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Hill Barn

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 and 6 April 2017 and was unannounced.

Hill Barn is registered to provide care for up to 26 people. At the time of the inspection 21 people were living at the home. The home supports older people, some of whom are living with long term conditions. The accommodation comprised of a series of refurbished barns and an extension over one floor, set in a large garden.

There was a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. For the purposes of this report we will refer to the registered manager as the manager.

At our last inspection in April 2016, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to the safe care and treatment of people who were living at the home. We found issues with how people's medicines were administered and stored. We found the medicine audits were not effective. We also found that staff had limited guidance about how to meet people's needs.

At this inspection on 5 and 6 April 2017 we found improvements had been made in these areas, so the service was no longer in breach of this regulation for these reasons. However, at this inspection we found two new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of our report.

Some communal areas of the home were unclean and some staff used unsafe practice that increased the risk of the spread of infection. People's medicines were kept secure however; people's prescribed thickeners for drinks were not kept in a secure place. This was a risk to people's safety.

The manager and provider did not always have robust quality monitoring systems in place. We found issues relating to the monitoring of the hygiene of the home, and how staff interacted with people who lived at Hill Barn. We also found issues with how staff and the manager protected people's confidential information. The manager also did not have effective systems to monitor staff knowledge and practice.

Staff did not have enough time to spend chatting to people or to engage with them in a social way throughout the day. The manager had not considered ways to encourage social stimulation within the home. There were no real plans in place to ensure people's individual social needs were going to be met. People had not been consulted with about their social needs with action taken to meet these needs.

The Care Quality Commission (CQC) is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. The service had made applications for authorisation to the local authority DoLS team. However, there was a lack of understanding around when a DoLS was required.

We have made a recommendation about the management of the home seeking advice and guidance about DoLS.

People received their medicines in a safe way. The administration of people's medicines was audited and checked. The manager and staff were proactive in responding to a change in people's health needs. The manager and staff knew about the risks which people faced and how to respond to these. The manager ensured that the equipment used was safe.

People spoke positively about the food and drinks they had. The chef had a good knowledge of people's likes and dislikes and people's specialist dietary needs. People also had good access to drinks and snacks.

People were supported to meet their spiritual needs and there were times when people were supported in a way which met their social and emotional needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some communal areas of the home were unclean that increased the risk of the spread of infection.

People's risk assessments were comprehensive.

The safety of the premises was reviewed on a regular basis.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff knowledge and practice was not always effective.

People spoke positively about their meals and drinks.

People had timely access to services to support them in maintaining their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always respond in a caring manner to people when they were distressed.

Some situations were not managed in a way which promoted people's dignity.

People's confidential information was not stored securely.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Staff did not spend time with people and engage with them.

There were limited social opportunities for people.

People's care records were person centred.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some systems and processes that were in place to monitor the quality of care people received were ineffective'.

There was a lack of quality monitoring of the service and audits were not always robust.

Hill Barn

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 5 and 6 April 2017 and was unannounced. This inspection was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we viewed all of the information we had about the service. The manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications the manager had sent us over the last year. Notifications are about important events the manager or provider must send us by law. We also contacted the local authority quality assurance team and local authority safeguarding team to ask for their views on the service. During the inspection we spoke with eight people who used the service and five relatives. We spoke with two health professionals, the manager, the provider, the chef and five members of care staff.

We looked at the care records of three people who used the service and the medicines administration records of four people. We also viewed records relating to the management of the service. These included risk assessments, three staff recruitment files, training records, audits, and records relating to the safety of the building and equipment used at the home.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 19 April 2016 we had identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were issues with the management and storage of people's medicines. People's medicines were not stored at the correct temperatures. This could have undermined the effectiveness of some people's medicines. There was no guidance or protocols for staff when administering people's 'as required' medicines. When medicines were delivered to the home, these were not always accurately recorded. The medicine audits completed by the manager or seniors were not robust because these issues had not been identified. We also found that people's care plans did not give clear and appropriate guidance to staff about how to manage the risks which people faced.

The manager and provider had resolved these issues. We conducted an audit of people's medicines. We found that they were stored at the correct temperatures so they were safe to use and there was a daily audit record of this. When we looked at people's medicine records we saw there was clear guidance for staff to tell them in what circumstances they should administer a person's 'as required' medicines. We also saw a member of staff putting this guidance into practice.

During our visit we looked at people's administration of medicines records (MAR) and found that there were no missed signatures. We also found that the medicines we looked at were all accounted for. This indicated that people had received their medicines correctly. Audits of people's medicines had been completed monthly and had identified any errors or concerns which had then been addressed. Therefore these audits were robust.

We looked at a sample of people's care records. The manager told us that these had been rewritten since the last inspection. We could see that there was detailed information about people's needs. There was information and guidance for staff about how to manage risks to people's safety. For example, one person had communication issues. Their care record contained guidance for staff about how to communicate with this person to express basic information to them. There was further guidance for staff to identify if this person was in pain and what a member of staff would then need to do to address this issue.

The manager and provider of the home had made improvements in these areas. Therefore they were no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for these reasons.

However, during our visit we observed that three people's prescribed thickeners, which was to prevent them from choking when drinking fluids, had been left in their bedrooms, and not stored securely. There is a risk of choking if a person was to ingest this product without the correct dilution of fluid. Some people in the home were living with dementia and were mobile. Therefore they may not realise the thickener could be a danger to their health. We spoke with a senior member of staff about this who said they would remove these prescribed thickeners and put them in the secure medication room. We were later told by the manager that

these had been placed in a locked cupboard in people's rooms.

During our visit we also identified some concerning hygiene and potential infection control issues during our visit. We found a number of infection control risks in all the communal bathrooms and toilet. We had seen staff go with people into these rooms to support them with elements of their personal care throughout our visit. These members of staff had not resolved these infection control issues which we found. We found a number of areas in these rooms where there was dried faecal matter on bathroom furniture and equipment. We also found used continence products which had not been disposed of in the correct way, to prevent the potential spread of infection. We showed the manager these hygiene and potential infection control issues. We later saw a member of staff enter one bathroom to clean it, but they were not wearing the appropriate infection control equipment, such as gloves.

We saw the cleaning rotas of these communal bathrooms and toilets and found they were not being cleaned daily. According to these records some of these rooms were not cleaned for some days. We spoke with the manager about this who said the day we visited they did not have a member of staff cleaning these rooms. On the following day we saw two domestic members of staff during our time at the home. We later spoke with one member of the staff team, who said the home did not always have a member of staff to clean the bathrooms on a daily basis. The manager said that a senior member of staff should be monitoring the bathrooms throughout the day and evening. However when we both checked the list of tasks for the senior staff, this task was not on this list. The manager later updated this list of tasks, to include this. We were also shown some staff minutes of meetings. On two of these minutes' records, domestic staff had raised the issue of care staff not always responding to hygiene and infection control issues when they happened. These records stated that the manager told staff that hygiene and infection control was everyone's responsibility. However, no system was put into place to monitor this issue. We concluded that there were insufficient measures in place to monitor the hygiene and manage infection control concerns at Hill Barn.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment checks were not fully in place. We looked at staff recruitment files. Staff identities had been verified and the Disclosure and Barring Service (DBS) checks, about staff's backgrounds, had been carried out. However, out of three staff files we looked at, two members of staff did not have a record of their full employment history. The application forms completed did not ask staff to give their full employment history. We did see that one member of staff had a gap in their recent employment history which the manager had asked them to clarify. However, we saw a further gap in another member of staff's recent employment history which had not been explained. We concluded that improvements were therefore required in this area.

The people who we spoke with told us that they felt safe living at Hill Barn. One person said, "Yes I feel safe, they [staff] come and sit with you sometimes. Oh yes, there's always someone there for me." Another person told us, "The staff are here all the time, oh yes I feel safe."

People were protected against the potential risk of experiencing abuse. The manager and a senior member of staff had a clear understanding about this. The staff we spoke with said they would speak with the manager if they had concerns about a person experiencing harm in some way. However, not all staff could tell us what the different types or signs of abuse were. Some members of staff were not aware of the outside agencies they could also report safeguarding concerns to. We concluded that staff knowledge and understanding of this important topic was not consistently good amongst the staff team.

We saw that people had detailed risk assessments when they moved into the home. These records were regularly updated and reviewed by the manager. One person was at risk of developing a further breakdown in their skin and had pressure sores. There was a turn chart and specialist equipment in place as a measure to reduce this risk. This demonstrated that the manager was aware of this individual risk and they had put systems in place to monitor and manage it. However, when we looked at this persons turn charts we found there were gaps in these recordings. On some occasions some hours had passed after the recommended repositioning periods. These were put in place by health professionals or by the manager to aid the recovery of this people's pressures sores and prevent them from developing a further breakdown in their skin. We were told by a health professional that this person's pressure sores had improved due to the intervention of the staff. We therefore concluded that this was a records issue. However, this record is important to demonstrate that the home is responding to this risk.

There were various safety tests arranged by the manager and provider which were carried out to ensure the building and the equipment used in the home was safe. The fire alarm was tested on a regular basis. Equipment used to support people to mobilise was serviced on a regular basis. The water was tested yearly for the virus Legionella. This is a bacterium which can grow in water supplies and can cause people to become unwell. There were regular tests to test the temperature of the water to prevent people from being scolded. However, there was also a system used by staff to check the hot water was of the correct temperature in the main bathrooms, so when people were supported to have a bath the water did not scold them. When we looked at this record staff were not always completing this record. It was later explained to us that this measure was an additional safety check to ensure people were not scolded. On the day of the inspection we raised this with the manager who said they would ensure staff completed this additional check in the future.

The manager had a system of identifying and responding to accidents and incidents. We looked at a sample of these records and we could see action had been taken to respond to an accident or injury to try and prevent it from happening again. The manager told us that they reduced the risk of accidents through generally observing staff and people at the home.

People told us that staff responded to their call bells when they pressed them. Sometimes there may be a delay they told us, but they said this was explained, and staff always returned to assist them. One person said, "If they're [staff] busy they'll come and say we'll be back in a few minutes…Oh yes, they do come back." Another person said, "I've not been kept waiting for any length of time at all."

The manager showed us the last six weeks staff rotas and we could see the same amount of staff were on shift providing care to people the days we visited. The staff we spoke with told us they felt there was enough staff to meet people's physical needs but at times they said they felt, "Pushed". On the day we visited we could see that staff were busy and we saw staff asked people if they could wait. We also saw these members of staff returned to these people quickly to support them. The manager and staff told us about plans to increase the staff numbers on the afternoon shift by another member of staff. The purpose of this, the manager told us, was to give staff more time to respond to people's needs. On the days we visited we saw that additional members of staff visited the home who were not rotated on. The manager said that the culture is that staff do, "Pop in to help." We saw that one of these members of staff were not providing support with care but completing other tasks and another assisted with the meal time. We concluded that there was enough staff to meet people's physical needs.

Requires Improvement

Is the service effective?

Our findings

The staff we spoke with felt their induction prepared them for their new role. Some staff had not worked in care before, however they felt supported in their new role by their induction and by their colleagues at Hill Barn. Staff told us that they completed training and then shadowed experienced staff until they started working independently at the home. We looked at the training programme for staff and we could see they had had regular and updated training in subjects such as health and safety, fire safety, first aid, diabetes, and falls prevention. The manager told us that if staff did not pass their on line training they would have to repeat the training. The manager also told us that if staff needed assistance with the training they would do the training together. The manager gave us some examples of when they did this.

We spoke with a health professional who felt the staff's skills and knowledge in supporting people who had pressure sores had improved. They gave the example of a person who had experienced a break down in their skin, resulting in pressure areas. They told us that some of these pressure areas had reduced in size and some had healed completely in the last six months. We observed staff administer people their medicines appropriately. We also saw staff assist people who needed to use specialist equipment to mobilise and transfer from one position to another, in the correct way.

The manager showed us a supervision matrix showing when staff had received their supervision. The staff we spoke with confirmed this happened on a regular basis and told us that they found these meetings with the manager useful. However, the manager was not checking on a regular basis if staff had a good knowledge of particular important subjects relevant to their work. We found some issues with some staff's knowledge about their work. For example we found issues with some staff's knowledge and awareness of safeguarding, infection control, bathroom hygiene, falls prevention and protecting people's confidential information. The manager told us that they completed general observations about staff practice. However, these were not recorded and they had no system to guide them in monitoring staff practice. As a result of this we concluded that improvements needed to be made with staff training, and the way the manager checked staff were competent in all areas of their work.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager had identified a person who at times lacked capacity to agree to receive their medicines. We could see the manager had followed the principles of the MCA and completed a best interest process

involving professionals and the person's relatives. There was a plan of action in place to support this person to receive their medicines covertly (hidden in food and/or drink) in their best interests if they refused to take them.

People told us that staff asked them if they wanted support with elements of their daily care. One person told us, "They [staff] say will it be alright, and if I think it's too early, they say that's alright and ask me how long I'd like to stay in bed." The staff we spoke with told us how they sought people's consent when they supported them with their care needs. Some staff talked about the importance of offering people choices and supporting people to make their own decisions. We saw staff asking people if they wanted to go into the dining room for lunch and asking people where they wanted to sit.

We found some issues with how some people had been identified as requiring a DoLS. The manager told us that they had made applications to the local authority for three people to be placed under a DoLS. They told us that this was because pressure mats had been placed by their beds as they were a risk of falls. However, they had not assessed the individual's capacity to see if they were able to consent to the pressure matts to be placed by their beds. We spoke with the manager about this; they told us that these people had capacity to agree to have a pressure mat next to their beds. Therefore if they had capacity to make this decision a DoLS was not required at this stage. The manager told us that they had contacted the local authority and was following their advice. We concluded that, positively, the manager had sought advice and acted upon it.

We saw one person who was regularly trying to leave the building, but as the doors were all locked, they could not leave the building. This issue had not been identified and investigated further by the manager or senior staff, to see if they were restricting this person's movement. We concluded that there was a lack of understanding of when a DoLS needed to be considered.

We recommend that the service seeks advice and guidance from a reputable source about how to meet the requirements of the MCA DoLS.

People spoke positively about the food and drink at Hill Barn. One person said, "The food is good, there's always a couple of choices, [chef] comes round in a little while, [chef] tells me what's on for tomorrow, you can ask if you want something different." We asked one person about the meal they had just had, they said, "I'm well fed, I enjoyed it."

People were supported and encouraged to make decisions about what they wanted to eat. In the morning we observed the chef asking people what they wanted to have to eat the next day. During lunch one person asked for something different to what was on the menu, we saw a member of staff ask the chef to make a different meal for this person.

We saw that meal times were well spaced and people ate at their own pace. Some people were supported to eat their meals. Staff supported these people at their own pace and staff checked if they were happy with what they were eating. On one occasion a person was asked if they wanted something different, and this was arranged.

During the day a member of the kitchen staff took a tea trolley around the home on two occasions and they asked people if they wanted a hot drink and a snack. We also saw staff asking people if they wanted other drinks during the day and they encouraged people to drink when they walked past them. Around the home there were bowls of fruit, we saw some people eating this fruit.

We could see real efforts had been made to make the dining experience a pleasant one. There were napkins on the table and table cloths. There was a white board with the menu options clearly written. Music was playing but this was on very low. Despite there being a strong staff presence in the dining room they did not take the opportunity to engage with people, while supporting them to eat or when eating their own lunch. We raised this issue with the manager who disagreed with us. They believed that there was a strong social atmosphere at lunch time. However, the manager was not asking other people about their views of the dining experience; they had based this view on their own experiences at lunch time at the home.

The chef told us how they encouraged people to try different types of meals and involved people in the planning of the menus. They also told us that they do not, "Stick rigid to the menus." They explained if the weather changes suddenly they can change what is on offer that day. The chef told us that most foods and meals were, "Cooked from scratch." They also made people a cake on their birthdays.

The manager had identified people who required a specialist diet. We spoke to the chef about these people. The chef was aware of these people's dietary needs. They showed us a list of what people were eating that day. It stated who was on a special diet. The chef showed us the guidance they followed from a specialist health team. This gave guidance when preparing people's food who were at risk of choking or those who were at risk of not eating enough to maintain a healthy weight.

People were supported to maintain a good health and had access to healthcare services. We spoke with visiting health professionals to the home. They told us that staff responded appropriately in a timely way when a person was unwell. We observed a health professional advising a senior member of staff about a person's dressings in relation to a breakdown in their skin. We then saw that this member of staff made a telephone call to arrange delivery for these dressings.

Requires Improvement

Is the service caring?

Our findings

When we visited Hill Barn we observed many interactions between staff and the people who lived at the home. We observed some staff treat people in a kind and caring way. We also observed some occasions when we found these interactions were not caring or respectful to people.

We saw that one person had had an incontinence episode. A member of staff ran towards them saying in a loud voice, "What have you been eating." Soon after, this member of staff asked for assistance from another member of staff. With the person then in the bathroom, this second member of staff said that they would now leave, this first member of staff then said in a raised voice "Stay, stay, don't leave." We felt the tone and approach did not promote this person's dignity and it was not respectful to this person.

We saw a person in the living room sit forward holding their head with their hands with their head on their lap, rocking forward. At this point a member of staff walked past them, they said, "Are you alright?" However, this member of staff did not stop to see if the person was well or needed support, they carried on walking. This member of staff walked out of the room and did not speak with this person. We observed another occasion when a person was distressed and staff did not stop to talk and see if this person needed support or reassurance.

At lunch time we saw a member of staff leaving the dining room quickly saying "I don't like secrets, I don't like secrets." We also saw a different member of staff leave the room saying, "I can't take this [swear word] anymore." We raised these individual situations with the provider and manager. The provider said these were "Banter, conversations." However, we looked in the room and we did not see or hear people or staff laughing at these times. We also did not feel it was conducive to a friendly and caring environment.

We looked into a filling cabinet where people's care records were stored. We found a collection of personal photos about a person's relative. These were on the drawer floor and some had been damaged by folders being taken in and out of the drawer. We spoke with a member of staff about this, who said, "They must have fallen out of [name of person's] folder." They made no attempts to put these back. We noted that these photos were still like this when we returned the following day. We did not feel this was respectful or caring.

Alternatively we also observed some thoughtful and kind interactions from staff towards the people at the home. We saw one member of staff on several occasions speak in a kind and caring way towards people. On one occasion we saw them hold a person's hand and gently place their other hand on the person's back, as they assisted them to walk. They spoke in a kind and encouraging way to the person. At the same time they communicated to this person in a respectful way. We saw another member of staff dancing with another person. A person spontaneously went up to the manager and gave them a hug. We heard another member of staff offer support and re-assurance when a person was distressed about a health condition they were living with. This member of staff spent time with this person, and spoke in a kind re-assuring way.

One person we spoke with spoke positively about the staff, they said, "They're [staff] very caring in looking

after me. The attention here has been excellent, and from all the staff, it doesn't matter who it is." Another person said, "The service is good, everything to my mind is first class."

We concluded that staff were caring towards the people at the home. However, there were also other times when staff practice in this way required improvement.

People told us that staff protected their privacy. One person said, "They [staff] knock before they come in." Another person said, "I feel it's a private conversation, anything of a personal nature they come and talk to me about it." During our visit we saw staff knocking on people's doors and saying hello before they entered.

However, people's confidential information was not always protected. The manager told us that the filing cabinet which contained people's care records was not locked. During our visit we saw four people's care records left unattended around the home. Two people's records were left near their room in the reception area facing the front door. On two occasions one of these folders was left open. The provider had asked us to be mindful of protecting people's confidential information during our inspection, but had not noted this issue in the home.

The staff we spoke with told us about the people they supported. They demonstrated they knew the people they cared for well. They knew about people's backgrounds, their likes and dislikes, and what they took enjoyment from.

Staff promoted people's independence. Different members of staff were observed at different times, support people to mobilise around the home. We also saw and heard staff encouraging people to make independent decisions for themselves.

Requires Improvement

Is the service responsive?

Our findings

The home had an activity co-ordinator who at present visited for two days a week to provide activities and engage with people on a social basis. We visited the home on one of these days. We saw a person who used to be in a band play the piano which was in the lounge. The activities co-ordinator was singing to people. Music was playing in the lounge at the home from the 1930's 1940's and 1950's. We saw a member of staff dance with a person. Some people were supported to play a quiz. The activity co-ordinator told us they were making plans to bake an Easter cake later that afternoon; they told us how they would involve people in this process.

However, on the first day we visited the activity co-ordinator was not working in this role. Most people sat in a circle in the lounge watching day time TV programmes. The sound was on very low and people were not responding to what they were watching. Some people played with their hands another person occasionally rocked in a forwards movement.

On this first day of our visit the manager had arranged for the local vicar to give a service. We saw people being encouraged to go and we later heard singing during the service. However, not everyone wanted to go and they remained sitting with no social interaction. When people came out of the service they re-joined this atmosphere in the lounge. After lunch people were sat in the circle with the TV on. We spoke with one person and they said, "I'm waiting for the next feed." Staff did not ask people what they wanted to watch on TV during our visit.

During our visit we did not see staff sitting and chatting to people or engaging in an activity. We spoke to staff about this. Staff told us that they did not have time to do this during their shift. One member of staff said, "I get into trouble for doing this, but I am still going to do it." Some staff said they used the time when they were supporting people with their personal care to chat and talk to them.

Some staff were concerned about people who spend most or all their time in their rooms, they felt these people did not have enough social interaction with staff and interests to follow. We spoke with two people who spent a lot of time in their rooms. One person told us about the interests they followed, another person told us, "I haven't seen people for a long time, just passing the door, that's all. I shan't see anybody for ages when you're gone."

People's interests were identified but these were not always explored with people. One person had a particular lifelong interest and their advocate was supposed to be planning for this person to attend an event, but this had not happened, and there were no plans to follow this up with the advocate. Another person had communication difficulties, although their care records were person centred, there was no plan to try and address this communication barrier.

Some staff we spoke with felt there could be more planned events and outings at the home. Some staff visited on their days off and encouraged their relatives to visit to chat to people. We spoke with the manager

about this who said arranging transport for people was too complicated. They felt it unfair to people who could not leave the home. They had decided to use resources to have entertainers visit the home instead. However, the manager had not asked each person what they wanted to do. There were also no current plans for entertainers to visit the home. After our visit the manager sent us information about two planned events taking place.

The manager told us that every person's needs were reviewed monthly. We looked at some people's care records and we could see these reviews were taking place. During our visit we saw a member of staff, who was not due to be on shift that day, asking people if they were happy with their care. However, we noted at people's reviews they were not asked about their social needs, and if they felt these needs were being met.

During our visit we spoke with the manager about these issues who told us of plans to introduce another member of staff in the afternoons. However, the manager and staff told us that this was to support staff with the tasks they completed. The manager also told us about plans to increase the hours of the activity co-ordinator but this had not happened yet.

We concluded that although there were positive elements in meeting people's social needs, this area of the service still required improvements to be made.

People were involved in the planning of their care. One person's relative told us, "Yes they filled it in [care plan] with [relative] and gave it to me to bring home and add any bits, more the history." Another person's relative also told us, "They have involved us with updating the care plan, fairly recently, I actually took it home and went through it. It's everything from what we wish to what can be done."

At this inspection we looked at a sample of people's care assessments. These were person centred documents covering in detail people's lives so far. We gained a picture of the individual person from reading these assessments and care records. Some of these people's documents contained photos of them and the important people to them in their past and present life. We could see people and or their relatives had been fully involved in creating these documents. When we went into some people's rooms we could see that people's interests and hobbies had been explored further.

We spoke with a member of staff who felt that the care plans had improved significantly recently. They told us how they encouraged people to get involved in the writing of these documents. However, they felt that staff should spend more time looking at these documents. These documents also contained detailed information about people's physical and emotional needs. We did raise this suggestion to the manager, who said they would consider a way to maximise these person centred documents.

People told us that they were offered choices with their daily life. One person said, I go outside (garden) in my wheelchair, they'll [staff] wheel me around, I go when I want to go, I tell them." Another person told us, "They [staff] say will it be all right, and if I think it's too early they say that's all right and ask me how long I'd like to stay in bed. I had a late breakfast today, sometimes I go down to the dining room, I decide."

During our visit we saw staff asking people what they wanted to eat and drink. Where they wanted to sit and if they wanted to attend a Christian service. When we spoke with staff they told us how they offered people choice with their daily needs. However, we found choices relating to people's social needs were limited.

The manager told us that the home had a complaints and compliments system. They said they had not received any complaints. We found a folder containing many cards from relatives expressing their compliments about the care their relatives had received.

Requires Improvement

Is the service well-led?

Our findings

There were times when the service was not well led. We identified numerous issues with infection control and the hygiene of the communal bathrooms and toilets on the first day of our visit. This could have caused people to become unwell. There were no robust systems in place to ensure good infection control measures were in place throughout the day and night at the home. Bathrooms were not being cleaned on a regular basis to ensure high standards of infection control. We noted in two recent staff minutes meetings that the manager had raised the view of domestic staff that care staff had not always responded to infection control issues, when they occurred. Despite this there was no robust plan or way of monitoring this issue. We concluded that there was a lack of robust monitoring and auditing of infection control standards in the home.

We found that some people's prescribed thickeners were not stored in a safe place. One person's daily notes were not completed and an incomplete record of bath temperatures had been kept. These areas were being audited but the fact we also found shortfalls in these areas, demonstrated that these audits were not always effective.

There were some shortfalls in staff's knowledge and understanding of certain important areas, such as safeguarding people from abuse, and protecting people's confidential information. The manager was not checking staff had maintained a good awareness and understanding of these areas. Important training areas were not revisited to check staff had a good knowledge in these subjects.

We also found some issues with how staff communicated with people or dealt with difficult situations with people. Staff practice was not observed or monitored in a robust way. There were no recorded quality checks taking place in these areas to ensure good standards of care were consistently delivered to people at Hill Barn. There was no testing of the culture of the service. What the aims and values of the service were and if these were shared and put into practice by staff.

Staff told us and we observed that staff did not have time to chat and engage with people on a daily basis. People did not leave the home unless their relatives took them out. There were no planned events to bring activities and events into the home.

We addressed all these issues with the manager and provider both during and at the end of our inspection. The manager addressed the initial infection control issue and put a system in place to ensure that senior staff checked infection control standards during their shift. However, the level of cleaning was not addressed nor was the staff's training or knowledge of this important area.

The manager said they recognised that there was limited interaction with people at the home. They told us about plans to increase staff numbers, and to arrange entertainers and events in the home. However, at the time of the inspection there were no concrete plans in place.

When we addressed the issue of staff responses to the people at the home the provider told us that we had taken what we had seen and heard, "Out of context." In reference to how one member of staff spoke with a person the provider said, "I would talk to my children like that." They did not consider our experiences and investigate the situation. They did not devise a plan to ensure how staff spoke and interacted with people was monitored and checked in the future, to ensure people's dignity and needs were placed first.

When we visited the home the last rating of the home was not displayed. We spoke to the manager about this who addressed this straight away. We also raised the issue of the rating not being displayed on the home's website address. We also spoke with the manager and provider about this. When we looked at the home's website sometime after the inspection we found this link was not clearly displayed, so that the public would be prompted to look at the last report and know the current rating.

There were no audits or quality monitoring assessments taking place from a third party arranged by the provider in order to give the manager and provider an independent objective perspective.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the home we initially found it homely. We could see that the manager had made efforts to engage the local community. There had been a fund raising event last year at the home. Two local Christian faith groups were visiting the home to provide a spiritual service to those who chose to engage with this. An Easter raffle had been arranged. People's relatives visited throughout our visit to the home.

People's relatives were asked about their views of the service and said they felt involved in their relative's care. We were shown 'resident's meeting' where a group of people living in the home and some of their relatives regularly met. We also saw that staff had been asked to complete questionnaires. However, some staff felt they could be more involved, and asked their suggestions about how the home could be improved.

A visiting health professional and members of staff spoke positively about the manager. These professionals felt the home had improved since the current manager started in this role over a year ago.

The manager had a clear understanding of the important events that they must notify, by law, the Care Quality Commission (CQC) about. Our records we hold about the service confirmed this.

We found that the recording and administration of medicines were regularly being audited. We could see when issues where identified action was taken to address these. Accidents and incidents records were also being checked on a regular basis.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. Regulation 12 (1) and (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. Regulation 17 (1) and (2) (a) (b) (d) and (e).