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Hilldales Residential Care Home

Inspection report

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Ratings

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

Overall summary

This comprehensive inspection took place on 23 September, 1 and 7 October 2015 and was unannounced.

The service was previously inspected in December 2014 and January 2015 when the service was rated as Inadequate overall. At that inspection we found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches related to the provider not having suitable safeguards in place to protect people from the risk of fire; a lack of suitable systems in place to protect people from unsafe management and administration of medicines; a lack of systems to ensure people were protected from the risk of financial abuse; people's dignity and privacy was not always respected; people's needs and risks had not been fully assessed and care plans did not describe how to support people; people who lacked mental capacity to make particular decisions were not protected, people

Summary of findings

were being restricted without appropriate Deprivation of Liberty Safeguards authorisations and there were a lack of systems to assess and monitor the quality of the services provided.

After the previous inspection, the provider had submitted an action plan in July 2015 showing what improvements they had already made or intended to make to address the breaches that had been found. We reviewed the progress against this action plan as part of the inspection. All actions in the action plan were due to be completed by August 2015 although some were identified as on-going actions which implied they had been implemented but would continue forthwith, for example service user surveys.

At this inspection we found there had been some improvements in relation to protecting people in the event of fire. We also found people's dignity and privacy was respected and there had been some systems introduced to protect people from the risk of financial abuse.

Since April 2015 new regulations have been introduced. These are called the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore in this report we describe the Regulation 2010 breach and how that is translated into the Regulations 2014. At this inspection we found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found breaches of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

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

At this inspection, there were 40 people staying at the home, all of whom had lived at Hilldales Residential Care Home for a number of years. Staff support was provided at the home at all times; however some people did not require staff support when away from the home.

At the last inspection, we found Hilldales Residential Care Home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. 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 CQC. At this inspection, we found that although an application by a senior member of staff for a registered manager had been received by the CQC, this had been rejected in June 2015 as it was incomplete and no further application had been submitted. Senior staff continued to manage the home in the absence of a registered manager. By the end of the inspection a recruitment process for a registered manager was underway.

There were still some areas of medicine administration which were not safe. Risk assessments carried out for people who self-administered their own medicines did not ensure that all risks had been considered, including harm to the person and to others.

We recommended that the provider should consider reviewing their medicines policy and procedures to ensure they are in line with national guidelines.

At the last inspection, we found the provider had not notified CQC about significant events that had occurred, including safeguarding concerns and incidents where the police had been involved. At this inspection we found evidence of events that had occurred since the last inspection, including incidents of abuse and incidents where the police had been involved. These had not been notified to the CQC. This meant that there was a continued breach of regulation.

Summary of findings

There were a number of safety concerns about the home relating to the building and equipment used. These included the laundry facilities and the infection control risks posed by the maintenance of parts of the building.

There were sufficient numbers of care staff to support people. However we discussed with the provider that the night shifts were very long and some staff doing these shifts were not getting sufficient rest between shifts. We also raised concerns about the cleanliness of the home as there were only two cleaners on the first day of inspection. The provider recruited two additional cleaners by the end of the inspection.

People living at the home and health and social care professionals described the staff as very caring and committed. Staff worked with people in a very caring and professional way. People were able to access food and drink throughout the day and night. A balanced and varied menu was offered and people were involved in choosing what meal options were available. People were supported by staff to access health professionals including their GP, dentist and community nurses. Health and social care professionals described staff as proactive in contacting them when they had a concern.

People who had their money managed by the provider were not protected from the risk of financial abuse as the systems did not ensure they were given information about their income and expenditure.

Staff had completed some training but this had not always been effective. Staff were not able to describe how they would ensure that people's capacity was assessed and where necessary, Deprivation of Liberty Safeguard applications submitted appropriately.

The provider had not complied with the regulation that requires providers to display their ratings from the last inspection.

There were 11 breaches of regulation. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

We are taking further action in relation to this provider and will report on this when it is completed.

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?

Inadequate

The service was not safe.

Although some improvements had been made to keep people safe in the event of a fire, evacuation procedures were not robust.

Staff administered medicines to people safely. However risk assessments had not been carried out to ensure that people who self-administered medicines were able to do so safely.

There were infection risks as there were insufficient cleaning staff to maintain the cleanliness of the home. There were no systems in place to ensure that soiled laundry was dealt with appropriately.

People were not protected from the risk of financial abuse.

There were sufficient care staff to support the needs of the people, although some staff working at night did not always have the legally prescribed rest time between shifts.

Is the service effective?

Requires improvement

The service was not always effective.

Although staff had received some training including training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), they were not able to describe how to apply these where they were needed. There was no evidence of how they had arrived at the decision to apply for a DoLS authorisation.

The home was not well maintained throughout. There had been some investment in some areas of the home including communal areas and fire detection systems. However other areas required redecoration and refurbishment.

People were provided with a balanced and varied diet and could access food and drink at all times. Different dietary needs were catered for.

People were supported to access health professionals including their GP to help them have their health needs met.

Is the service caring?

Good

The service was caring.

People said they liked the staff. Health and social care professionals commented about the dedication, care and loyalty staff showed to people living in Hilldales.

Throughout the inspection, staff were observed being caring about people who used the service and supported them in a kind and friendly manner.

Summary of findings

Staff showed respect for people and ensured they were supported to express their views.

People's privacy and dignity was maintained and upheld by staff.

Is the service responsive?

Requires improvement

The service was not always responsive.

A new care record system was being introduced which involved people in the development of their care plan. However only a small number of people's care records had been transferred to this system. Some of the records did not reflect all people's health needs.

The service did not have a system in place to identify and respond to people's concerns and complaints.

Meetings with people living at Hilldales had occurred, but there was no evidence that these had resulted in changes or improvements to the home.

Is the service well-led?

Inadequate

The service was not well-led.

Staff, health and social care professionals commented that the home was not well led.

There was no registered manager in post.

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

Although some audits, surveys and systems had been introduced to monitor the quality of the home, these had not been effective in improving the service.

Hilldales Residential Care Home

Detailed findings

Background to this inspection

We carried out this comprehensive 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 check whether the provider had taken action to address the breaches of regulations which had been identified at the last inspection.

This inspection took place on 23 September, 1 and 7 October 2015 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor (who was present on the first day of inspection). The specialist advisor was a registered provider of another care home.

We also reviewed the notifications we had received from the provider since the last inspection. Notifications are forms completed by the organisation about certain events which affect people in their care.

We spoke with 10 people receiving a service and 10 members of staff. We reviewed six people's care files, two staff files, staff training records and a selection of policies and procedures and records relating to the management of the service. Following our visit we sought feedback from 12 health and social care professionals to obtain their views of the service provided to people. We received feedback from 11 of them.

Inadequate

Is the service safe?

Our findings

At the inspection in December 2014 and January 2015, we found a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.People were not adequately protected against the risks of fire. This regulation is now covered by Regulation 12 of the 2014 Regulations.

Although there had been some improvements to keep people safe in the event of a fire, there were still some actions outstanding. During the last inspection we raised some concerns about people's safety in the event of a fire. Because of this, staff contacted the local fire officer who visited the home and identified a number of concerns in relation to the building and the procedures that staff should follow in the event of a fire. The fire officer required the provider to submit an action plan to address the concerns. We were informed by the fire officer in May 2015, that the provider had taken action to address the concerns in relation to the fire equipment, including smoke alarms and fire doors in use in the home.

During the inspection we contacted the fire officer who said they had recommended the provider install an emergency fire box which would include personal emergency evacuation plans (PEEPs) for people living at the home. The home did have an emergency fire box in the administrative office; however this only contained laminated floor plans of the home. There were PEEPs in each of the care records reviewed, however these did not provide sufficient information to ensure people's safety as they only described the route the person would need to take if evacuating from their bedroom. We discussed what information a PEEP should hold with the fire officer. He said it should describe the physical and psychological needs of the person in the event of a fire and whether particular equipment would be needed to move them safely. He said the PEEPs should be used to inform staff training for emergencies.

A list of people living in the home entitled 'fire register' was pinned to a notice board in the administrative office. This showed which bedroom people were in and a column indicated some needs for some people, for example "needs motivation"; "may need assistance"; "wheelchair needs assistance". Some people did not have any note against their name and it was unclear whether they did not require assistance or it had not been added. It was also unclear what actual assistance would be needed, for example equipment such as a hoist or more than one member of staff to support the person. We also noted that one person who used a wheelchair was described as "confused needs assistance" but did not mention they required a wheelchair.

We discussed the emergency fire box and other documents with senior staff and they agreed to review the fire register, the PEEPs and the contents of the emergency box.

Staff said that most people who smoked now came downstairs to one of the two smoking lounges or sat outside when they were smoking. However they also said that a few people in the home did smoke in their bedrooms on occasions. Staff said that where this was detected, staff would ask people to extinguish their cigarette or take it to a designated smoking area. However, there were no individual risk assessments or follow up actions relating to any of the people where this had been identified as an ongoing issue.

Some senior staff had received fire warden training and further fire warden training for other senior staff had been booked. Other staff had received fire prevention training. However staff were unable to clearly describe the actions they would take in the event of a fire, for example whether people would be asked to stay in their room or whether they would be evacuated and if so what evacuation procedure would be used.

At the inspection in December 2014 and January 2015, we found a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as medicines were not always administered safely and there were no recorded audits of medicines. This regulation is now covered by Regulation 12 of the 2014 Regulations.

Some people self-administered their own medicines, although staff were responsible for the collection of these people's medicines from the pharmacy and the disposal of unused medicines. Where a person self-administers their own medicines a risk assessment should be completed, which considers the risks to the person, the risk to other people and the risks associated with the storage of medicines. Risk assessments had been completed in July 2015, however these did not cover all the relevant areas, including the risk to others and themselves. Since some

people living at Hilldales were at risk of hoarding medicines rather than taking them at the appropriate time, this was a risk to the person and potentially others. There were no audits of medicines for people who self-administered.

Staff said where people were responsible for administering their own medicines; they stored the medicines in their bedroom in a drawer such as a bedside cabinet, which does not follow the guidance for storing medicines. We discussed this with a senior care worker who arranged for lockable medicines cabinets to be fitted to the wall in all rooms where people administered their own medicines. By the third day of inspection these had been installed.

We also observed staff who were administering medicine using the same disposable plastic pot to dispense peoples' medicines rather than using a new pot for each person. Although the tablets for each person were tipped into their hand from the pot, there was a risk of cross infection and cross contamination. A senior care worker said they would ensure that staff were aware that this practice was not acceptable.

We found that there had been some improvements in medicine administration. We observed two staff administering medicines to people in the home. Staff ensured the correct medicines were given and taken by people before recording it on the medicine administration record (MAR). MAR charts had been completed fully and accurately and there were no unexplained gaps in the entries. Where medicines were administered on an 'as required' basis, staff spoke to the person to check whether they needed the medicine at that time and recorded their response. During one of the medicine rounds, the staff member was interrupted a number of times about issues not related to the medicine administration. This could have caused errors in medicine administration to occur. We discussed this with the senior care workers who said they would consider ways to ensure that people and staff were made aware of the need to avoid interrupting staff during medicine rounds.

The provider should consider reviewing their medicines policy and procedures to ensure they are in line with the national guidelines.

On the first day of inspection, we found bedding in some rooms was engrained with dirt and one duvet cover which had dried food on it. We discussed the arrangements for laundering people's bedding with a senior care worker who confirmed there was no system in place to ensure bedding was changed on a regular basis. By the second day of inspection, there was evidence staff were ensuring that bedding was laundered on a regular basis.

Laundry was washed and dried in an industrial washing machine and tumble drier located in a corridor outside the administration office. There were no systems for separating clean and dirty laundry, or separating those items where there was a high infection risk such as soiled garments or bed linen. We observed baskets of laundry on the floor outside the office which people were walking past. Staff carried soiled laundry through the home which had not been bagged up or put in a container to reduce the risk of infection.

We discussed our concerns with senior care workers on the first day and also with the provider on the second day of inspection. He agreed to review the arrangements and said he would consider relocating the laundry facilities to another part of the building.

Staff did not always use personal protective equipment (PPE) in a way that ensured people were protected from risk of cross infection. We observed two staff leaving toilets, where they had been supporting people with their personal care needs, continuing to wear the protective gloves. This meant that surfaces they came into contact with around the home could be contaminated which placed people at risk of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On the first day of inspection we found the premises had not been cleaned effectively, which meant that people were not kept safe from the risk of infection. Floors were not clean, particularly under beds, at the edges and in the corners of rooms where there was a build-up of dirt and debris. There were a significant number of cracked floor tiles throughout the home where dirt had collected in the cracks. This meant that people were not protected from the risk of infection because safe hygiene standards were not maintained. We discussed our concerns with senior care workers and with the provider and were informed that there were two cleaners for the home. The provider

decided to recruit two additional cleaners. These new staff were in post and undergoing their induction, which included working alongside the other cleaners, by the third day of inspection.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had not taken action to ensure that people using the service were protected from the risk of scalding. For example sinks and baths were not fitted with a temperature control valve to ensure people were not at risk of scalding. Staff confirmed that these were not fitted on the sinks or baths in the home. The provider said that he would ensure that all hot water taps which were used by people in the home would be fitted with a temperature control valve.

At the inspection in December 2014 and January 2015, we found a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risk of financial abuse. This regulation is now covered by Regulation 13 of the 2014 Regulations. In the action plan to address the breach submitted to the Care Quality Commission in July 2015, the provider described the actions they would take to ensure people were protected against the risk of financial abuse. These actions included gaining a person's consent to manage their money and a more robust recording system with a clear audit trail.

At this inspection a member of staff showed us a file which contained information about expenditure that had been made on behalf of a person. Each entry had been signed by the person to acknowledge the expenditure. The provider said entries from this log were then used to update a spreadsheet for each person. However, the provider added that they did not give each person, information about their income and expenditure. They stated this was because if people knew how much money they had, they would "Go and spend it on a bottle of cider". We discussed our concerns that appropriate assessments had not taken place to ensure people had capacity to understand how their money was managed, or where they did not have capacity, families or the Court of Protection had been involved. The provider was not able to give an answer to this. The provider said he did undertake six monthly audits of people's finances and that he was about to undertake an audit of the finances. However it was unclear how this audit provided assurance to anyone about their finances as this was not shared with them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff had an understanding of processes to safeguard people from harm and had received training. There were reports of incidents where a person had allegedly abused another and records showed that staff had taken appropriate actions to ensure people were kept safe. However staff had not fully assessed the likelihood and risks of a recurrence or evidenced what actions they had taken to reduce the risk. This meant that staff had not proactively assessed the risk of people being harmed or identified ways in which they could reduce the risks.

Most people said they felt safe and cared for at Hilldales, although one person commented that they sometimes felt threatened by other people living in the home. They said staff tried to ensure their safety, however they found it was easiest to avoid the person.

One person said "Gold stars to all the staff" and another person said they thought "things had improved" in the last nine months, adding "staff are ok."

There were sufficient care staff on duty at all times. Staff worked with people in a calm and unrushed way. We observed people who needed support to move between areas, saying they wanted to go back to their bedroom and getting immediate help from staff to do so. Health and social care professionals described how staff were normally available and able to support people during their visits. They also commented that senior staff were always willing to meet with them if required. Staff said they felt there were enough care staff on duty during the day and at night to support people safely. However we raised our concern with senior staff and the provider about the length of the night shift as staff came on duty at 5:00pm and did a 15 hour waking shift until 8:00am the following morning. Some staff did this for four consecutive nights without a legally required minimum of an 11 hour rest between shifts. The provider agreed to review the shift patterns.

In addition to the care staff, there was an administrator, two chefs, a maintenance person and two cleaners. Two additional cleaners were in post by the end of the

Inadequate

Is the service safe?

inspection. We discussed whether checks had been made on these two new members of staff prior to their employment. Staff said references for each member of staff had been received and they were waiting information from the Disclosure and Barring Service (DBS) for them. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. In the meantime, risk assessments had been completed consider whether the staff should be able to work at the home prior to receipt of the DBS check. The risk assessments had included a requirement that the staff should not work alone in the home at any point until the DBS information had been received and reviewed. We were sent copies of these risk assessments.

Requires improvement

Is the service effective?

Our findings

At the inspection in December 2014 and January 2015, we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People who lacked mental capacity to make particular decisions were not protected. Staff were restricting people but had not applied for Deprivation of Liberty Safeguards (DoLS) authorisations. This regulation is now covered by Regulation 11 of the 2014 Regulations.

At this inspection we found evidence that the Mental Capacity Act (MCA) 2005 was not being followed when complex decisions needed to be made such as whether a person was able to understand and retain information relating to their finances. Where staff had a concern that a person did not have capacity, no capacity assessment had been completed. 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. There was no evidence that best interest meeting had been held or best interest decisions made for people without capacity.

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

There was no mention of DoLS applications being made in people's assessed needs. For example, one person's care file did not show some information leading to a DoLS application being made. However, a DoLS application had been submitted to the local authority although there was no record of mental capacity assessments and best interest decisions being completed prior to this, including any involvement of relevant health and social care professionals. As a result, it was unclear about the rationale for the DoLS application as there was no clear audit trail to show increasing risks with a need to deprive the person of a particular liberty. We asked whether there was any more paperwork to demonstrate the decisions to apply for DoLS authorisations and was told there was none.

Staff had submitted applications for DoLS for seven people living at Hilldales. One person's authorisation had been granted although they had subsequently left the home. A social care professional said they had been involved in supporting the home to make the application successfully. One other application had been rejected on the grounds that the evidence was insufficient. All the other applications were still awaiting assessment by the relevant local authority. Although there were DoLS applications waiting to be assessed, we did not observe people being restricted in terms of leaving the home during the inspection.

Staff were unable to evidence what processes they had undertaken and were not able to describe how they had arrived at the decision that a DoLS application was needed. These processes might have included a review of any recent concerns relating to the person's capacity around a specific issue and a best interest meeting involving family, staff and health and social care professionals. This showed that staff did not fully understand what they needed to do when a person lacked capacity.

One care record had a review of needs which had been carried out by the commissioning authority. However some of the information had not been transferred to the person's care plan drawn up by staff in the home. When asked, staff were not aware of the contents of the review Therefore this meant staff were not aware of all the necessary information about the person to ensure care could be delivered effectively. No capacity assessments had been carried out by staff at the home for this person, although when asked, staff said the person "Had capacity". However this conflicted with what the local authority had recorded in their assessment.

After the inspection we spoke with a member of staff at the local authority DoLS team. They looked at the information they had about two applications for DoLS. They said the applications had been reviewed when first received and considered low priority in terms of dealing with them in comparison with applications from other care homes. They described the information in the applications to be 'scanty'.

Requires improvement

Is the service effective?

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

At the inspection in December 2014 and January 2015, we found that staff had not received appropriate support, training, supervision and appraisal to enable them to carry out their duties effectively.

At this inspection, we found that staff had received some training although some staff said they found some of the training difficult to follow and complete. Some staff also said they did not feel confident that they understood the training. Staff had received face to face training in fire evacuation and some senior staff had done fire warden training, with other senior staff booked to attend a fire warden's course in the coming months. However staff were not able to describe how they would safely evacuate people in the event of a fire. We discussed this with senior staff who said they would discuss further evacuation training for staff with the company that did their fire safety checks. Less than 50% of staff had completed training in health and safety, first aid and safeguarding vulnerable adults.

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

Over 95% of staff had completed food hygiene and infection control training. Senior staff said additional sessions had been booked for staff to attend first aid training in October 2015 and a course in managing challenging behaviour in November 2015.

10 staff had completed a level two or level three qualification which related to the work they were doing. Staff said they were supported to undertake qualifications from time to time. One person said they had not been given any time to support them with a qualification, although they had been promised this when they agreed to undertake the training.

Staff said they had received supervision on a regular basis and records showed that most staff had had at least two, and in some instances, three supervision sessions since January 2015. However there was no evidence that supervisions or appraisals had identified the concerns staff had in respect of the training they had received.

Some parts of the home were not well maintained or decorated. For example one bedroom, which a person had moved into in the last six months, had wall decorations from the previous occupant, which they said they had not chosen to have remain. We raised this with staff who arranged for the room to be redecorated by the end of the inspection. Throughout many of the communal areas there were cracked floor tiles and walls which needed redecorating as they were dirty and had damp patches showing. The provider said he would undertake a redecoration programme to address these areas.

Some investment had been made in the home with three new bedrooms and some communal areas had been redecorated and refurbished. For example there was a non-smoking lounge area which had been redecorated and refurbished. New extractor fans had been fitted in both the smoking lounges which improved the air quality. Smoke detectors and new fire doors had also been installed. A wheelchair storage area under the stairs had been created where three wheelchairs could be stored and outside a shed with sloping access had been constructed to provide people who had mobility scooters, a safe place to store them.

People were supported to have enough food and drink throughout the day. Meals were freshly prepared by two chefs and a choice was offered. One person who had specific health conditions said they were offered alternatives which took into account their dietary needs. People commented that they liked the food and there was plenty of it. Comments included "The food is really good", "I can have something different if I don't like what is on offer". Throughout the inspection we observed people who were able, helping themselves to refreshments. We also saw people who were not mobile being given drinks and snacks. We observed a member of staff talking to one person about what they wanted for the evening meal. When the person said they didn't like either of the choices, the staff member asked whether they would prefer an omelette instead which the person said they would. There was evidence of meetings with people living at Hilldales to discuss menus.

People were supported to maintain good health. Staff worked with other health professionals, including GPs, community nurses, dentists and hospital staff to ensure that people's health needs were addressed. People were referred to healthcare professionals appropriately and we

Requires improvement

Is the service effective?

saw records where people had accessed their GP, district nurses and specialist consultants. Staff also arranged for a chiropodist to visit the home so that people could have their podiatry needs met. A health professional said the staff always welcomed them when they came to the home and ensured that the person they were visiting was ready for their appointment. They described staff as "Proactive" in calling them if they identified a problem. During our visits we observed staff dealing efficiently and effectively with an emergency situation where a person had become unwell overnight. This included calling paramedics who attended the person and arranging for them to be transferred to hospital.

Good

Is the service caring?

Our findings

At the inspection in December 2014 and January 2015, we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People's dignity and privacy was not always respected. This regulation is now covered by Regulation 10 of the 2014 Regulations. At this inspection we found that the breach had been met, as people's privacy and dignity was respected.

At the last inspection one concern that had been identified was that people were asleep in bedrooms with their door open. Staff were unable to show that the person had been asked whether they wished this to be the case. We also observed people receiving chiropody treatment in communal areas which did not show respect for them or the other people in the room.

At this inspection, improvements had been made to ensure that people were afforded privacy and dignity. People were asked whether they wished to have their bedroom door open when they were asleep in bed and their choice had been recorded. People had completed a form which showed their preference and this was held in their care record.

The provider had changed a bedroom to a quiet room where treatments could be carried out in privacy. This room was also available to people if they wanted to meet with a person in private.

Throughout the inspection there were positive interactions between staff and people. Staff were kind and caring towards people, talking to them in a kind and friendly manner. Staff showed an in-depth knowledge of people and were able to describe their likes and dislikes. Staff were available in communal areas of the home and helped to create a happy and friendly atmosphere. While supporting people, the staff gave them the time they required to communicate their wishes and it was clear that they understood people's needs well to enable them to provide the support people required. One person said, "Most of the staff are marvellous, nothing is too much trouble." Another person said "Staff have really helped me get well again."

Nearly all the staff, including care staff, domestic staff and administrative staff had worked at Hilldales for a number of years and showed loyalty and commitment to the people living there. People were encouraged to express their views through individual and group meetings.

Health and social care professionals described the staff as "Very committed" and "Good with the service users." One professional said "The over-riding impression that I always get when I go into Hilldales is how dedicated the staff are to their job and how proud they are of the often difficult work that they do. The staff appear very caring and there always seems genuine warmth in their interaction with the clients. Some carers have spoken to me about how protective they feel about the clients as the local community attitude is not always friendly or supportive towards them."

Another professional said they had no concerns about the staff's ability and approach to people in the home and they were happy with the care people were receiving. They described how the staff would phone their office for advice or guidance if they had a concern about a person. They added "The staff know their residents very well and are very caring."

People were supported to express their views and be involved in making decisions about their care. Staff were respectful of people and offered them opportunities to decide what they wanted to do. For example, one person described how they had chosen to move to another room because of easier access. They said staff had supported them with this.

People were able to attend meetings held by the provider and staff to discuss the running of the home, including the activities that were offered. Staff were also working with people to develop care plans which described how they wanted to be looked after.

Requires improvement

Is the service responsive?

Our findings

At the inspection in December 2014 and January 2015, we found a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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 meet those needs. This regulation is now covered by Regulation 9 of the 2014 Regulations.

At this inspection, senior staff said they had worked on a new format for care plans. However on the first day of inspection, only one care plan had been updated to the new format. Staff said they had not yet had time to ensure all care records were up to date and in the new format. By the third day of inspection, senior staff said they had completed four care plans using the new format and were working on a fifth. They described how they had involved the person in the development of the care plan and said as a consequence "We have found out quite a lot about the person which we didn't know about before."

We reviewed two care plans which had been put into the new format. Although the care plans had more detail about the person including their likes and dislikes, some of the information relating to people was incorrect or vague. For example, one care plan described someone as having "fits" and there was no mention of a health issue that had significantly impacted the person's sight in the last year. The record also did not adequately describe a disability other than to say this had caused the person's 'other medical conditions'. This meant that staff might not fully understand what health issues the person had. We discussed the person's health with two members of staff, one of whom said that the person had had a stroke the previous year, whilst the other said they had "Had a fit." We discussed this with a senior care worker who described an incident where the person had had an epileptic seizure and had been supported by the staff accompanying them. However, there was no information about how frequently the person had seizures or what actions to take if the person had seizures. This showed that some staff did not have a good understanding of each person's risks and needs or how these should be met.

One health and social care professional said that whilst staff were kind, they did not always ensure that they took into account what people wanted. They said staff sometimes had a "Paternalistic view of what people ought to do" and therefore did not always explore with or assist people to achieve their ambitions. They described one person who wanted to move to another county but who had not been supported to achieve this aim as staff had not considered it to be possible. The provider informed us after the inspection that they had been working with the local authority and advocate for a person who wanted to move from the home.

Another professional said "Staff appear to know clients' preferred routines to enable then to deliver care in a person-centred way although client's care plans do not always reflect this personal approach". Two senior staff described their role as keeping people safe and healthy.

There was a weekly activities programme on display in the dining room. The programme listed one activity each weekday which started at 2pm. The activities consisted of one session each week of bingo, karaoke, pampering, a quiz and a film session. On the first day of inspection, the activity was supposed to be a quiz, although there was no evidence that this happened. One person said they enjoyed the bingo session, but did not want to participate in any of the other activities as they did not enjoy them. Another person said they enjoyed the weekly karaoke session. However there was very little evidence that people's individual preferences had been explored with them and activities arranged to suit their preferences.

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

Two people went out with an organized walking group and one person said they had "A great time." The staff at the home had supported these people to develop links with other local walking groups.

There was a complaints policy which was dated 1 April 2015. However the document was a generic document which had been downloaded from the internet and did not describe how complaints would be managed and dealt with in the home. The policy made reference to a complaints procedure, but when this was asked for, we were told the procedure did not exist. We were shown a document which described a complaint that had been received. However the description of the concern and the lessons identified as having been learned did not provide

Requires improvement

Is the service responsive?

assurance that the complaint had been resolved to the person's satisfaction or that systems had been put in place to consider what learning had actually happened. Two people also said they had raised concerns in the past but these had not been dealt with. A health and social care professional said they had worked with a person at Hilldales who had made a complaint but that this had not been dealt with to the satisfaction of the person concerned.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider does not require a registered manager to be in place unless he is not involved on a day to day basis. At the inspection in December 2014 and January 2015, we identified that there was no registered manager in post and the provider was not involved on a day-to-day basis. The provider said that he was considering how to address this issue. He later said that a person working at Hilldales was applying to register with the Care Quality Commission (CQC) as the manager. At this inspection, a senior member of staff was acting in the role of manager. Although an application was made for a registered manager, this was rejected in June 2015 as the application was incorrect. No further application has been received since the rejection. The provider said he was unaware of the application rejection. This meant that at the time of this inspection, the home did not have a registered manager in place or an application in the process of being considered. We discussed this with the provider during the inspection. He said he had decided to advertise for a registered manager. After the inspection, we were informed that a recruitment process for a registered manager was underway.

At the last inspection we found 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.

In July 2015 we received a statement of purpose from the provider which stated the aim of Hilldales as offering “men and women over the age of 25 who may have mental health problems and/or alcohol problems the opportunity to live in a caring environment with support from our care staff.”

The statement of purpose also described the beliefs and core values as:

“Lead as fulfilling and independent lives as possible by the provision of services within the home.

- Be protected from harm, abuse and exploitation.
- Grow and develop as individuals.
- Contribute to their community as citizens.
- Not be disadvantaged or discriminated against on grounds of gender, ethnic origin, age, disability, religious belief, sexual orientation, social class or cultural background.”

We asked the provider to review the content of this against the requirements on the CQC website and resubmit it. This had not been done by the time of the inspection.

However it was not clear how the people at the home were supported to achieve these beliefs and values. One person said they had been supported by staff to move on, but another person said they did not feel that staff supported them to achieve their ambition to move closer to their home town. A health and social care professional said that they felt staff had not supported a person who had said they wished to move from the home.

Health and social care professionals said that though staff were very caring and senior care workers worked hard to support them, they did not think there was good leadership. One professional said “Senior workers do their best but it is difficult for them to manage this as they should when they spend so much time actually caring.” Another said “The service is not always well-led”.

Staff also commented on the lack of management. One member of staff said “The management of the home requires improvement as although it’s not always a major problem for staff or residents, the system has been a bit chaotic.”

At the inspection in December 2014 and January 2015, we found a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not have systems in place to assess and monitor the quality of the home. This regulation is now covered by Regulation 17 of the 2014 Regulations.

Although the provider had implemented some systems to assess and monitor the quality of the care provided, these were not effective. At this inspection, systems had not been introduced to assess the quality of care that was delivered. A new care record format was in the process of being introduced at the home. However, the content of those care records which had been transferred to this system had been reviewed. There was evidence that significant issues relating to one person’s medical history and current needs had not been fully completed.

Inadequate

Is the service well-led?

There were meetings with people living at Hilldales in March and July 2015. However, the records of the meetings showed very little evidence that there was a meaningful discussion with people in the home, as the minutes described information being given out to people. For example people were told by a senior member of staff about where they were allowed to smoke in the house. This included informing people about the escalating penalties that would be imposed if they persisted to smoke in their bedrooms, including "the resident will be fined" and "possibility of throwing the resident out of the care home."

The records of the March 2015 meeting contained two requests from people living in the home, one relating to having a larger print menu and another requesting "day trips to start again". These had not been actioned.

In the July 2015 meeting, people had requested access to the internet router hub and a smoking area outside to sit and smoke with tables and benches. These requests had not resulted in any action or explanation as to why they could not happen. During the inspection, we observed people sitting on the steps outside the home and one chair placed in a parking area where several people frequently smoked.

People had completed a recent survey about living in the home. Staff had also completed a survey. However, the provider was unable to describe what improvements or changes had been made as a result of the survey. We asked the provider for the analysis and action plans from the survey but have not received them.

Although a new system for auditing medicines had been introduced, this did not provide assurance of the stocks of medicines held by the home. A senior care worker said they would consider how to improve the audit so that it gave the assurance needed.

Staff meetings had been held in March and July 2015. However the minutes of the meetings did not show any evidence that staff had been actively involved in discussion as the minutes only described information given to staff about what they should do in respect of training, safety and care planning.

Although the provider said they undertook regular monitoring visits to the home, these visits had not identified the issues that that we found in the medication audit or in the cleanliness of the home.

The provider did undertake a six month review of incidents and accidents that had occurred in the home. He stated that through this he had identified the need for staff to receive training in relation to moving and handling and in relation to managing challenging behaviour. We asked the provider what incidents or accidents had occurred that had led to the need for staff to need moving and handling training. He said some people had had falls. When asked whether this was as a result of staff not using correct person handling techniques, he said it was not and was unable to explain how the training would prevent or reduce people from falling.

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

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 the death of people living at the service, allegations of abuse, incidents involving serious injury and incidents involving the police. At the last inspection, we found that the provider had not notified us of incidents other than the death of people using the service. Since the last inspection the CQC had received some statutory notifications from the home relating to four deaths that had occurred. However there were other incidents where the home had not submitted a statutory notification including incidents of abuse and incidents where there was police involvement.

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

It is a legal requirement to display the lasts CQC rating. At our inspection we found that the ratings from our previous inspection were not displayed anywhere in the home. We discussed this with senior staff on the first and second days of inspection and with the provider on the third day of inspection. The provider said the ratings had been displayed but a person living in the home had taken them down as they did not like notices being displayed. However we saw evidence of notice boards around the home on which there were a number of notices which staff said had been pinned there for a number of weeks. We also found no evidence that actions had been taken to rectify the problem when it occurred.

Inadequate

Is the service well-led?

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessments had not always been carried out to determine the risks to people of self-medicating. Evacuation procedures in the event of a fire were not robust. People were not protected from the risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Some areas of the premises were not maintained fully and some areas required redecoration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People had not always been protected from the risk of financial abuse as there were no systems in place to manage and audit their money effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Although staff had received some training, they were unable to describe what they would do in the event of having to evacuate the building. Staff had completed some training face to face and some e-learning, however, less than 50% of staff had completed training in health and safety, first aid and safeguarding vulnerable adults.

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 9 HSCA (RA) Regulations 2014 Person-centred care Staff did not always ensure that people were supported to make choices about their care and treatment. There was little evidence that people's individual preferences had been explored with them and activities arranged to suit their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The complaints policy did not adequately describe the systems and processes by which complaints were dealt with in the home. Complaints were not dealt with in a satisfactory or timely manner. Complaints which had been raised had not be dealt with to the satisfaction of the complainant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Although the provider had implemented some systems to assess and monitor the quality of the care provided, these were not effective. Visits by the provider to the home to undertake quality assurance checks had not identified concerns relating to the maintenance and cleanliness of the home. A survey of people living at Hilldales had not resulted in improvements or changes to the service. Although the provider reviewed incidents and accidents every six months, there was little evidence that this had led to improvements including a reduction of such events happening. There was very little evidence that meetings involving people living at Hilldales or staff working there, had engaged people in meaningful discussions about how service provided. The minutes of meetings described

This section is primarily information for the provider

Action we have told the provider to take

information being given out, including information about punitive measures which would be imposed on people should they not follow new rules that were being imposed. There was no evidence that suggestions and comments from people living at Hilldales had been acted on.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Notifications of incidents including safeguarding concerns and incidents where there had been police involvement had not been submitted to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not completed all the training needed to ensure they were able to undertake their role effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments The ratings were not displayed at the location.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's consent had not always been obtained before care and treatment was given. People's capacity to make certain decisions had not been assessed.

The enforcement action we took:
We served a Warning Notice