provided some personal history and information about what people liked and did not like. Three care plans contained evidence people had been involved at some point. For example one person had been involved in their care plan when they had first moved to Hilldales several years ago, but there was no evidence that they had been involved in its review since then. Staff said people would often not engage in the process. However, three people said they had not been involved in their care plans, although they would like to be. There was no evidence of reviews of care plans regularly involving the person.

There was evidence some risk assessments had been carried out, but these were lacking in detail about what the risks were and what actions were required to address the risk. For example, one person had been assessed as requiring support with personal care but there was no indication as to what support was required. A senior care worker said the person needed prompting to take toiletries and towel when going to the bathroom, but it was not clear in the care plan that this was the level of support required.

One person's care record showed they were at increased risk of falling. There was evidence the care plan had been updated to take into account this risk and that, for some aspects of care, it had been identified the person should be supported by two care workers. However it was not possible to determine from the daily notes whether this had been fully implemented. There was also evidence in one person's file that they had been identified as incontinent, although there was no information in the care plan about how this was to be addressed. Another care record had no information about the person having gone missing for several hours on two occasions.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the three days of inspection, people spent time watching television in the lounges, spending time in their bedrooms, going out unaccompanied or with staff. Staff at Hilldales did run some activities for people including bingo sessions, karaoke and movie nights. One person said they enjoyed these events, although they did not know always when they were going to be run. Another person said "Karaoke and bingo run twice week, but that's it." indicating that those activities were not enough for them. One person said they worked at a local hotel in the kitchens on a voluntary basis at weekends which they enjoyed. When asked whether they got involved in cooking at Hilldales, they said they hadn't. Two people described how they often accompanied the manager on the "bread and milk run" in the mornings which they enjoyed doing. One person said they loved gardening but there was no garden. Another person said they were "happy to do my own thing" . We also observed some people have friendly interchanges with each other and go to each other's room.

The manager said people would normally talk to them if they had a problem and that they tried to resolve concerns. We saw the manager and other staff talking to people throughout both days of the inspection, helping them with issues and making sure they were alright.

There were minutes of menu meetings which were held with people living at Hilldales, although these were not well attended. The menu meetings were chaired by the catering staff who said they encouraged people to make suggestions of what they would like on the menu. They said they had introduced changes to the breakfast offered on Thursdays, such as eggs Benedict, croissants and porridge as alternatives, so that people had some variety.

People said they knew how to make a complaint, although some people said they were not listened to. Four people said there had been a problem with the hot water in one of the bathrooms for several years which had not been fixed. When we checked the water temperature, we found that it did take several minutes to run hot but did eventually work. A member of staff said the problem had taken a long time to be sorted out as it had had a temperature suppressor on it. Another person showed us a cracked window in their bedroom, which they said had been cracked for over two years. They said they had reported the problem but nothing had been done to repair it.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in post. The regulations state “If the service provider is an individual, they do not need to have a manager unless they are not a fit person to manage the regulated activity, or do not intend to take on the role of a manager in day-to-day charge of how the regulated activity is provided”. The provider said he was "not involved on a day-to-day" basis with the running of Hilldales and he only dealt with finance and administration. Therefore there should have been a manager of the service registered with the Care Quality Commission. Although there was a manager who had been in post for several years, this person had not registered with the CQC and said that he did not intend to. The provider had been in correspondence with the CQC about appointing a registered manager and said, at the inspection, he was considering how to address the issue.

People had not been protected through the notifying of incidents. All adult social care providers must notify the CQC about a number of changes, events and incidents affecting their service or the people who use it. These include death of people living at the service, allegations of abuse, incidents involving serious injury and incidents involving the police. The provider had submitted statutory notifications in respect of the death of people living at the home, but had not submitted any other statutory notifications. The records we hold about this service showed the provider had not informed the Care Quality Commission about any safeguarding incidents or any incidents which had involved the police and what action they had taken to make sure people who used the service were protected. However staff described instances where people had reported abuse to them and when the police had been called to deal with incidents in the home. The manager said he did not realise that he had to report these issues to the Care Quality Commission.

This was a breach of regulation 18 of Care Quality Commission (Registration) Regulations 2009.

There was not a clear vision and values of what the service provided. The provider described the service as providing support to people with mental health and alcohol issues, which were sometimes "chaotic and challenging". They said a positive outcome for people might be to return to their home town, however they were unable to describe how they were supporting people to this end.

There was a lack of clear direction from management. Although staff were caring and conscientious, there was no evidence, for example from records of staff meetings, that they understood what the purpose of the home was in terms of supporting and developing people.

People’s independence was not promoted. For example, some people were given 'pocket money' each week. Some people had signed a document saying staff could manage their money, but a number of these people said they were unhappy with this. One person said they had refused to sign the form, which had been presented to them in the last week. They said that they had not however been given their money. The manager said that a condition of the person coming back to the home was that they had to hand over their money and bank cards as they were at risk of spending money on alcohol.

The manager was present throughout the three days of our inspection, working closely with people living at the home. It was evident he had a very good relationship with people and staff and was seen as a practical problem solver. However, when asked about his role in terms of managing staff, he was not able to demonstrate he fully understood the responsibilities. For example although staff had undergone an appraisal within the last twelve months, much of the paperwork had been completed with one word comments and none of them showed there had been any reflection of their performance by him. When asked about what he viewed the purpose of appraisal to be, he was not able to give an answer.

The provider said that he visited the home most weeks when he would meet with John the manager and office staff. He also said he was in email contact with staff. The provider described how he did a tour of the building including bedrooms with maintenance staff regularly and would talk to people when doing so about whether they were happy with everything. However these were discussions were not recorded. There was no evidence that the provider undertook any other audits to monitor the quality of the services provided.

A senior care worker said they and another senior care worker planned to undertake audits of medicines for each other's area of responsibility. They said that these audits would commence in early 2015. However, they had not commenced by the last day of our inspection. Other

Inadequate

Is the service well-led?

aspects of medicines were managed well. The senior care worker kept records of all the medicines ordered, received and returned to the pharmacy so there was an audit of medicine use.

There was no evidence the provider had taken steps to systematically elicit the views of people using the service, their relatives or staff for quality assurance purposes. The provider said that he would consider doing so during 2015.

Although incidents were recorded and copies were placed on people's care records, there was no evidence any analysis of these events had taken place, or that there had been any learning from the individual events to drive improvements. There was also no evidence the provider had a system for recording, monitoring and learning from complaints.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not have suitable safeguards in place to protect people from the risk of fire. Regulation 10(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider did not have suitable audit systems in place to protect people from the unsafe management and administration of medicines Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider did not have systems in place to ensure people were protected from the risk of financial abuse Regulation 11(1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People who lacked mental capacity to take particular decisions were not protected. Staff were restricting people but had not applied for Deprivation of Liberty Safeguards orders. Regulation 18

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People's dignity and privacy was not always respected. Regulation 17(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Care records did not show evidence that people's needs and risks had been fully assessed. Care plans did not describe how people's needs were to be met and daily notes did not show what staff had done to support people. Regulation 20(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not have systems in place to assess and monitor the quality of the home. Regulation 10(1)(a)(b)(2)(b)(i)